

**Transcript of the Public session of the Council meeting held on Tuesday 2 December 2008 at 1 Lambeth High Street, London, SE1 7JN.**

[NB: Decisions in square brackets and narrow type are taken from the unconfirmed minutes of Council and therefore are subject to amendment].

*The Transcript of the public meeting of the Council is not the formal record of the meeting. The formal record comprises the papers presented to the meeting and the minutes as subsequently approved. The policy of the RPSGB is actively debated at the meeting. The views expressed in the transcript do not necessarily represent the Society's agreed policy.*

**PUBLIC BUSINESS**

**Present**

President	Mr S Churton
Vice-President	Mr M Astbury
Treasurer	Mr A Gush
Mr S Acres	Ms S Agha
Mr G Alexander	Mrs M Allan
Professor N Barber	Mrs C Brown
Mr David Carter	Dr B Curwain
Mrs D Drury	Dr C Duggan
Dr P Entwistle	Mr J Gentle
Mrs S Hikins	Mrs L Jacobs
Mr R Jobling	Mr J Jolley
Mr A Kershaw (until 08/146)	Mrs S Kilby
Ms Y Liddell	Professor B Michell
Ms A Moore	Ms M Saunders (until 08/148)
Mr D Simpson	Mr D Thomson
Professor K Wilson	

**In attendance**

Mrs S Melville, Chairman of the Scottish Pharmacy Board, Mr R Daniszweski, Vice-Chairman of the English Pharmacy Board and Mr P Jones, Vice-Chairman of the Welsh Pharmacy Board

Mr Jeremy Holmes, Chief Executive & Registrar

**Mr Steve Churton, the President:** Good afternoon, Council

**1. Apologies for absence**

We have apologies from Jane Ramsey.

**2. Declarations of interest**

Could I remind members to declare interests at the start of the relevant items?

**3. Welcome to guests**

First of all, could I welcome our guests for today, who are Anne Everden of the Northumbrian Branch, Ben Marks from Barnet Branch, Graham Pickup, Chair of Bolton and District Branch and Paula Wilkinson from Chelmsford and District Branch.

**4. Minutes of the public business part of the Council Meetings held on 7 October and 6 November 2008**

The minutes of the public business part of the meetings of Council on 7 October and 6 November are attached. I take it that we are content that they actually accurately reflect the meetings. **(Agreed)**

**Mrs Alison Moore:** On page 6 of the October minutes, I thought that we had also agreed we would get an opinion from WHO on the subject. I know we agreed those actions, but I

thought we had agreed to ask for their opinion on the use of drugs in those circumstances. Am I recalling that correctly?

**The President:** We can check the transcript and make sure we have not missed that.

**Mrs Alison Moore:** I thought that was an important point.

**The President:** I cannot remember. We can check the transcript.

**Mrs Sandra Melville:** One part on transition, page 3/5, overseeing transition of the leadership body.

**Ms Averil Ridgway, Head of Secretariat:** It is the second set of minutes for 6 November.

**Mrs Sandra Melville:** There was a question about numbers of nominees on the Pharmacy Board. We had a bit of discussion on that and it was not minuted. It was suggested it could be reviewed in the future. There is nothing about that at all in the minutes.

**The President:** We will make sure they go in there. With the exception of those two matters, are we content to accept the minutes? **(Agreed)**

[With the addition noted, Council resolved that the minutes of the public business parts of the meetings held on 7 October and on 6 November 2008 be received and agreed as a correct record.]

#### **5. Matters arising from the public business parts of the Council Meetings held on 7 October and 6 November 2008**

No matters arising have been notified.

**Professor Bob Michell:** Page 8. There is a list of minutes under 8. 127 -- circulated to members of Council, but the Veterinary Pharmacy Group met in June and I do not see that those have been circulated.

**Ms Averil Ridgway:** We do not circulate those through the Secretariat.

**Professor Bob Michell:** Through you, President, that is an issue which we have discussed before, that members of Council should have minutes.

**The President:** I do not recall personally having discussed it before, but I am happy for you to correct me.

**Professor Bob Michell:** It was long before you were on Council. It is an old issue.

**The President:** Is it?

**Professor Bob Michell:** The fact that that group is differently constituted is our only source of information on issues concerning veterinary pharmacy. It is absurd that they meet, they spend time, they spend the Society's money. It is a matter of sheer luck that anybody knows what they are doing.

**The President:** Do we circulate minutes of other groups?

**Ms Averil Ridgway:** We circulate the minutes of committees of Council and the Boards, but not any of the special interest groups.

**Professor Bob Michell:** I do not mind, but it is emblematic that this Society -- which pretends to regulate veterinary pharmacy -- fails to do so, and it something we are coming back to later on.

**Mrs Sue Kilby:** As far as I am aware, IPG are not circulated either. I think it would be very useful for members of Council to be able to see these minutes from the groups -- especially

as we now have the joint website. There is no issue why they should not be posted on the website.

**The President:** Why don't we do that, then?

**Mrs Sue Kilby:** There is issue about veterinary medicines over and above the other groups. We can put them on the website.

**The President:** Let us agree we will put them on the microsite going forward. (Agreed)

[Council agreed that, going forward, the minutes of the special interest and membership groups should be posted on the Council member microsite.]

## PROFESSIONAL LEADERSHIP MATTERS

### 6. New Professional Body Prospectus

**Mr Jeremy Holmes, Chief Executive & Registrar:** I hope everybody has received their copies last week. The first signs are that it has been very well received, and my thanks to Trans Com and the design team for putting it together. It is getting good exposure in the press. I hope Council would have seen the article in *The Chemist and Druggist*, which talked to six grassroots pharmacists, and four out of six gave the professional body as described here 8 out of 10. It is getting good press. The Transitional Working Group, which Council has agreed to take forward the design as laid out in the prospectus, met for the first time and agreed eight work streams. Council members will have received the minutes of the action note from that meeting and the eight work streams, all agreed on 20 November. I have had responses from three Council members as to work streams that they would like to make a contribution to. I am grateful for that. We have had responses also from three Board members, who would like to make a contribution to those work streams. We have now sub-divided one of the work streams on membership services, which is the most substantial of all the work streams, into four sub-work streams, because that is a crucial component, and we are breaking it down into manageable pieces. The next meeting of the Transitional Working Group is Monday 8th. We do not have the opportunity for full attendance at that, but I would like to assume that we can have a deputy for Sandra. I think it is proposed that it is Alastair.

**Mrs Sandra Melville, Chairman, Scottish Pharmacy Board:** Yes, my Deputy cannot come but I hope to join by teleconference. I believe that is possible.

**Chief Executive & Registrar:** If Council is content with that, we have to move with some speed here. We cannot be held up by diaries all the time.

**Mrs Sue Kilby:** If there are deputies for Scotland, I assume there will be deputies for Wales and England as well.

**Chief Executive & Registrar:** If the nominated Board member cannot make it, I would suggest that is a good principle to work to. Are Council content with that? **(Agreed)** One last point to make is that one of the debates that has been going on over the last few days in relation to the prospectus is the position of *Pharmacist Support*, which was formerly the Benevolent Fund. There was a little bit of confusion that arose from the TransCom description, which is on page 9 of the prospectus. It says: "A range of other services, including Pharmacist Support, as the Benevolent Fund is now known, for those in difficult times would be provided by the professional body." Just for the avoidance of doubt, *Pharmacy Support* is a separate charity. Although the trustees have hitherto been named by Council they operate independently of the Council. David Thomson and I have been working on a clarification statement, so everybody is clear about that. David Carter has been helpful on that too. That is the only point of detail I wanted to raise. Thank you for the support and I think we will get a good press on this.

**Dr Catherine Duggan:** I wanted to congratulate the people who took away the comments made by Council last time. It was really gratifying to see how much had been incorporated.

And the final product was something which was really exciting to see, even if you were immersed in it during its inception. I wanted to comment upon the feedback I have had, which follows from what Jeremy was saying. People who have spoken to me feel proud of that document, are excited by it and want to feed back and very much welcome the tear-out sheet and are pleased with it. I have not heard anybody say, "I can't be bothered with it" -- yet, anyway -- and maybe they would not -- but that is a very encouraging sign.

**Mr Douglas Simpson:** I wanted to make couple of general points. The cover says the New Professional Body for Pharmacy. I wanted to declare an interest as a former member of the staff of the Society and member of the pension scheme. It is really the continuation of the life of the Pharmaceutical Society as now. We are sitting in a very nice building in Lambeth. The reason we are sitting in a nice building in Lambeth is that the fathers of the Pharmaceutical Society in the 1840s had the good sense to buy the building on a prime site in Bloomsbury Square, which was sold for about £6 million which financed this building that we are sitting in today. So the Society is a continuum since 1841. It started off as a professional body for pharmacists, a professional association, to raise the status of pharmacists, to raise their education and to create a distinctive profession in the interests of the public.

In the 1930s it took on regulation. It did not really want to. I think at the time William Glynn Jones was the Secretary and Registrar, and he wanted the Government to set up a GMC-type operation. But the Government, in its wisdom, decided it was not going to do that, but would make the Society a hybrid body. Now Government has decided, because of the fashion we are seeing today -- generally speaking because of the way the medical profession has regulated its members -- that representation and regulation can no longer sit in the same organisation, so the Government has decided to split the Society into two, and we are having to carve out a new future for ourselves, minus regulation. But as far as I know, there is no proposal we set up a separate legal entity. The Society will carry on. The Charter changes that I have seen proposed do not propose a change in the name. In fact, it is recognised that the name should continue, because it is valuable in terms of the Society's publishing activity, which is half of the Society's income and turnover, and is therefore a very important part of what the Society does. A lot of staff will carry on doing what they are doing at the moment, under the same terms of employment. Of course, the regulatory staff will go to the new regulatory body, but the non-regulatory staff will carry on doing a lot of the things they have been doing since the beginning. A lot of these things are very valuable: things like the library, which was the first thing the Society set up in the 1840s; the museum activities; representing the profession, conferences. All these things will carry on. What we will see in the future is a new body -- in the sense it is not the body that exists at the moment which has regulation -- but a body which will build on the representative side, the professional association side of the pharmacy. I am sure it will be immensely attractive to members. I want every member to join. Our exercise now is a retention exercise to retain as many people as possible who are existing members at the moment. I know from branches that I am speaking to, there is a lot of goodwill for pharmacy. The President has apologised on a couple of occasions for what the Pharmaceutical Society has done. I worked for the Journal for 34 years and I am not apologising to anybody for what I did on the Journal. The Journal is a fine journal, a fantastic journal and there is no reason to apologise for that.

The apologies come as a result of the regulatory activities of the Society, and the Society has again been following the fashion of the age, where regulation has become much more systematic and is across all the health professions. A simple complaint can no longer be dealt with in a semi-informal way. It has to go through this fantastic machinery, which causes an awful lot of ill-will until the complaint is resolved. An awful lot of members feel that they are caught up in this sort of grindstone, if you like. I would say it is that that has brought about the unpopularity of the Society, the regulatory activity. Again, it is the Society following the fashions of the age.

The Society itself is not regulated badly, funnily enough. It is the medical profession that has let everybody down and the Society has been caught up in this.

One other point I wanted to make was concerning the negotiations; the work stream that Jeremy mentioned. He talked about the negotiation starting with third parties, their

engagement with the reformed Society. I am very concerned that these negotiations have started before we even know who it is being negotiated with. We are the governing body of the Society. In any ordinary way, the board of directors of a company would not start negotiations unless the board of directors knew who it was going to be negotiating with. So I think before any negotiations start -- obviously the College of Pharmacy Practice -- and I personally have no concerns about the College being welcomed back into the Society. It has been created by the Society and I am sure it has a future as part of the Society family in the future. But before any of these negotiations start, I am sure the Council should have a list and approve that negotiations should take place.

There are two things really. The main one is to make it clear it is the Pharmaceutical Society in a new age that we are talking about, not a new body. And the other thing is that we need to know who the negotiations are going to be held with before they start taking place. Thank you.

**The President:** Just before I ask Jeremy to comment, can I remind everyone that we are in public business.

**Mr Douglas Simpson:** I know we are.

**Chief Executive & Registrar:** You are right, Doug, that there is a work stream on discussions with third parties, and they will be fully reported into the Transitional Working Group and the action notes from those meetings will be available on the microsite.

**Mr Douglas Simpson:** I think the Council should decide before these negotiations start. We have been left behind on an awful lot of things on this particular body, in my opinion.

**Chief Executive & Registrar:** Before we get to point of serious negotiations, there is a process of informal and increasingly formal discussion. Indeed, that process has already started, because a number of those organisations who put their hands up and said "We wanted to be part of the new professional body," have engaged in dialogue through TransCom and indeed with the President and myself. So those discussions are already underway, but that will be fully reported at the Transitional Working Group. At the point where there is the prospect of a real commercial negotiation, that will be reported back to Council, over and above the standard action notes in the Transitional Working Group Reports.

**Mr Douglas Simpson:** My concern is that a lot of people have talked about wanting to join the new professional body, and there has been loose talk in papers of partners, which implies some sort of legal link between people. Again, I am not aware of any partnership agreements being drawn up in any formal kind of sense. My concern is that the new professional body should be able to operate in a clean, lean and effective fashion. I am very worried that we might find all sorts of people want to park their administrative work on us, so their particular special interest is taken care of. I am worried about the new professional body being burdened with an awful lot of administrative work to look after special interest groups, when it should be focused on the main target of the successful launch of new professional body, in clean and lean fashion.

