

## Royal Pharmaceutical Society of Great Britain

### Transcript of the Public session of the Council meeting held on Tuesday 1 December 2009 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].

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#### PUBLIC BUSINESS

#### COUNCIL MEETING

##### Present

President	Mr S Churton
Vice-President	Mr M Astbury
Treasurer	Mr J Gentle
Mr S Acres	Ms S