**Chief Executive & Registrar:** I am very supportive of clean and lean.

**The President:** You are correct, Doug. Council will have involvement as Jeremy has said before any firm commitment is given to bring people into the new organisation, Council will be consulted, absolutely. But that is not within my remit or Jeremy's remit to take that decision.

**Dr Brian Curwain:** I wanted us to remember that although the name is not changing, and the body has been here and the building will remain, what we are seeing for the Royal Pharmaceutical Society is a substantial step change in its culture, its objects and in its main focus. That step change is being pursued vigorously, energetically, skilfully and very positively. I would not want us lose sight of that.

**The President:** Any more comments?

**Mr Douglas Simpson:** When I think of the people I have worked with over the years, and they have been working in a positive way, thinking of the members all the time, first and foremost. There is a step change in the sense that regulation will be going, but a lot of what we are seeing now is a development of what has been going on for many, many years, with great energy on behalf of members.

[Council agreed that deputies could be designated for Chairmen of the national pharmacy boards unable to attend meetings of the Transitional working group, and noted the report.]

## **7. Pharmacy Practice Framework**

**The President:** We move to item 7, Pharmacy Practice framework. We talked about this at the Council meeting at Cardiff, and subsequently the Education Committee under Sue's [Mrs Sue Kilby] chairmanship has reviewed and made some recommendations, which members will see tracked on the copy at Appendix 2. Those tracked copy amendments are both amendments which were requested by Council in October, and also the subsequent changes that the Education Committee asked for.

I do not think we would benefit from a long debate again about what is in the document. Therefore I think we should move without much hindrance to consider, approve and agree the publication of this framework, (i), (ii) and (iii). I am happy to take any comments people have on the tracked changes only, please.

**Mrs Sue Kilby:** This is not on the track changes. There is another issue, which has been taken up with Jeremy. I guess Bob is also going to mention it, because we have been approached by the Chair of the Veterinary Pharmacy Group. I admit it is my error as Chair of Education. I should have viewed it from this perspective, but the concern was that there was not any mention of veterinary pharmacy medicines within the documents, although it could be applied, if it is also relevant to it. The trouble is that if there is not the word "veterinary" somewhere in the document, it might be totally overlooked. I would not want to delay the publication of this paper in any way, but I wondered whether it could be included somewhere to actually give the impression that it is also relevant to veterinary medicines in pharmacy. The reason why I say it is important is, firstly, I know it is unlikely but it is possible that any day one pharmacist in a community pharmacy could be faced with a veterinary pharmacy script, and therefore needs to be aware of the regulations and needs to know what they should not be doing, as we do not want them before the fitness to practise mechanisms. Secondly, anybody could come in and be asked to advise on a commission which could be linked to... **(Inaudible)**

Thirdly, we have got an increased number of products that are available over the counter in pharmacies, such as Frontline. We are aware that one of the major wholesalers, UniChem, will be storing veterinary medicines within their wholesaler chain. Therefore, I think it is important that pharmacists should have a basic understanding and awareness, and know where to go to get further information around veterinary medicines. No-one expects them to be an expert in this area, but they do need some knowledge and understanding. That is why I am asking. I know I should have picked it up and made mention of it at Education Committee, we did not have a veterinary expert on the Committee.

**Professor Bob Michell:** President, I know you do not want to discuss what is in it. I want to discuss what is it 'not' in it, because it is so emblematic of what we have come back to again and again, which is that the Society pretends to regulate veterinary pharmacy. It does not, and it is not interested in the fact that it does not. Now this document, according to the minutes, is intended to provide a foundation for the development of an advance framework in key areas 'like' veterinary pharmacy." It actually says that in the minutes which we received today. I do not want to be boring about this, but I would like you to look at pages 46 and 47 of 51. If we look at page 46 at 4: "Pharmacists have a key role in working with the patient to assess their health status and needs." Or, on page 47: "Activity 3: to evaluate the patient's signs, symptoms and health parameters as appropriate." Do not bother to turn your page, but on page 39 the pharmacist "should be in a position to discuss and agree therapeutic objectives," or on page 18 "to monitor and modify therapeutic approaches." Lastly, on page

15, this is supposed to reflect "core practice in all sectors."

The fact is that when page 30 speaks of safe practice in any sector from day one, the Society is in no position to assure that their members -- their registered members -- have any verifiable competence in the use of medicines in dogs and cats. If you do not believe it, do a survey and find out how many pharmacists have had any training whatever that relates to the use of medicines in dogs and cats. And then, in the subsidiary question: How many have ever answered a single examination question on this topic? We are in dereliction of our duty, and the day that there is a high profile court case (if there is), and if it happens while this Society exists, not only will the Society be in deep water, but so will every one of us as Council members, very repeatedly made aware of this and failing to do a single constructive thing about it.

**The President:** Do you have a suggestion, Bob, as to how we might integrate your requirements into this document?

**Professor Bob Michell:** I personally will reject this document until there is a competent section on the responsibility -- the burgeoning responsibility -- of community pharmacists, with special regard to dispensing of companion animal medicines. Because, as we have said many times before, pharmacists working with farm animals and horses -- it is a different thing. They know who their clients are. They do not just come in at random. They have had appropriate training. They know what they are doing. We are talking about community pharmacists increasingly exposed -- with Government encouragement -- to prescriptions for companion animals medicines who have no -- not just slight, but no -- verifiable competence. The first duty of a regulator is to ensure that their members have verifiable competence. Not competence; it just stems from, "Well, I think I am competent."

**Professor Nick Barber:** Just to say that I am an external examiner in various universities. Over the time when I go, I have to sit through the dispensing exam, as it is a requirement of the Society, and I normally see a veterinary prescription there. So in terms "can they dispense a veterinary prescription legally?" I cannot say for all schools of pharmacy, but certainly my experience is that they do have that and do that.

**Professor Bob Michell:** I am sure many vets have seen a human prescription.

**Professor Nick Barber:** They have been tested on it. It is part of the dispensing exam, which they have to pass to qualify as a pharmacist. If they do not pass that exam, they do not qualify as a pharmacist. It is on the critical path.

**Mrs Margaret Allan:** I would like to draw attention to page 26, which is the glossary of terms, which actually describes what medicine is, as the terminology of medicine is being used throughout the document. I refer to the last sentence, which states: "A medicine can be for human or veterinary use."

**Dr Sue Ambler, Education Policy Lead:** We are in public business and it is incumbent on me to say that the accreditation standards and criteria in all the schools is very explicit about veterinary medicine. I am very pleased to hear Professor Barber say that he has seen it assessed. That is the way veterinary medicine is dealt with, and we are assured that when people join our register they can do that. In relation to this document, no specialties are mentioned. It is intended to be a generic document, so that it can be read, understood and applied across all sectors of the profession. No-one has been singled out, and that was deliberate and made very clear to the Veterinary Pharmacy Group when I went and spoke with them twice. I guess I can either take it away and write a document for every specialty, or we can agree that it stays as it is -- as a generic document, referring to the generic activities of the very early years -- or I can go away and several documents can be written, as we have indicated, for specialty areas, which would be an absolutely sensible thing for every group associated with the professional body to go away and do. If we write these in as day one, then I am afraid we are going to have to revamp the entire undergraduate curriculum. When you see the standards the next time around, Professor Michell, as I have given my word of honour -- and I have never done anything to make you not trust me on this -- there would be

exactly the same requirement around knowledge, knows and knows-how that there is in the current accreditation system and standards against which every MPharm programme, new and existing, is accredited.

If we start taking this away now, I will have to write one for the industrial pharmacists, one for the veterinary pharmacists and one for every specialty in the room. That is not what this document was ever intended to be.

**Mrs Lorna Jacobs:** I am cautious about entering this debate, but would it be possible to judiciously add some words to make it clear that "patient" -- which I think is defined as "any user of health care" -- includes animals? Would there be a few other places where a few extra words inserted would make it very clear that it related to animals? Would that be feasible rather than, as Sue is saying, writing a whole extra document? I ask the question.

**The President:** That is a very constructive suggestion. I do not know how Sue feels.

**Dr Sue Ambler:** To redefine "patient" in the glossary would be easily done.

**Dr Brian Curwain:** Can I just interject, because the patient definition is helpful in the document as it already is. Because it says it is: "Any health care system that includes the representative or other properly authorised person, if the patient is not competent to understand the needs of the pharmacist." So if it is a cat, it is the cat owner. **(Laughter)** Seriously; this is what it is saying.

**Professor Bob Michell:** We are still, after four years, dancing on the head of a pin, shirking our responsibilities. Okay, they may have seen a veterinary prescription, but I ask again, in the terms of this generic document: how many pharmacists confronted with a dog or a cat can -- I quote "evaluate the patient's signs, symptoms and health parameters as appropriate"? And I quote: "Can they discharge a key role in working with the patient - their owner, in other words - to assess their health status and needs?" We all know they cannot. I do not think that the Veterinary Pharmacy Group have actually seen this document.

**Dr Sue Ambler:** They have, Professor Michell, on several occasions.

**Professor Bob Michell:** I do remember when you came to talk to us, and I do not see that any of that feedback had any impact on this document. I think this document will be a concrete block around the neck of the Society as a regulator if and when there is a high profile case where a pharmacist is in error and the owner of the dog or cat can afford an expensive and good barrister.

**Dr Sue Ambler:** Can I say that when I left the Veterinary Pharmacy Group I undertook to talk to the providers of preregistration training to see whether or not they had a sufficient caseload that we could make that assurance you are asking for now. Whether rightly or wrongly and it is a chicken and egg questions, to use a veterinary term, there are not enough cases going through the pharmacies for the pharmacy tutors to sign off that level of competence. That is why we cannot write it in here. That would be an absolute dereliction of duty you are quite right. The solution that I put to the Veterinary Pharmacy Group was that they wrote a separate document that tied into the additional qualification, and what they needed to do was to make sure that once there are enough cases going through, that the tutor can sign somebody off and say "they have seen, they know how and they do." We can then write it in there as a "does" competence on day one. But until we reach that point, we have no way in teaching, learning or assessment terms to deliver what is wanted by the VPG, so we have to find another solution which was: "You write a separate document which ties in with the specialist training, you make sure you are putting forward the right case to get the right number of people who can then tutor and assess" But until we are in that position with the assessment, we cannot write it into the final Framework at the moment.

**Professor Bob Michell:** I think that proves exactly what I am saying: they are not competent to dispense.

**Dr Sue Ambler:** They can dispense.

**Mr Douglas Simpson:** Since we are in public business, perhaps we ought to be reminded of the restrictions of anyone other than a veterinary surgeon being involved in the diagnosis of animals. Perhaps Professor Michell can remind us of that.

**Professor Bob Michell:** That is another issue; that technically, diagnosis of an animal disease is something that is restricted to a veterinary surgeon, whether that would now stand up in a court action I think most veterinary surgeons would recognise is open to question, because there are a number of diagnoses which essentially flow, almost without question, from laboratory data. But Doug is right: technically a diagnosis of an animal disease can only be done by a veterinary surgeon. That is quite right.

**Chief Executive & Registrar:** Can I reinforce Sue's point, which is the opportunity for a separate but complementary document, authored principally by the Veterinary Pharmacy Group, because this is a big topic. When the document is written I think it should cross-refer to the practice framework and vice versa. I think that is the way we should handle it. I think trying now to manipulate this, in the nicest sense, to reconstruct the wording of this would be a suboptimal solution. I think there is a better solution, which is a separate but complimentary document, that cross-refers to this.

**Professor Bob Michell:** I accept that, but I think this must refer to the fact that that document exists.

**Chief Executive & Registrar:** Yes.

**Mr Andrew Gush, the Treasurer:** We have had a major discussion on one small part of the document. I just want to say in public I think it is a very good document. Well done to Sue and the team.

**Mr Martin Astbury, the Vice-President:** My comment is on what Bob has said -- and I understand his concerns -- in public business that he feels we might be in dereliction of our duties. I do not want to cause any conflict, but I would like to be assured by staff that as far as we are concerned -- and I think I know the answer -- the Council is not in dereliction of its duties. I want to get that on the record.

**Chief Executive & Registrar:** Not at all. I think Sue's and Nick's comments reinforce that.

**Mrs Lorna Jacobs:** Taking up the Vice-President's point, what I understand Sue is suggesting is a separate document which I think -- and maybe I misheard -- she was suggesting was specialist or advanced practice; whereas my understanding is that this document relates to a day-one pharmacist. I am trying to get clarification in my mind of our duty as a regulator. As people come in at day one, are they or are they not competent, and is that encompassed in the document? Sorry if I seem to be slow.

**Dr Sue Ambler:** This document is not the standards document. The document you need to worry about is in the next set that will come to you, which will be the education standards documents. Those are the ones which the visiting teams use when they visit the schools of pharmacy. They are also the ones that will drive any changes in the exam and pre-registration syllabus. Those are the ones against which providers will be judged. There is a section in there which, as Professor Barber says, is about dispensing. I cannot sit here and say to you that pharmacists will be able to do all of those things for humans, let alone animals, if we did we would be writing a medical, veterinary and pharmacy curriculum. That will not happen. There will be enough in there, there has to be, to allow pharmacists to do what they do, which is to dispense for veterinary practice. What you are seeking, and what happens on the post registration veterinary course, would have to be pulled back into the MPharm/pre-registration year, by that stage, we will probably have specialist registers or the General Pharmaceutical Council may have specialist registers. But you will see knowledge in the standards and can demonstrate that they can dispense a veterinary prescription at a "shows how" level. There will not be anything in there that will say they will be a vet.

**Ms Marcia Saunders:** I wanted to support Sue's responses. I think Jeremy's proposal is very sensible. I would like to formally propose that we agree to publish this, and that the covering press release can make mention of subsequent documents.

**The President:** Is there a seconder for that? **(Mr Ray Jobling)** Thank you. Could we therefore agree as Council to approve and agree publication of this practice framework with the tracked amendments on that basis? **(Agreed)**

**Mr David Thomson:** I have issues with two aspects which are minor details. On page 16 in the first paragraph, the last wording "but this English document is particularly key and explicit." I do not think that comment necessarily helps the previous discussion. I would suggest that it is removed from the text and that the sentence finishes with "Northern Ireland". It is page 16, the top paragraph at the last line. And the other bit I mentioned on SNC at a previous discussion. I am grateful for it being included. But on page 32, at the last line, it might be appropriate to include SNC as an example, as we have references in the glossary, but we have not demonstrated an example of it in the text.

**The President:** Are there any amendments that people want to see, outside the veterinary discussions we have just had, along the same lines as David's? **(None)**

**Professor Bob Michell:** Just as a matter of fact, veterinary pharmacy is no longer a specialist activity. That is the point. That is where things changed three years ago. It used to be. Pharmacists used to choose to dispense prescriptions for farm animals and horses. It was as a direct result of a Competition Commission report and its implementation that it is now expected that community pharmacists should be able to dispense companion animal prescriptions. It is no longer specialist. That is why the Veterinary Pharmacy Group is so exercised by this problem.

**Mr Ray Jobling:** Sue [Ambler] drew a distinction between the practice framework document and the standards document. Bob feels passionately about this and clearly there is a group position on it. Surely the way forward is for them to have some input into the process going forward to the standards document, because that is what will count, in terms of what is accredited and what goes into examination. I think that is Bob's point. He should continue, but put it into that part of the process -- he 'will' continue, but put it into that part of the process. Then we all have something from the discussion.

**The President:** Just so I am clear, I was suggesting that that input into the standards documents supersedes, if you like, the suggestion made from Jeremy.

**Mr Ray Jobling:** I was really speaking in support of Jeremy.

**The President:** You are talking about the same document. Fine. On that basis, can we agree as Council, to approve and agree publication of the practice framework? **(Agreed)**

2 (iv). Sue, can you take us through the timetable, please?

**Dr Sue Ambler:** Over the summer we were running the two projects in parallel, reading across from this document into the review of the standards. It is not the only input to the review of the standards; that is why we have got a bunch of educationalists and pre-reg. providers sitting around the table. But this is one of the key checks that the outcomes that we have claimed in here on day one are unfamiliar; either "shows how" or "does" at the point of registration. We have got as far as we can and then held off until the practice framework is finally signed off. There will have to be a set of meetings to get the drafting group to complete their drafting. Then the normal process would be that they go to the Education Committee and then come to Council for sign-off, to go out for wider stakeholder consultation, which of course will include the same people who have commented on this. At this point, we will be talking about the very details of what knowledge, skills, attitudes and values are going to be taught, learned, assessed and when across the five years.

That would be the traditional process and that would normally take six months, if you include three months' consultation, time to analyse the consultation, write the consultation analysis, make any changes, bring them back to Council or go back to Education Committee and then bring it back here for sign-off by the Council and adoption by the Council of the Society. That process has been delayed and it is likely now that that process will run over and overlap with a similar process that will be undertaken by the General Pharmaceutical Council, or the shadow Pharmaceutical Council, for it to set up and have its own standards. So rather than just carry on, those on the regulatory side feel a tiny bit concerned that that posed a real risk. So I have recast the timetable, and there are several options that Council can consider, which are laid out for you on pages 2 and 3.

There are a couple of things that you might want to think about. One is the length of consultation. The Cabinet Office guidelines and best practice are three months, and I really would advise that you stick with three months, for all the reasons that we have just had. There will be debate. There will be a lot of angst about this. If we do not listen to people, hear them and clearly articulate what we have and have not been able to take on board this discussion we have just had will be a minor irritation.

So I would not advise that you go for less than three months' consultation. I think that would send out all the wrong messages. So if you are going to truncate the process, I would not suggest that you go there.

The other problem we have is that the Education Committee meets in January. There is no time to get things finalised between now and then. It does not meet again until May. We have put in a couple of options of what we might do to still have Education Committee's input and still be able to bring them back to Council for sign-off and implementation.

The reason why the Education Committee cannot put them out for consultation itself is because the Committee has its own statutory accreditation responsibility. It is not good practice to have the standards set by the committee that makes the decisions. So that is quite different to the Law and Ethics Committee, where those two things are separate.

We have set out some options for you. I think options (i) or (ii), and (v) and (vi) are the preferred ones, because they stick with the three months' consultation. Options (i) and (ii) allow for the input of Education Committee, which I think you would find helpful before you consider it. Of those, there are two options: (i) which would allow us to start consultation before the Education Committee, and then come to Education Committee in May. Or alternatively, to have a minuted teleconference with Education Committee -- because I am on pain of death not to agree to another full meeting of Education Committee -- around February or March, and then bring them to Council hopefully in March, otherwise in June.

At that point, before we go out for consultation, we may want to reflect where the GPhC is in its work, and think about the wisdom of having two sets of standards out for consultation at the same time.

**Mrs Sue Kilby:** First of all, a couple of points. Thank you, Sue. Obviously, it is really important that Education are involved and kept in the loop -- in fact, I think it is essential. I know that you are saying that the standards will not be ready for January. I am wondering how far off they are; whether there is a possibility to see them in some form of draft format before the actual January meeting -- with the acceptance that they are not in the finished format -- bearing in mind there has been very little change in the Practice Framework since the last Council meeting and this. So it will not have made fundamental changes to the standards development process anyway. I wonder whether it is possible to see them in a rough draft version, on the understanding that there might be some changes in January. I have tried to ring people -- although I have been busy with my daytime job -- and personally I think there is no reason why we should have not a teleconference. I would like to agree to take a teleconference -- unless the rest of my Committee say they are not happy. I am used to doing international calls, as Jeremy would have done. For me to do one is not an issue. I am aware everybody has very busy diaries, and it is not possible for everybody to get to Committee meetings. Given the expertise we have on Education Committee I think it is

important to engage with as many people as possible. First of all, I would like to know would you be able to get a rough draft to us in January, bearing in mind there is six weeks between then.

**Dr Sue Ambler:** Yes, if it is going to serve a purpose. I am happy to do one.

**Mrs Sue Kilby:** A working document.

**Dr Sue Ambler:** You can have it as work in progress, provided it is clear that is what it is. In terms of the teleconference we can look round for a date in the diary as soon as we can.

**Chief Executive & Registrar:** Just to clarify, we are really talking about option (ii) here, which involves a teleconference with the Education Committee.

**Mr Ray Jobling:** Just to comment, I am not enthusiastic about the teleconference. I think it is not the same at all as being able to sit in a discussion and read the body language and that kind of thing. If it is the general view that we should go for that, then I will favour it. Having a draft in January is a good idea. We need to have it in ahead of time, so that cuts down time -- and other events will intervene. It is compressing it, but we must push on with it. That is the thrust of what is being said from here. So whatever is necessary, but my own view is that I do not think a teleconference meets the task.

**The President:** We have a commitment from Sue to get the draft for January. We are being recommended towards option (ii). Does anybody want to speak against (ii)?

**Mrs Alison Moore:** I am not against it, but just to ask: if you are getting a rough draft version in January, do you still need a teleconference in February rather than to rubberstamp any little changes that might have happened? It is not going to be a major teleconference if you actually get the chance to discuss the meat of it in January.

**Mrs Sue Kilby:** The reason I suggest a rough draft is that we could get agreement over most of it. Because it would have gone back to the drafting group, I would expect there would be some changes and they will need to finalise agreement. But it will not be such a long process as if we had done it straight way. That is my thinking on it, but we still need something pencilled in.

**Dr Sue Ambler:** There is one caveat I would make. If we do bring them to the Education Committee in January, and we have not managed to get a meeting of the drafting group before then, if the Education Committee said they want "this, this and this," I could not tie the Drafting Group to that. They have to sign off and be happy with it. It would just be for noting and work in progress in January.

**Mrs Sue Kilby:** At least you would have our thoughts on the process, which would hopefully support what you doing anyway, Sue.

**Dr Sue Ambler:** That is fine, as long as we are clear that we cannot hold the drafting group.

**Professor Keith Wilson:** I wonder does it have to be option (i) or (ii), because if the draft proposal came to Education Committee in January and it could feed comments back, then the consultation could go ahead and you could then come back to Education Committee in a considered way in May, and so meet the target for (i). That allows Education Committee to meet as a group. I do agree that there is value in interaction between people on the group, because the Committee has to be more than the sum of the individuals connecting by phone.

**The President:** So you are suggesting a hybrid between (i) and (ii). Is everybody comfortable with that?

**Mrs Margaret Allan:** I do not understand what Keith is saying. It has to come back to Council, does it not?

**Professor Keith Wilson:** It does, yes. But option (i) is that the draft goes to Education Committee in May, but to speed the process the Education Committee could give some initial feedback and go straight into the consultation. Then you get the best consideration of it, both through the consultation and Education Committee being able to come back at the end.

**Dr Sue Ambler:** We could start an informal consultation. So we could perhaps start bilateral meetings with the Veterinary Pharmacy Group, and some of the special interest groups internally, and start to get a sense of whether or not there are going to be problems. You cannot start the formal consultation until the Council signs it off now, you are right.

**Mr Ray Jobling:** It sounds a better process. Keith's suggestion is very helpful. It makes for better consultations to proceed in that way. You still come up with the outcome at more or less the deadline.

**The President:** It seems we are coming up with a hybrid solution between option (i) and (ii).

**Dr Sue Ambler:** Can I check that we will take an initial draft of where we have got to in January; whether or not we have been through the Drafting Group to Education Committee. Then we will start informal discussions, perhaps with special interest groups internally, and go to formal Education Committee in May, then Council in June and out to consultation at the end or the middle of June. Thank you.

[Council approved (i) the final draft of the Practice Framework; (ii) agreed the publication of the Practice Framework, and (iii) the following timetable for the preparation of and consultation on new Education Standards based on outcomes derived from the Practice Framework. January 2009 initial draft to Education Committee (whether or not Drafting Group had been able to discuss); February/March informal discussions with special interest groups internally; May Formal consideration by Education Committee; June Formal consideration by Council; Mid-June Consultation]

## **8. Professional Body Assembly and National Pharmacy Board structures**

**The President:** If we could move to item 8, paper 117.

**Mrs Christine Gray, Head of Corporate Governance:** This paper builds on your discussions at the Strategy Day on 21 November, when we looked at the route to the Assembly and Board structures for the professional leadership body. At the meeting, there was general support for the first three points in the recommendations. So:

- (i) that the National Pharmacy Board Election Scheme should be amended for the 2010 elections, so as to allow Council members to stand for the Scottish and Welsh Boards, and also to reflect the future board structures, while taking into account what each board will require;
- (ii) that all NPB members should be asked to stand down in 2010 for those elections; and
- (iii) that draft new regulations, and a new election scheme for the NPBs should be prepared but not made in advance of when regulation transfers to the GPhC, so they could be put in place quickly by the professional body then.

Could I ask whether there are any comments upon those three points first?

**Mrs Alison Moore:** Paragraph 2/7. You have 1(a) and (b). It does not say in the things that we are agreeing. It was just to clarify that if we agree this, we are not necessarily agreeing that there will be sectoral arrangements put in place. We are agreeing that whatever is decided will be the structure for new professional body will be reflected in the Boards. Is that correct?

**Mrs Christine Gray:** 2.7 is seeking to reflect the discussion at the Strategy Day, but yes, we would aim to reflect in the revised election scheme for the 2010 elections arrangements, as far as possible the proposals for the future boards at that stage.

**Mr Peter Jones, Deputy Chairman, Welsh Pharmacy Board:** Could I clarify that point 2, at the end of the regulations to allow Council members to stand for Scotland and Wales. But it is the timelines -- are we then saying that if the professional body is not in place by then, that those elections will stand for three years?

**Mrs Christine Gray:** That is point 4. We have not got to that yet. Point 2 is simply that all people who are on the National Pharmacy Boards, at that time that the election takes place in 2010, would be asked to stand down. This is in response to concerns raised that to date people have been elected to, and have voted in, the Board elections on the understanding that it is to fulfil the role as a Board member; whereas in 2010, people should stand and vote with the understanding that people who are elected to the Boards may also serve on the Assembly of the future professional body, which was the reasoning behind the suggestion that all Board members be asked to stand down for the 2010 elections.

**Mrs Sandra Melville:** Under 2.7: "The new professional body members elected in June 2010." Will they be elected under the old Society system of elections and that electorate, or will they be elected by the new professional body under regulations by the future electorate?

**Mrs Christine Gray:** In the 2010 elections, i.e. the elections that will be kicking off in January 2010, we anticipate that will be the Society's electorate, because we do not anticipate that we will actually have the professional body electorate in place to run those elections. The professional body electorate cannot exist before day one.

**Mrs Sandra Melville:** Is there not a danger, if they are serving a single term of two years or three years, that you then have a body in place that do not actually have the proper mandate, because the people who elected them are not the current electorate?

**Mrs Christine Gray:** That is point 4.

**Mrs Lorna Jacobs:** My point is exactly the same, in that I thought point 4 was this. I am a little confused. My concern is to ensure that whoever is elected in 2010 by members of this organisation do not have up to three years being on the Assembly of a new organisation.

**The President:** We will come back to point 4 in a second.

**Mr Martin Astbury:** This gives a bit of a mandate to those people and makes them aware of the responsibilities they are taking forward, for that interim period. But you are right, it does not give them a full mandate; that would come in point 4. This would give them some sort of mandate going forward.

**The President:** Could I ask Council to agree to (i)? **(Agreed)** (ii)? **(Agreed)** (iii)? **(Agreed)**

**Mrs Christine Gray:** Moving on to point 4, once the professional leadership body has put the new Boards' regulations and election scheme in place, all Board members would need to stand down again at some point to allow the membership of the Boards to be elected by the professional body members; i.e. by the new electorate, and under the new regulations and new election scheme.

There were three different suggestions made at the Strategy Day for the term of office for those elected to the Boards in the 2010 elections. This is bearing in mind that at this stage, we do not know when day one will be. The three options are set out in paragraph 2.5. The three that were suggested -- and obviously another option could be suggested, but this is what was discussed at the Strategy Day -- were: Two years from taking office (i.e. until June 2012) or the period between taking office and day one, plus two years from day one; presumably with the caveat that all together that could not be more than three years; or to say up to three years from taking office, but on the understanding that when the Assembly requests, all the Board members will stand down, so it is essentially when the Assembly is ready to go ahead with the elections under the new regulations. So seeking the Council's views on the terms of office for the Board members elected in 2010.

**Mr Martin Astbury:** Here is the fourth option. It is one of the hybrid models. If you look at the third option under 2.5 it is changing it up to two years. So it would read up to two years from taking office, with the understanding that new Pharmacy Board members would stand down at the Assembly's request. That is to cover the exact reasons that we have a group of people who have a mandate -- as good a mandate as we can give them -- but they need to move as quickly as possible to the new mandate, by those who have voluntarily joined the new professional body. It gives them the flexibility of using up to two years, but two years is plenty of time. I would hope they would do it within one year, but it gives them flexibility. I do not believe they need three years.

**Mrs Christine Gray:** Two years should be easily enough. If you say up to two years, there is a potential risk attached to that, in that we simply do not know at this stage when day one will be, so how much time the Assembly would have to get the new regulations and election scheme in place. So it would be safer to say up to three years, because you know that is the normal term anyway in the expectation; that it might happen, say, after a year. But it is up to you just to bear in mind that there is a risk associated with a smaller length of time, because we just do not know when day one is at the moment.

**Chief Executive & Registrar:** If things run very late.

**Mrs Christine Gray:** We just do not know what will happen between now and then.

**Mr Martin Astbury:** I accept that. But if we accept that, then it means we do not have the options where we have one option, which is the third option. You would have to discount the first two options as well, under those circumstances.

**Mrs Lorna Jacobs:** Taking up that point, I think it is the middle one which takes that into account, which is the period between taking office and day one, which could be as long as a piece of string. Then this option says: Plus two years from day one. My concern would be that that period to have a whole group, a whole assembly, who are elected by RPSGB members, sitting for two years (or up to two years) for the Assembly for the new professional body, I would be very concerned about. So the period between taking office and day one, plus a shorter period, so that that assembly has got an obligation to have an election of at least some of its members -- maybe this is the point about having a rolling membership, so you do not want all your membership of the Assembly to go at one point anyway. So there is within this an obligation to hold an election within a year, perhaps not of the whole group.

**Mrs Christine Gray:** The work involved in holding an election for part of the Boards would be no less than to hold an election for all the whole of the Boards. You would still have to make the new regulations and the election scheme. So I would think if your concern is that the Boards should be as soon as possible, elected by the professional body members, then it makes sense to suggest that everyone should stand down for the first election under the new regulations and election scheme for the professional body. You could adjust the second option in 2.5 to say something like the period between taking office and day one, plus up to two years from day one. I do think there is a difficulty in having such an indeterminate term of office, in that we just do not know what the period between taking office and day one might with. It could end up being longer than you think.

**Mrs Alison Moore:** I was going to comment along some similar lines to both Lorna and Martin, in that I think it is quite important that we have the new mandate as soon as we can. It is trying to think of a way of phrasing this, that gives that flexibility. So you get a little bit of continuity but you get the new mandate as soon as possible. I suppose I am wondering why there is that length of term. If you are going from day one, plus two years, if you are going from day one why does it have to be two years? If we know that the regulations will be drafted, that we are just asking the Assembly to agree them -- and we will have seen them in advance -- why do you need such a long time? My other question is, if we are covering our backs to try and give them flexibility, is there an option of putting a caveat in to say, "It is expected that this will be no longer than 12 months"; just to give them a push to say, "Look, we are expecting you to re-elect people quickly. We understand there might be some

technical reason why it might take longer, but that is not what we are expecting.

**Mrs Christine Gray:** The Council could certainly make a statement that they would expect that the Assembly will move to hold the first elections under the new regulations, within a year of day one. It is just for safety to have a longer time. We are saying now, the regulations and elections are going to be prepared in advance. You just do not know what might happen to cause a problem with that, for example. It is simply for safety. But there would be no problem in making a statement that the expectation was that it would happen within a year.

**Mrs Sandra Melville:** I feel it is important. There has been a lot of debate in the press about whether this is a new professional body or not. It is important that we put out that message, if you have people in elected positions, being elected by the old Society under the old Society rules, and they do not have the proper mandate by the new professional body -- I think what was agreed at the Strategy Day and what we are agreed on, is that it is important that we reflect that these elections should be held as soon as possible. I think that is really, really important. There is possibly a danger that if you leave that for the old or shadow assembly to decide -- you will forgive me, but at this time of year -- it is like asking turkeys to vote for Christmas. Our members are not stupid and they will pick that up.

**Dr Brian Curwain:** I declare an interest that I am an elected member of the English Pharmacy Board, and thus being asked to stand down in 2010. You need to take my comments with that as background. I read the paper and thought, "This is complicated," and listening to the debate, and so on. I take the argument that the present members of the English Pharmacy Board, Welsh and Scottish Boards have not been elected on the mandate for the new professional body. I think we have to echo Sandra's feelings, that the sooner the election is held the better, under the new rules, and so on. The other issue about asking people to stand down at this point is because we apparently on the Boards have not been voted on as potential Assembly members, or Council members, or what have you. I suppose that is a very watertight argument in theory, but in practice I doubt the voters understand the difference in skill set required. I think it is a sophisticated argument that we can take as such. I suppose my feeling is that what we are asking essentially is to have quite a lot of elections quite quickly, two lots of people standing down quite soon after they have just been elected, and why are we doing that? Would it not be simpler to move things in place, and insist that the new body -- and this will insist itself anyway, I am sure -- elect people as soon as it can afterwards. Also bearing in mind Christine's point that we really do not know when day one is going to be yet.

**Mrs Sue Kilby:** I want to support what Sandra is saying. I think we are going through a big step-wise change. I hope we will still be based on the heritage that Doug has been talking about. But it will be a very different organisation going forward. We are not in a position to dictate to them what we want. We can only advise and suggest. We do not even know how many members will be retained for the new organisation. We do not know what financial commitments they will have either, because it will depend on the membership as to what they can put in place. So we are in a very difficult position. All we can do is advise that the advice of the old Council is that there should be elections as soon as possible, in whatever format is appropriate to the organisation going forward. Because it will depend on the membership, because that will dictate the resources and what is feasible for the new organisation as well.

**Dr Catherine Duggan:** I have to declare that I was not there on 21st, and I know that these documents always arise as a result of an awful lot of in-depth and considered argument and discussion. I wanted to make the point -- backing up what Brian said -- about a notion of simplicity, and to back up what Christine said about maybe introducing the flexibility pre-day one, and then having the shortest timeframe possible for the elections post that. But should that come sooner than we imagine -- well, it will not be sooner than we imagine, because we imagine it is going to be a year's time -- then we would be ready for that. But if it takes longer, then the electorate does not feel that there is any notion that people want to stay in positions for longer than they should, and that this ought to be as new as possible and involving their votes, if you like. So I think simpler is better. I have to say, coming at it without the background of the discussions it seems there are all the options there and it is complicated.

**The President:** Let me try and clarify the option that we seem to be talking about. We seem to be focusing on the second bullet point here, which says the period between taking office and day one, plus up to two years from day one, with an expectation that elections will be held as soon as reasonably possible.

**Dr Catherine Duggan:** Yes, very good.

**The President:** Can I ask Council to agree that? **(Agreed)**

**Mrs Christine Gray:** We will have to check it is technically feasible to do that, because it is a very indeterminate term of office that you would be electing people for.

**The President:** Subject to that being okay.

**Mrs Christine Gray:** An indeterminate period, then another indeterminate period after a date which we do not yet know.

**The President:** Let us break for coffee.

[Council agreed (i) that the National Pharmacy Boards election scheme be amended for the 2010 elections; (ii) that all National Pharmacy Boards members be asked to stand down in 2010; (iii) that draft new regulations and a new election scheme for the National Pharmacy Boards should be prepared but not made in advance of when regulation transfers to GPhC; and (iv) that the term of office for those elected in 2010 should be the period between taking office and day one, plus up to two years from day one of the Assembly, with an expectation that elections would be held as soon as reasonably possible.]

**(After a short break)**

### **9. Referral of Law and Ethics regarding the posting of medicines**

**Mr David Carter, Chairman of Law & Ethics Committee:** The paper before you, Council, is all about the posting of medicines. Having read through it, we were approached by a post delivery service to consider amending our standards in relation to the posting and delivery of medicines. This is covered in two of the seven professional standards and guidance documents, sale and supply of medicines and internet pharmacy service, which supplement the Code of Ethics. They were seeking changes to allow the delivery of medicines to third parties. The current draft of the standards means that technically -- which was not our intention in the first place -- medicines can only be delivered to the patient or to the patient's carer.

The Law and Ethics Committee agreed, I think for good and pragmatic reasons, that medicines could be moved, delivered to third persons. It was not our intention in the drafting of the standards originally to prohibit this in the first place. This is the recommendation of Council.

Turning to the recommendations, the Law and Ethics Committee would like Council to agree to (i) which is delivery of medicines to third persons, and (ii) the associated changes to the Code of Ethics.

**Mr Gerald Alexander:** As member of Law and Ethics, although I am part of the Committee I really am not happy. The reason I am not happy is that I never felt that posting or delivering to third persons was a good idea. But I will park that, because I am part of the Committee and the recommendation is as such. But why I am unhappy about this paper is that the guidance that is put in both appendices 1 and 2 does not really represent the discussion. I thought -- maybe rightly or wrongly -- that at for instance 7.1, I say this is inadequate because there are no scenarios placed in the guidance. I had hoped that scenarios could be given to pharmacists as a means of guidance. For instance, when you have a flat with half a dozen people living in it. You could get a signature from a patient to have that delivered there, but you really have no guarantee that one of those individuals in that environment is the correct recipient. I am unhappy about it. It just says: "Take adequate steps to ensure." That is not giving any guidance to the pharmacist. It is saying, "That is how you do it. Then

you have to figure out that the delivery mechanism used is secure and that the medicines are delivered to the intended user, promptly, safely and in a condition for use. That is good advice if you are a regulator, but if you are a professional body you give advice. There is a whole range of scenarios we looked at. You could think of blocks of flats with different postal arrangements. I am concerned about it. I also do not think there is any urgency for this to be agreed by Council. I am not happy to think that the guidance that is here reflects the discussion we had in the Law and Ethics Committee.

**The President:** Could we get Priya to comment on that point?

**Ms Priya Sejpal, Head of Professional Ethics:** There are two issues that the Committee discussed at the meeting. What we had in the original standards -- and you have some tracked changes in appendix 1 and 2 -- I do not believe it was ever our intention, but we think it was an oversight when we first drafted the standards. What we talked about, having spoken to our Legal Advisor here and looking at the technicalities of the words, was delivery to patients or carers. So for example, if we think of me having my medicines delivered to me, and we talk of the need for signatures, apart from in exceptional circumstances etcetera; technically the wording, as it would mean that it could either be delivered to me or a carer (which I do not have). If, for example, I said to the pharmacist, "On this day, I am not available. Would you please deliver to my mother, father or colleague at work who I am giving consent to have the medicines delivered to," we do not have the scope, because of the use of the words patient and carer. So the only amendment here is the other intended recipient, and insertion of words around "appropriate consent". So if I, as a patient, wanted my medicine to go to someone other than me or my carer, if I did not have one, there are standards that would allow for that. Addressing the point in terms of guidance, these are the standards in two of the seven supplementary documents to the Code. None of those documents contain scenarios of how these standards would be applicable. So I can certainly take on board the scenario example to talk about the fact that we could publish some scenarios around how this would work, but that would not be something that (i) would be included in standards documents, and (ii) generally speaking in practice guidance that we produce on the Code [of Ethics] or on the legislation is not necessarily something that would come to Council.

**Mr Gerald Alexander:** I understand that. But there was a discussion about scenarios in Law and Ethics, and we talked around that. It was my understanding that we would have seen something of that, so I am sorry.

If we go to page 2/4, at the fourth paragraph it says: "The Committee recognise the occasions when a patient would want their medicines delivered to a third person, which is what you have just alluded to: For instance, a family member. That is fine. "The Committee agreed that consent must be sought for 'this' delivery, which implies one delivery, one supply and therefore some form of written consent. I am happy with that. But if that is interpreted differently, consent could be the renewal of consent for the deliveries to the same person ad infinitum. We have not actually thought about renewal of consent and a timeframe.

In the previous paragraph it says, "There is wide support from pharmacists to be explicitly allowed to supply medicines to a third person where the patient has provided consent." The question is: how often does a pharmacist require the renewal of consent? Also the question: Under what timeframe should that renewal take place? You have patients who receive medicines on a monthly basis. It could be that they decide they want all their repeat prescriptions delivered to this particular address. Patients move. Nobody asks the patient when they have moved. The address on the prescription has not changed, the doctor has not altered it. You could still attempt to deliver it to the wrong address.

The question is there has to be a timeframe, and we need to be a bit more explicit about consent. I think this paper needs a little bit more work. I am happy to go along with what the Law and Ethics Committee goes along with. My personal feelings are that this is going in the wrong direction. Internet pharmacy, cross-borders with the EU -- we do not know where this is all going. I am really concerned from a patient safety point of view, at the wrong individual receiving the medicine. It is fine if you have got safeguards, but what I really am concerned

about is the professional standards and guidance for the sale and supply of medicines, there is not enough information there, other than the negative: "Take adequate steps." You should be explaining what those adequate steps might be. I think it needs better guidance please. It says: "Ensure the delivery mechanism used provides a veritable audit trail from the point at which it leaves the pharmacy to the point at which it is handed to the patient or other intended recipient or return to the pharmacy in the event of delivery failure." Then "What ifs?", and that is not explicit enough, and that is linked with 7.1. I am just unhappy that this would be signed off by Council and put into practice by our already stressed colleagues. I think we need to give them a little bit more information. The posting of medicines is a difficult subject. I am not happy with it, but if we are going to do it, we have to do it properly.

**The President:** I am happy to let others speak, but on a process point, my understanding is that this paper was produced on the recommendation of Law and Ethics and it had the agreement of the Law and Ethics Committee. Now it clearly perhaps does not have the agreement of every member of the Law and Ethics Committee, but is the Chair of Law and Ethics Committee satisfied with the paper, or do you want to retract it and resubmit it?

**Mr David Carter:** I think it is a reasonable paper. If it is the will of Council that we take it back, then ...

**The President:** I am just asking whether you as Chair are satisfied with the paper as it stands.

**Mr David Carter:** Yes, I think I am.

**The President:** Let us proceed.

**Ms Seema Agha:** Can I just add that this posting meeting was in two parts. You, David, were not part of the first debate. I think what Gerald is saying, to be helpful, is that there was an extensive discussion in two parts, because the Committee was very, very concerned. I think what Gerald is saying, and I would like to see, is a document that is much more fleshed out, and also about where it is not appropriate to have this mechanism of delivery from patient safety. For example, how do you know the person has the ability to give consent? I have fundamental issues.

**The President:** I just want to talk about the process.

**Ms Priya Sejpal:** It might be helpful to come in on a couple of points here. When the Law and Ethics Committee considered these standards, these standards have been in place since August 2007. Use of words like "take adequate steps" and "verifiable audit trails" have been here since 2007, and at no point were there discussions around clarifying what 'adequate steps' meant, or what 'verifiable audit trail' meant. When we reviewed the Code and produced the standards, there was somewhat of a move to move away from being overly prescriptive in a number of areas, where it is ultimately up to the individual to decide how best to implement that.

In terms of the consent area, we have an entire professional standards document around consent and the different type of consent there might be. So implied consent; what a patient does when they hand you a prescription; written consent; explicit consent. Again, we have not specifically in that document, or in any other documents, talked about exactly what consent, should it be written or implied, for specific services, because it is very much going to depend. I do take on board though that there is probably scope here for us to produce some practical guidance, but that would not specifically be something that would come to Council to consider. But I can certainly take that away and work with colleagues on scenarios. I do not feel that we have gone outside the scope of what Law and Ethics agreed, which was to extend delivery to enable a third person, not being the patient or carer, to receive medicines where a patient has said that this is something they would like to happen.

**Mr Gerald Alexander:** Sorry to interrupt. The question is: Why are we doing that without guidance which is full and expansive? I think we need better guidance? Is there a rush for

this Council to agree this? That is the question.

**The President:** David, do you want us to have this debate, or would you prefer to go away and reflect on it?

**Mr David Carter:** I think in view of the debate we will take it back and reflect on it.

**Mr David Thomson:** As a fellow member of the Law and Ethics Committee, can I offer my observations on the process. We have had debate at a number of meetings at Law and Ethics, with a presentation by major suppliers. I feel the paper is adequately covering the main concerns. It is flexible enough to accommodate the various models out there for delivery. It is not restrictive enough to restrict professional judgment as to how the process is handled within every pharmacy. I would be reluctant to debate this at a further meeting of Law and Ethics. I feel we have sufficiently covered it in the past and would support the paper as it is written and submitted.

**Mr Douglas Simpson:** Can I suggest a way forward; that Council agree that further guidance be produced to augment this particular proposal?

**The President:** Let us hear a few more views.

**Mrs Lorna Jacobs:** I was only going to comment that the bit about, wherever possible a signature should be obtained, I thought was rather leaving it in the lap of the Post Office, who can be a bit dilatory. I have had recorded delivery items "signature required" put through my door, which alarms me on things much less significant as the delivery of medicine. I would like that put not as "where possible".

**Mr Ray Jobling:** A similar point. I can believe there has been lengthy discussion and I raised a point before the meeting about it. To me, coming at it for the first time from the patient's point of view, it still leaves a lot of questions in my mind. My understanding is if you put something into the post, the Royal Mail undertakes to deliver it to "an address." So if you are going to get it to a particular addressee, or somebody who is acting as their agent, we need to know how that would be done. I would have thought a verifiable audit trail would involve a signature, or must involve a signature. That is just looking at it crudely and coming at it cold. We should not just take what the Royal Mail has asked of us, that seems to be absolutely certain. There is more to it than they have understood. I would be content with this, provided those of us who have questions and doubts can have input into the next stage of the process, as it were.

**Mr Martin Astbury:** Following on from that, it is absolutely vital not only that we remove the "whenever possible" so it is "a signature should", but we also move the words above it. It is very important that those two bottom bullet points are not in good practice. I do not know if everybody is completely aware of the difference between something being in a standard and something being good practice. If it is in standards, you have got to follow it, or you have to give a very good reason why you have not followed it. If it is in good practice, that is not necessarily the same. It is vital that that bit of the signature if not put in the good practice guidance, and is moved up into the standards. Personally, I would like the bottom one in standards as well.

**The President:** We could spend an awful lot of time on what apparently on the surface of it is a simply decision to make. What I am going to suggest, with the agreement of members, is that this does not go any further today. We will go round the table and record comments that people would like to see incorporated into this, and if the paper can be brought back in February.

**Ms Priya Sejpal:** I am going to need to go back and look at the consultations we held, in terms of the specifics. If we are looking at moving other pieces of the standards around, I need to ensure we have gone through due process, in terms of consulting the members. I am not sure it will be back in February. It will take a number of weeks to consult them.

**Mr Andrew Gush:** It would be helpful to staff and Chairs if people indicated that there was something fundamentally wrong with a paper before we came to the meeting.

**Mr Gerald Alexander:** Can I answer that? I was at Law and Ethics Committee and I remember a discussion about potential scenarios being put into the guidance documents.

**Mr Andrew Gush:** I meant in relation to the papers circulated beforehand.

**Mr Gerald Alexander:** If they are not there, and I expect them to be there, I do not see why I should pick the phone up 48 hours before the Council meeting to say: "Where are they?"

**The President:** It would be helpful to ease the discussion. Does anybody want to put any comments into this?

**Mrs Cathryn Brown:** Just a process point. My understanding is that it is only the stuff that is underlined in these professional standards and guidance that has been changed. So all the rest of the stuff in here has been previously agreed by Council.

**The President:** That is the case as I understand it as well.

**Mrs Sandra Melville:** I would like to make the point that there is a danger that we get too bogged down in being too prescriptive. I think this has got the right balance. Particularly with "take adequate steps." Situations locally are different. If a pharmacist working should be able to judge what is appropriate and what is not. If you are too prescriptive, it actually becomes too constraining and becomes counter-productive. I think this has the right balance.

**Mr John Gentle:** I would like to support what Sandra said. But in support of something Gerald said before about the difference between advice given by a regulator and a professional body, one of the complaints -- particularly about the legal department here (and I know there are reasons why it happens) -- is when a member phones up, they are not often given the kind of advice they are after. They are given very sort of wishy-washy or sit-on-the-fence type of advice.

It seems to me that if this is agreed by Council -- but now it is going back to Law and Ethics -- that some kind of Law and Ethics bulletin would have gone into the Journal, to advise members of the change in policy, or the slight amendment. It would have been a good idea then to put some examples of the kind of thing we would expect, so not being over-prescriptive is what Sandra said, and I would support that. But I also support what Gerald said before; that it would be nice if we give examples of what we mean when we say "this is good practice," or "systems should be in place". So when it went as a L&E bulletin into the Journal, there are examples of the kind of thing we would like to see in certain circumstances that would have been a good idea. I comment on whether consideration was given to controlled drugs. It seems to me if you are posting beta blockers, that is one thing; but posting controlled drugs through the post is another thing. We might want to consider saying that if it goes by post, it would have to be by recorded delivery and special circumstances for those.

**Mrs Sylvia Hikins:** I am a member of Law and Ethics Committee. We had wide-ranging discussions in Law and Ethics for a long time and we are having in a shortened version now. The whole Committee was concerned and uneasy about public safety, and we recognised the need to progress, but we wanted to have the right constraints around that progression, so that there was not a big risk to the public. A lot of discussion was around the audit trail and the fact it is being widened out to another intended recipient and how you prove that. My only issue is that I agree with those who have said that wherever possible it should be deleted and it should say: A signature should be obtained. Because I think that is necessary in an audit trail. We have a Law and Ethics meeting on 6 January. If the Committee could have the revised draft, so it could come back to the Committee, that would be helpful.

**Mrs Sue Kilby:** I get the impression that we are talking about internet or community pharmacy. I remind you that it is quite common practice in hospitals to post medicines,

obviously with specialist medicines; trying to get them out, and not to come up with any system, that actually hospitals would not operate, because it is important that they are actually within the system, and not overcomplicate the systems for them.

**Mrs Lorna Jacobs:** Is it feasible to put "or other named intended recipient." Again, that is kind of part of the audit trail -- It is not just an intent -- but the pharmacist who is sending it out knows they have the name of the person, not just "my mother" and that that is required.

**Mrs Alison Moore:** I am concerned that we are sending it back to Law and Ethics. I know we have just done it, but surely this is intended to clarify an unintentional anomaly in guidance. I am sure there are many pharmacists and support staff out there who do not know that at the moment they should not be sending stuff to somebody's husband or mother, and they are doing it all the time. I do not understand why we cannot just agree the phrasing and send it back to Law and Ethics for further changing, because this is happening all the time constantly. People do deliver stuff to people's husbands, understanding they are complying with current law and ethics.

**The President:** If we were to agree the wording and send it back to Law and Ethics for further review in January, what is going to happen between now and January.

**Ms Priya Sejpal:** I want to clarify a couple of things. I know we are looking at de-merger and are increasingly looking at what is regulatory and what is professional body. The current page in the standards are mandatory, and they are part of the fitness to practise procedures. Things like scenarios and practical guidance, which come from the professional body is certainly something that I can produce as soon as possible after this. It would never have been our intention not to have gone down that route. Those kinds of things would not have gone into the standards.

If we are looking at amending some of the other wording around possible signatures, I highlight that we do talk about the fact that you have to have a verifiable audit trail from the point at which it leaves the pharmacy to the point at which it goes to the patient/carer/third person or comes back to the pharmacy. Therefore, in essence you would have a loop. I am happy to go back and look at wording around signatures etcetera. I just want to address the issue of the advice that comes out of the Society at the moment, in terms of being a bit wishy-washy or woolly. I think sometimes there is a tendency that as pharmacists we want to be told exactly what to do, and unfortunately sometimes it will be up to the professional's judgment. I think that inevitably some of the advice that we provide will have to be woolly, as we need pharmacists as professionals to exercise their professional judgment. But I can certainly feed that back to our advisers. Just as an example, last week I met groups of pharmacists and I could not say, "You must do X and Y in these situations," because it is up to them ultimately to decide. I do not know that our Code of Ethics should be so prescriptive that we remove their judgement from them.

**The President:** So we have decided we are going to send it back for January, and bring it back in February. Is that all right?

[Council noted that the paper was withdrawn pending further consideration by the Committee.]

## **12. A quality management feasibility study for the Pre-registration Scheme**

**Dr Nicola Tyers, Head of Pre registration:** This is the Deanery Project that we started looking at in 2007. It is not just about a Deanery but about a quality management strategy for the pre-registration training pharmacy scheme. We were looking at how we could better manage the quality of all aspects of the scheme. Further to Council agreeing and Education Committee agreeing in 2007, we commissioned some research, which was undertaken by the University of Keele, to look at good examples of pre-registration pharmacy practice at the moment, and also to look at structures within the West Midlands Deanery to look at PMETB, and see how these might be looked at in a pharmacy way.

A Steering Committee was set up to look at this, and you have before you the report produced by the University of Keele. On recommendation of the Education Committee in

October I was asked to produce a foreword to this, which I did, and which you can find in appendix 1. You are asked to look at the report and agree that it can be published with that clear forward, contextualising the text and then to note that any recommendations made in the report will be looked at by the Pre-registration Division to consider whether they are feasible and what we should address in the future.

**The President:** Would anybody like to comment?

**Dr Catherine Duggan:** Thank you, Nicola. I am a bit concerned that we go off in several strands, when there are huge overarching changes going on professionally, notwithstanding including the potential for integrating the pre-registration year and the MPharm degree and some of the discussions and models we are involved in developing for managing support for practitioners following registration, which the new professional body will hopefully take forward. So I just have a bit of concern that we go off on several streams of work without (a) being mindful of everything else that is going on politically and professionally, and (b) how these things are communicated to others who may have networks established, or maybe working and seeing these things as evolving separately from what they are doing. We are in a moment of trying to draw everything together, and this may throw the cat among the pigeons.

**Dr Nicola Tyers:** Point (a) About being mindful of the changes, this happened at the end of 2006 to 2007, so that was early on and a lot has changed since then. Obviously we know things are changing and therefore that is why we need to look at the recommendations and think them through, based upon the changes that are happening. Obviously we are not going to be thinking just of moving at this point in time. Number 2 is looking at organisations who are providing these things. This looked at some things, but there is a lot more happening than just what was in this report on a local level, say, at the London Deanery, for instance; York Postgraduate Deanery and what is happening there.

So we do understand a lot of things are happening. We did have a stakeholder event, where we asked for some of these examples to be highlighted to us. It is really to take a view, to say, "Actually, these are some of the problems we know exist and we need to start looking at them." That is where we want to go.

**Dr Catherine Duggan:** Just a point of clarification, the Joint Practice Board is not called that any more.

**Professor Nick Barber:** I think at the conclusion of Appendix 1 you say, "The Society acknowledges and agrees with many of the recommendations made in this report." Where did that agreement come from?

**Dr Nicola Tyers:** We were saying we were agreeing, and we agreed in Education Committee that a lot of changes needed to be addressed. If you want me to amend the wording, that is fine. There are things that we know about, and I believe we had that conversation about why do the research, if we know about them already. We know about them and we need to address them.

**Professor Nick Barber:** My memory was that there are some issues. We noted the report. We commissioned the report and it should be published. We are in open session. There was some debate about the report and I think it ties in with what Catherine was saying. I think there are a number of issues, which we need to be cognisant of and take account of. Some of them are mentioned in here and there are others as well. I would not want this report to be seen as driving the agenda on this really, because I am not sure whether I agree with many of the recommendations.

**Professor Keith Wilson:** Like Nick, I am a member of Education Committee and there was a lot of debate about this report at Education Committee. Quite a lot of concerns were expressed, and the view was, as I recollect it, that we noted the report, it is a piece of work that has been done and it should go through and be published, but we should not actually imply that the recommendations should be accepted, because the work actually related really

to one example of a Deanery, and there is no common Deanery model even; it is different in every part of the country. The West Midlands Deanery is a deanery within a deanery. It is a somewhat unusual model. Therefore, if the future debate was focused around this particular model, then it would be excluding many other possible models or possible ways of functioning. Also the other context which Catherine has alluded to is that although it is only a couple of years, things have moved on so quickly in terms of postgraduate education, that this actually is already showing the aging process, if you like, in medical education. By all means, I think we felt yes, publish it, the work had been done, but please do not confine the future discussions and deliberations to what has been done in this particular piece of work.

**The President:** Can I ask other members of Education to comment on that?

**Mrs Sue Kilby:** I concur with what we have already said. I think Nicola has taken this on board and has recognised and made clear today this is not the only model. There are a whole range of options that need to be looked at. The issue is that we did agree that it would be appropriate for it to go forward to be published, but obviously we need to make it clear it was not necessarily the direction of travel that the GPhC or the professional body will necessarily go in, other than it is important to ensure that there is a quality management system in place, and we are openly looking at other systems as well. On that basis, perhaps we could come to some sort of agreement to go forward on that.

**Mr Ray Jobling:** I am a member of the Education Committee. These are fair comments on the discussion. I think we are being asked here to agree to publish the report. I think we have done the research we should, and to get the recommendations looked at by the division, in the context as it unfolds, and that is really what is looked for. That could be achieved if, in the conclusion to the appendix, it simply took out "and agrees with many of" and just acknowledges the report. Then it would go forward. I think we all know that this is an emergent sort of picture in general medical education, as in pharmacy.

**Professor Bob Michell:** I agree. The research has been done. It must be published. There will be feedback of various sorts, which the Pre registration Division and eventually Council will need to listen to. But I think there is a key thing in the background at 3, which I think preferably needs to come out, because it says: "The Society's role will be to quality assure the respective organisation's quality management." It would be someone's role, but I think it is very much open to debate whether it would be the Society's, and I think that might irritate people if it were left in.

**Dr Nicola Tyers:** We can only answer by saying that we the Society now, until we split. Therefore, if it is to be published now, we have to say the Society.

**Professor Bob Michell:** I understand that while we exist, we need to regulate those things which we regulate, but this is talking about a new long-term strategy really. By the time it was implemented, it would be very, very close to the existence of the GPhC.

**Dr Nicola Tyers:** This is about publishing the research. The next thing is the strategy. Then we will be saying more clearly what we do and what parts we will be taking up.

**Mr David Thomson:** Just seeking clarification. The model, as you know, is different in Scotland. We allude to that, but do not give specific details of it in the explanation. I think that might be helpful if it was expanded.

**Dr Nicola Tyers:** It is frustrating in that obviously we did not do the research ourselves; somebody else did, and they have a lot of the transcripts to do with the Scottish discussion. So I take your point on board, that it did not come up in the final report.

**Mr David Thomson:** Would the Deanery model be applied in Scotland?

**Dr Nicola Tyers:** It is using the Deanery model as an example. It is not saying that it is the only way. It has said it could be through non-NHS employers, NHS employers or other mechanism.

**Mr David Thomson:** Or the Scottish model could be...

**Dr Nicola Tyers:** Yes, absolutely. If you would like know add in the Scottish model.

**Mr David Thomson:** It is so radically different, it might be useful for others to be aware of the context.

**Dr Catherine Duggan:** Might it be useful, just drawing together those comments, if in the foreword you made mention of the prospectus and the fact that this is an evolution, and what have you, and it brings it bang up-to-date then, and make mention there that in time we will have a new regulator; to place this in the context of when it was done, a little more strongly, I think that would really help; that would be the solution. "Different models will have to emerge; this is one model we have looked at, and here is the report, but we are mindful of other things that have gone on." I think that would help.

**The President:** With those suggested changes, and specifically the changes to the conclusion to take account of the concerns that were raised in terms of the Society agreeing with many of the recommendations in here, could I ask Council to agree to publish this report? **(Agreed)** And also to note that recommendations will be considered by the Pre registration Division.

**Professor Bob Michell:** That just solves the problem that I raise. At the bottom of page 3, "not only employers of the NHS"; if the next sentence began "The regulator's role" there is no problem. For the moment, we are the regulator; eventually we will not be.

**The President:** Thank you, Nicola.

[Council agreed (i) that the report 'Future Quality Management Strategies for Pharmacy Pre-registration Training: A Scoping Study' be published with a clear foreword contextualising the research; and (ii) noted that the recommendations of the report would be considered by the Pre-registration Division.]

#### **11. Referral from Governance Committee: Remit of Science Committee**

Could I take item 11 and then item 10? Paper 11 is paper 120.

**Mrs Lorna Jacobs:** This is a matter that came to Governance Committee to formalise and to clarify an item under the remit of the Science Committee, to add to the remit of the Science Committee, to advise the Council on policy proposals relating to the Society's museum and to monitor the implementation of such policies. This is clearly something that has happened in the past, but it has not been specifically in the remit of the Science Committee, so it came to Governance Committee to ask us to agree that that should happen, which we did. There was also, you will see on part 2: To consider whether the Information Centre should be included in this amendment. But I think Jeremy can clarify further thinking on that.

**The President:** Let us concentrate on (i) first.

**Dr Brian Curwain:** I have very little to say on (i), except that it seems to us on Science Committee that we are interested in, and realistically and reasonably interested in the museum, in terms of our scientific and professional heritage, and we would commend (i) to this group.

**The President:** Do I suggest that Council would like to agree (i), please? **(Agreed)**

**Chief Executive & Registrar:** (ii) is not unrelated to the work that the Transitional Working Group is doing, because the Information Centre will be an important part of the suite of services the professional body should seek to offer. Brian and I have had a chat about this and indeed Lorna and I. My feeling is that it would complicate things to have Science Committee charged with that remit, alongside the Transitional Working Group, that has a remit to develop member services, a key part of which is the Information Centre. So my suggestion is that regularising the museum is absolutely right and proper, but transporting the

Information Centre with the museum would not be the most effective way of dealing with this.

**Dr Brian Curwain:** Thank you, Jeremy. What you said is what we just discussed, and I do not have any problem with that. I suppose I am really thinking that it would be nice for the Science Committee to be able to discuss the library services and Information Centre, should it feel the need to do so, and to inform the work of the Trans Com Working Group. As long as we can still continue to do that, I am content with your suggestion.

**Chief Executive & Registrar:** I absolutely agree. I think that we have a mechanism for input into the Transitional Working Group, either through the Science Committee chair or any other Council member, and it would be absolutely appropriate for the Science Committee to make that kind of input.

**Mr Douglas Simpson:** I am a bit concerned about the Information Centre. It is a key element of the Society's output, and has been for many years, both hard and soft versions. I am a great believer in IT-based information, but I would not like it just to be based on the shifting sands of the Transitional Group. I would prefer to see it permanently anchored in one of the Society's established committees, until such time as these committees no longer exist. So I am very happy for it to go into the Science Committee and I support the amendment.

**Professor Nick Barber:** I supported Jeremy's view. I think there are many things which could happen with the Information Centre, and it will require some fluidity to think that through. I think it is better in TransCom at the moment. Otherwise we just end up with these barriers of committee meetings and structures slowing down the change process. The other thing which I would add which is perhaps, which I think we need to discuss at some stage, is whether the historic books in the library/information Centre become part of the museum or part of the library, and whether there may be merits in having them as part of the museum.

**Mrs Sue Kilby:** I understand why Jeremy wants the Information Centre as part of the Trans Com Group, and I think it needs some high level strategic thinking around how we develop this, because it will be quite key to the new professional body. It will also be key to GPhC, as well, having some sort of Information Centre, I assume. In the list of services the museum also came under that as well. So if we are applying the criteria that the Information Centre goes under Trans Com, have we given up on the museum or what? I am just thinking of clarification here. They are happy to give the Science Committee the museum, but not happy to give the Information Centre.

**Mr Andrew Gush:** During the Trans Com discussions, which were obviously prior to the Transition Committee meetings, one of the things which we looked for were areas where there were synergies, and vehicles for those synergies, and the Information Centre was identified as a vehicle which would enable many synergies throughout the proposition. Is that one of the reasons you want it to be there, Jeremy?

**Chief Executive & Registrar:** That is absolutely right. There is an additional distinction here, which is that the museum, as I understand it, is already in effect overseen by the Science Committee. This is just a question of regularising the remit of Science Committee. Whereas the Information Centre does not have such a locus within Science Committee at the moment.

I think the third reason is that the museum status is the subject of a separate paper, and is being treated discretely anyway, whether it should seek charitable status being the key part. So it has a different complexion to the Information Centre, for those three reasons.

**Dr Brian Curwain:** Just a further thought. I think it might be helpful, and I have suggested already that Science Committee would wish to be able to input to the TransCom Working Group, and I suppose I would like to feel that the TransCom Working Group would come to us with a few questions and thoughts, if they so wished. Maybe this is one of the work streams that the Chair of Science, or some similar person, should offer to contribute to under the TransCom process. I have been struggling in my own mind with what to offer in this context, but perhaps that is one thing we should do.

**The President:** Could I suggest in consideration of (ii) Council would not consider it appropriate for the Information Centre to be included in the amendment?

**Mr Douglas Simpson:** Could you put the amendment as it is?

**The President:** As it is, it reads: "To consider whether the Information Centre should be included." Those against? **(Agreed)**

**Mr Douglas Simpson:** I was not happy with that vote, I am afraid. There was a 'yes' over here and a 'no' over there. Could we have a show of hands?

**The President:** Okay. Doug has requested a vote on this. Going back to paper 120, which is on the screen. (ii) To consider whether the Information Centre be included in the amendment by adding "and the Information Centre" following the word "museum". All those in favour of inclusion. **(Vote taken: Lost)**

[Council (i) agreed that the following be added to the Science Committee remit:

To advise the Council on policy proposals relating to the Society's Museum and to monitor implementation of such policies, and (ii) rejected the proposal that the Information Centre should also be included in the amendment.]

#### **10. Referral from Science Committee: Future strategy for the Museum**

Now on to item 10, paper 119.

**Dr Brian Curwain:** Thank you, President. Briefly, this is a short paper with a briefing paper that went to Trans Com from the museum staff, subsequently to the Science Committee's meeting. It is asking to support the museum remaining in the professional body, but to be mindful of other options and supports seeking charitable status for the museum, which we think is actually very important. This is an "in principle" decision. There is work to do before we say yes for sure this is going to happen, although there is work that our staff in this building need to do, and that is stated in the second paragraph of this paper. We did have a lengthy debate and discussion, and towards the bottom of the first page, were the options that were looked at. They are not all mutually exclusive. Going for charitable status with the museum would seem to have a lot of things going for it, particularly in terms of potential extra sources, or other available sources, of funding; of setting it up on a separate basis, so that it would not then be something which the professional body has actually to fund itself, if it can be properly dealt with. The other recommendation, that we are very keen to pursue but it is not going to happen tomorrow, is option (v) which is to seek a merger with one or more other museums with similar themes and objectives. Because there is the possibility of producing a really excellent open-to-the-public museum of medicines. There are people around the country who are interested in doing this, and this will involve other bodies such as the Wellcome Trust and others, but it is not going to happen as quickly as we thought it might, but it is not something that we would wish to lose sight of. I think one of the important things with a museum is that where possible it can be open to the public. In terms of keeping it in the professional body, it is worth remembering too that the museum at present -- and thus preserving its existence if you like, in whatever form -- is part of our face to the world, and particularly to young people. Significant efforts are made to school children and school teachers, and so on, in terms of showing it to the world and as part of pharmacy, and part of our own advertisement for ourselves and our profession. So I commend the recommendations to the meeting. I have invited the museum staff, the Keeper of the Museum Collections, Briony Hudson, who is here already, to make any further comments that she feels necessary in light of subsequent discussion.

**Mr Gerald Alexander:** In general I think it is right that the professional body, the Society, looks for possible alternatives. But if we read 7.2 of the document, it just lacks optimism. If we are actually positive and optimistic about the establishment of a new professional body, then I think we should be optimistic about the future of the artefacts and the display of artefacts and the way we should be keeping artefacts in the future that represent the past. If you just look at 4, page 3/5 it says: "Issues that need to be addressed. The existence of the museum at the moment is inexorably linked to the Society's building at Lambeth which

displays a fraction -- well, I am beginning to think there is less than a fraction displayed at the moment. I mean, I used to come into this Council chamber and enjoy looking at some of the paintings. In fact, this is the fourth year we have been modernised by sitting with this new MFI furniture (which has now gone out of business). **(Laughter)** And I see that room 111 has been MFI'd as well. I am not going to comment on that, but I think it is a shame. I would like to see Jacob Bell -- unless he is jangling his chains round here at Christmas. **(Laughter)** But I would like to see around the available spaces in this room some of the history of the Society, and the same would apply to the Council chamber, that we never ever use, which is in the basement. For some reason it is again being used by somebody else today. I think there is something going on down there. Okay, that is timetabling. You have those dreadful lights from the 1970s that stick up all round the edges. You could have hung loads of paintings round there, instead of sticking them in some vault -- I do not know where it is; probably beneath the River Thames I should think at the moment, with the water of the Thames dripping on all those wonderful paintings and they will probably all be ruined! **(Laughter)** I am sure, Brian, that is not the case.

**Ms Briony Hudson:** They are in climate-controlled storage. **(Laughter)**

**Mr Gerald Alexander:** Even though we have only a year to run before we de-merge, I would have thought it would be -- we have been modernised; why not influence the new with the old and have a little bit of history attached. If you go into the area outside, it is a bit soulless. The lights are out out there. Jeremy, please consider what I am saying. I would like to see some of the history brought back. As to the options, I think it is good to pursue options and to look at possibilities, but the paper does lack optimism. We have this community of 50,000 members plus who are going to be in membership. Let them enjoy the assets of the old Society in the future. I just think we should be more optimistic about the future, and we should not lose that history that has been attached to the past.

**Mr Douglas Simpson:** We are not appraised of the value of the museum collection. I understand it is considerable asset to the Society. It enhances the quality of the building. It enhances the quality of a visit to the building. It improves the appearance of the building. And round the side of the new Two Pound coin, standing on the shoulders of giants, and we ought to remember that is exactly what we are doing. I think it is a terrible shame that we have not got Jacob Bell on display any more. In the Society he is a very important person. I hope room can be found for him. We are told the portraits are in climate-controlled storage, but of course climate-controlled storage does catch fire from time to time. When things are off site things can come into danger. I would prefer these things were back in the building, because our heritage is vital. The museum has been going since the Society was originally founded by a couple of years, I think. It is an important asset and I think we should do everything we possibly can to preserve and nurture it, because it does enhance the building and enhances the profession and much of the content was actually donated by pharmacists over the years.

**Mrs Sylvia Hikins:** I agree. I think this is a rather gloomy paper from you, Bernard. I think the museum is one of the Society's best kept secrets. When I first came to this building, I was fascinated by this stuff in there. My only regret is that at the moment, and as it was prior to today, it was not really available to the public. I would really love to see our museum merge. There are lots of museums round here. There is the operating theatre down the road, where you could put displays of pharmacy equipment and so on. I would like to see it, so it could be seen by the public. I suspect we have lots of it in storage, and that seems a great pity too. I would like us to be more upbeat about the future of the museum. I felt this was actually gloomy. But we are to be reminded that we do have a responsibility for the safe-keeping and storage and eventual transport of the museum. In your penultimate paragraph on 5 you say "such a merger could not be achieved at low cost." I do not think we should expect that, but realise that it is in our safe-keeping, and it is going to cost us something to do something with it, and we should be prepared to do that whenever we finally intend to do it.

**The President:** Could I ask Bernard to respond? Before I do, I should point out that appendix 1 is a historical paper. It was in August,.

**Mr Bernard Kelly, Director of Finance & Resources:** A couple of points. I am sorry that Mr Alexander does not like the modernisation process that is going on around the building, but I would point out that it is still work in process.

**Mr Gerald Alexander:** I did not say that, Bernard.

**Mr Bernard Kelly:** The bust of Jacob Bell would have been removed for its own safekeeping, because there has been a considerable amount of building work taking place in this area. I would also like to point out to you that as a result of the modifications made to 110, we should expect in 2009 for all of the Council committee meetings to take place in the basement, which is part of the juggling of demands on the meeting space in the building.

I am sorry if I have appeared gloomy. It is part of my responsibility in terms of the management of the Society's assets and fund flow, but I will not apologise for being realistic about the cost in the future. Sylvia pointed out that to preserve the museum will cost money. Putting it into a charitable status is a step towards hoping to, mitigate the cost of doing so. I think I would be derelict in my duty if I were not to point out the pitfalls as well as the up sides of the options that are in front of you, as a Council to make decisions on. I would actually point out that this is an "in principle" decision only. I would also point out that one of the things that TransCom said is that the museum should be part of the future professional body, if the membership choose to fund it. I think that is the key point that needs to be made. All these are going to be questions about how we allocate resources, and what we decided is affordable and should be paid for out of the membership funds of the professional body in the future. I make no apologies for that.

**Mr Andrew Gush:** Bernard said exactly what I was going to say. £338,000 is a substantial part of potential income. We just need to put that into perspective.

**Professor Bob Michell:** I declare an interest as trustee of the [inaudible] museum. It is not so much a declaration of interest. It is remarkable, the degree to which that, which is founded on an extremely ancient and almost dry-as-dust collection -- although it is actually extremely interesting -- is used by the Royal College of Surgeons to project the image of modern surgery, and to project it in a way that is very attractive to children, to school groups and so on. I think that when we talk about the museum as an asset -- and I fully accept what Bernard said; that in the end, what is affordable depends on the membership of the new professional body. What I think has been absent from this discussion is that the museum is not the only asset that hangs on this. The museum curator could be someone approaching retirement with a feather-duster who replaced the labels that were getting a bit brown around the edges. Instead, we are fortunate to have a curator who in her own right is an asset. I have heard her on the radio. It is a great draw to project a very exciting and positive image of pharmacy to children. So there is a human asset that comes with the physical asset of the museum.

Lastly I would say this. Veterinary history tragically is scattered all over the place. Some of it is in the British Museum. Some of it is in University College. Some of it is in Wellcome and some in country museums. Some of it is in the Herriot Museum. I think, on the whole, the profession is really deeply sorry that there is no place where you can get a consistent image of where the profession came from, and the interest also of projecting forward to where it might go in the future.

**Ms Briony Hudson:** Thank you, Bob, for your kind words, but I would point out that I am not the only member of the museum staff. I have a team of three paid staff and also a minimum of four voluntary staff, so it is very much a team effort, and they are all assets.

**Professor Nick Barber:** Really supporting the proposal, which is that we have to be realistic, but with a reasonable membership, it is going to be £10 or £15 a head to go to the museum. If we can reduce that, then make that a voluntary contribution. If we can reduce that, I think that is good. I am a bit worried about the idea that the big museum for medicines is going slowly. I think we do have a lever here to press on people to shroud-wave (as they say in medicines); to say, "We have until 2010". Then it may be the membership decides not

to accept this museum and not to support it. So we do have some leverage at the moment to get money and support. I think actually the museum needs more money. Doug is quite right about the value of the assets. We do not know really what the value is. We have not even catalogued all the assets, if I remember rightly. So there is a need for work to be there to really turn this into a real asset.

**Mr John Jolley:** I also support the motion, because I think this is a very necessary process, in order to protect a very valuable asset. This is our heritage, and I see this as being the only mechanism by which we can do this. I do not see the down side, as others do, because by creating such a trust, we then will open that trust up to opportunities to get income from other charitable sources. I know for a fact that PTECO -- I think we have only been able to contribute from PTECO in one of the years. So this will in itself make itself available for tax-free income.

The other factor which always disappoints me is the very, very small proportion of the artefacts that we can get to see. I would love to see more of it. This mechanism is one whereby we can get more visibility of the treasures we do have, then the sooner it comes, the better.

**Mr Andrew Gush:** Can I reinforce what John says, because he is absolutely right. Recent work on the trust deed of PTECO has widened its objectives to include research as well as education and the museum. However, because of changes to legislation in 2006-2007, grants made from PTECO may only be made to a registered charity, so it would facilitate things greatly for us in the museum.

**Mr Martin Astbury:** I supported the paper, I want to make a comment, as Nick pointed out, that this would be a contribution of £15 to £20 for the new members of the new professional body would be making, at present funding. I would be happy to pay that, but we have to bear in mind that it would be 10 percent of whatever they are paying towards here. We would also have to look at the public being -- 15 percent would probably be looked at. Branches would want 15 percent. Then we would all be happy to do that. There would be 30 to 40 percent going towards the Boards and the Assembly. There has to be some percentage to pay for your members of staff, and so on and so forth. So we do have to remember that. But we are right to look forward.

**Mr Andrew Gush:** Could I just say Martin used arbitrary figures and they were not accurate.

**Mr Gerald Alexander:** Can I just say that there is nothing wrong with these recommendations. My comments were purely the fact that the history has been taken away from us. It does not mean to say it cannot be put back. I am actually saying we should be supporting these options, because all options should be open to us, and thank you, Bernard, for even presenting it in the time-honoured accountant's manner. **(Laughter)**

**Mr Bernard Kelly:** I am not sure I should say thank you for that or not!

**The President:** Recommendation (i)? **(Agreed)** (ii)? **(Agreed)**

[Council agreed (i) to support the Museum remaining in the professional body if possible, but to be mindful of other options, and (ii) to support exploring charitable status for the Museum.]

### **13. Top-ups: NHS Guidance consultation**

**Mr David Pruce, Director of Policy & Communications:** I hesitate to present an item 13. I hope it will be lucky! This is purely a way of asking your agreement to a sign-off process. There is currently a consultation on top-ups from the English Department of Health. Although it is an English consultation, it has implications for the other countries in GB. The timing of it is such that it was issued in November and the deadline for submissions is 27 January. That does not fit with Council's timetable.

What we are asking you is that Council delegate to the Officers Group, along with the

Chairman of the English Pharmacy Board, the authority to approve the Society's response to this consultation. As we are preparing a response, we will be seeking an input from the National Pharmacy Boards, the Society's Public Liaison Group and relevant stakeholders. We will also be posting the consultation on the microsite for comment and discussion. On this occasion, and probably this occasion only, we are suggesting that it should also be informed by a virtual review by the policy communications forum. That is because of the implications for the other countries. We feel it is important to get the buy-in of that group and the input from that group.

**The President:** Would anybody like to comment on the recommendation?

**Professor Nick Barber:** It is a very pragmatic way forward and we have to respond to policy within tight deadlines, and we need to find a way of doing that. I do think though that this is a nontrivial thing, and clearly you are debating it with other people and are asking for input. I think that should include the Association of Teaching Hospital Pharmacists and the Guild, because there are a lot of big issues to do with drugs here. For example, could somebody use an unlicensed drug anywhere in the world, or unlicensed in the UK? What are the safety implications and responsibilities of this? If a patient is using a drug, how can a pharmacist monitor it? The examples are very outpatient; but if it was an in-patient example, how is the drug going to be recorded? How are people going to get the drug up to the ward and be monitored, and so on? There are pragmatic holes in the legislation, which medicines bring to the fore, which is so often the case.

**Mr John Jolley:** I think it is fortunate that we have already in part discussed some of the issues related to top-ups, and I would certainly hope that those comments are forthcoming in the final policy paper. I was pleased to see that the President did in fact represent much of the earlier discussion, and I would reiterate the one major concern, in that NICE are at the present an obstacle to much of the accepted use of licensed medicines. Because, as we have heard from a number of eminent speakers on this subject, the evidence that NICE require will quite often prohibit the use of new medicines which can in fact be life saving at the end of the day. I take Nick's point about unlicensed medicines, but would respectfully remind him of the existing practice, where unlicensed medicines can be given on a named patient basis, by any physician. So that issue I do not believe is the critical issue here. The critical issue is that those medicines which have been accepted for their quality, safety and efficacy by the regulatory authority are brought into question, in terms of usage, and that NICE are preventing their use. What we need to do is to look at ways of circumventing that, not with a view to totally eliminating the impact and necessity to evaluate the efficacy of drugs -- that can always be done in time with patient usage. What we are talking about is new drugs coming on to the market which could possibly give life to somebody who has otherwise been given a deadline for quite often a matter of months. I think we seriously withhold that right, if the regulatory authority have given their approval.

**Mrs Sylvia Hikins:** Really just to add to what John said, I am happy to delegate this to Officers, providing you remember the kind of discussion we had at our last strategy day, which I thought was very good and all embracing. I would like views of IPG to be considered as well, which I did report at that meeting. I have them handwritten in pencil, and I will hand them to David at the end of the meeting.

**Professor Nick Barber:** I thought the discussion that we had at the meeting was quite poor last time. I thought a lot of people were quite uninformed. I think that to criticise NICE is political suicide at the moment. Most people support NICE. Drugs can be used when NICE have not given their approval. I think we will look as if we are industry-driven, if we go down that path. Whether we agree with it or not, I do not think we need to go down that path, but politically that is my concern.

**Mrs Eileen Neilson, Head of Policy:** It might help if I clarify the subject matter of the Richards Report consultation, which is actually about the implementation of the new Government policy to permit top-up. It is really about how this would work in practice in the NHS. It is not really about the role of NICE, but NICE have their own consultation out at the moment, which is about the approval of drugs for care at end of life, and making some

changes to thresholds to the approval process for those drugs.

**Professor Bob Michell:** I think in principle doing it the way we are going to do it is essential, because we have to get a response in, as time is short, and that is fine. What we have to be cautious about in making that response are two practical issues. There is this issue of separation of private treatment and NHS treatment, and there are guidelines as to how this might be accomplished in hospital. What we have to be very careful about is nothing unworkable and appalling in a domestic situation comes out of that. Clearly more and more terminal care, desirably for policy and financial reasons, will be done at the home. If, for example, you got into some crazy situation, where the Marie Curie nurse on the NHS contract could deliver the NHS drug, but you then had to get someone else to deliver the top-up drug -- and God forbid in a different room -- there is scope for nonsense there. The second thing is that there are some shadows which fall across this from the EU document 18, which we have not yet discussed, and I think that needs to be looked at carefully. I cannot comment in detail, but there are some grey areas there in both directions.

My last comment is about NICE. NICE is excellent, to a degree. Many other countries envy its existence. But the two points I would make are that it is not to attack NICE, but to recognise its limitation; to point out in the first instance, that if you look carefully at their own literature, what they are primarily concerned with is not so much to be unassailably correct, as to be unassailably transparent. And the measures that they use -- for example QALY's (quality adjusted life-years) and then ISAs (or whatever they call them), which is QALY;s adjusted for cost compared with next best treatment -- I do not think that NICE on oath would pretend that they are infallible. What they do think is that they are transparent. And the last and most constructive point I would make is this. If you consider both the grey evidence and the randomised controlled trials, and all the rest of it, it is extremely relevant if you are a young hypertensive, a young diabetic, or even middle-aged or both. If you have got nine months to live, and already you have multiple organ impairment, because your cancer is spreading, and you have multiple drug interactions, because you have underlying diseases, and your terminal disease, you will not find peer-reviewed evidence on this, because this is precisely the kind of patient that is excluded from peer-reviewed type material, because understandably the experimenter needs a design that will yield scientifically significant results. Those kinds of patients introduce all sorts of imponderable variability. If somebody said to me: What would probably be the best source of information for that kind of patient -- not the only, but the best -- I would go to MacMillan and see if they would be willing to spell out some of the experience produced outside their organisation that their nurses, their few pharmacists and their even fewer doctors are putting to brilliant use in individual patients every day, which is blending the evidence with their own flying-by-the-seat-of-the-pants experience on behalf of the patient.

**Mr David Thomson:** Hopefully encouraging the Policy Development Unit to look at the co-payments discussion elsewhere, that it might be useful to include in this debate as well as a comparisons, so we are comprehensive in our response.

**Dr Catherine Duggan:** Just a couple of points following in from Bob's. I wanted to say that we need to note that top-ups will not exclusively be about cancer, although that is the focus at the moment. That might be worthwhile thinking about. I wonder whether there is an opportunity here for the new professional body to capture some of the expertise that will exist in the profession around researching small numbers of patients, and getting pharmacists to be part of that -- especially in the specialist groups, where such evidence might be and such evidence might be sparse -- including models whereby pharmacists work with MacMillan to provide different models of care, and this might be a spearhead piece of work we can do in.

**Chief Executive & Registrar:** I wanted to make the point that alongside our response to the Richards Review, there is also a House of Commons Select Committee inquiry into purchase of drugs by NHS patients. Our suggestion is that we prepare submission to that inquiry alongside this in very similar terms. If council is content with that. I do understand the imperfections in the process so far. But as a way of working, I think the model that we have got based on the strategy discussion on 6 November, and now being able to respond with fast turn around to this request for input on the Richards Review is a pretty good model, and

where appropriate involving other players, including the Policy Communication Forum, the IPG and the Guild and so on. I think it is a very workable model, so thank you very much.

**The President:** Can you turn to the recommendations. Are we agreeable to delegate on the information contained therein? **(Agreed)**

[Council agreed to delegate to the Officers group with the Chairman of the English Pharmacy Board, and informed by a virtual review by the Policy & Communications Forum, the authority to approve the Society's response to the Department of Health's (England) consultation following the Richards Report: Guidance on NHS patients who wish to pay for additional private care.]

#### **14. Members designated as Fellows of the Society by the Panel of Fellows under Regulations Section 12**

Moving to item 14, paper 123. Just to remind Council that in paper 123 there is a biography of Members awarded Fellowship in your files. Hopefully you may have retrieved that.

**Chief Executive & Registrar:** This is to note the decision of the Panel of Fellows, for those that they wish to designate as Fellows of the Society and to agree the common seal of Society be affixed to the certificate of Fellows designated in 2008 who are on page 2/5.

**Mr David Thomson:** Can I clarify, is Robert Clayton a self-nomination?

**The President:** Would anybody like to comment?

**Mr Martin Astbury:** I would like to give congratulations to Cath. It is a shame she is not here. To note the decision of the Panel of Fellows, (i)? **(Agreed)** (ii), to agree that the common seal is affixed? **(Agreed)**

[Council (i) noted the Fellows designated by the Panel of Fellow in November 2008 as circulated at paper 08.12/C/123 and the addendum, which had been tabled, and (ii) resolved that the Common Seal of the Society be affixed to the certificates.]

#### **15. Public interest and health issues**

**Professor Bob Michell:** There is nothing more today under this, but because it is a standing item, could I suggest that in future it says, "public interest and health issues (standing items). I think it should say to consider any matters raised with due notice. The point is that it would not necessarily be just to note; it might be to consider.

**The President:** We agreed on 6 November as part of the horizon scanning process for the policy development, that we would provide an opportunity for Council members to formally bring to Council's attention any issue under the general heading of public interest and health issues, and for Council to decide if it wished to refer that to the Policy Development Unit under Eileen for other further consideration and priorities for other policy development. Averil did ask for nominations. We have got none on this occasion. But I think that is what we should use this standing item for going forward.

**Professor Bob Michell:** My real point is that it is not always going to be to note. It could be something people want to consider or discuss there and then, hence the importance of due notice.

**The President:** If that is the case, the member should come prepared to discuss it.

**Mrs Lorna Jacobs:** I was only going to say that on due notice, if there is to be a discussion, there should be sufficient notice that the person who wanted to raise that matter can circulate information to Council members, and/or that staff can circulate information. So in other words, due notice must be such as to allow an informed debate.

**Ms Seema Agha:** There is a public interest in health issues, which I spoke to you about at lunchtime and to Jeremy. I only got up-to-date information yesterday. It is actually on the case of Baby P. There was a ministerial announcement by Ed Balls on a future action plan,

which provides an opportunity for pharmacists to use as a leadership issue and respond accordingly. Ed Balls has put out a very extensive work programme at very high level which includes Lord Laming, providing an update into the safeguarding of children in the community and integral review of safeguarding procedures for all agencies. That involves health, police and all those who are involved in the lives of vulnerable children. He mentioned a review of the NHS to look at its procedures, and therefore no pharmacies will be involved in the NHS, and that is the important bit about health. Do pharmacists play a role in safeguarding of children? They do, but they do not seem to feature in what Ed Balls is saying. I think it is an opportunity to capture. You have seen there has been a focus completely back on to the role of social workers. I think it could be any professional when things go wrong in the system with systemic failures. I think we have the responsibility to ensure that pharmacists know about their safeguarding roles. I recall that there was some guidance provided last year to pharmacists around their work with vulnerable children. I think we need to be very proactive. I suggest an action plan, including an article, which I would be happy to contribute to, in looking at safeguarding the role of pharmacists. I would say that we looked at the guidance and said, "Does it need to be updated?" There will be a cut-off date in March that Ed Balls is asking for all agencies to report back in March to say what is pharmacy going to do to change its procedures? Does it need to? Is it relevant? Is it fit for purpose? I would suggest that a letter goes to Ed Balls in terms of what pharmacists are doing in responding proactively to safeguarding, and could they do more? And similarly, putting that to the health ministers. I think that is the way forward. This statement came out last night at about nine o'clock. I think we have got time to put something in the press to say, "Pharmacists, take this seriously. This is what we are doing as a professional organisation."

**Mr Gerald Alexander:** Seema's point stands alone. It is shame that the Director of Policy is not in the chamber at the moment, but I am sure you will inform him. Public interest in health issues: Bob pointed out to note any matters, and then he said, "Council should consider." I would say Council may consider any matters raised with due notice and therefore it should be at the discretion of the Council with the President's direction. Therefore, we should have that discretion. It is not an automatic note of these issues. There could be issues that we may need to discuss even at this late hour. So I think we have discretion that should be written into the standing item.

**Mrs Dorothy Drury:** All pharmacists, both when I had my hospital job and community job, and the PCT have provided various levels of training in child protection. So I think we are in a position to help with that.

**Ms Seema Agha:** I think there is a leadership issue. Because you have not been mentioned by Ed Balls, you should go back and remind him, because you are the heart, eyes and ears of the community, and they do not remember that. You will pick up something that GPs will not even pick up. You see the woman bringing the child in. There are noticeable signs and you have accountability as professionals. So I think it is about reminding [people] and it is a good opportunity to tell the public now and the pharmacists. We are active on this.

**Mr David Thomson:** Building on what Seema is saying, it is very worthwhile and to be encouraged. The comparison north of the border is that community pharmacists are involved in the process of child protection legislation. It is particularly useful where children of recovering drug addicts are visiting the pharmacist on a daily basis. This is a routine mechanism that has been used unfortunately on a number of occasions to help protect that child.

**Mrs Sylvia Hikins:** I hope we will move on this quickly. It is disappointing Ed Balls has not mentioned pharmacy as being one of the agencies, and this is important to raise the profile of the profession. When I was at the Leadership Forum there was no-one representing pharmacy there, and we need to keep plugging away with Government Department that we have a real role to play and that is another example.

**Chief Executive & Registrar:** Thank you Seema, that is a timely suggest. I have asked David to get on the case and make contact with you, a letter in the PJ and, if you are happy to co-operate, looking at guidance, which can be done swiftly and a letter to Ed Balls. We have

to present it to the outside world carefully so pharmacists are not presented as policemen, but we can do that and present it constructively.

**Ms Seema Agha:** And it is a reminder to the public that they are part of the community in health care that are involved in this.

**Mr Gerald Alexander:** In addition, Pharmacy Network is one of the social determinants of good health and well-being.

[Council agreed that the matter be referred to the Director of Policy & Communications to take forward.]

The President closed the meeting, to recommence at 0900 the following day.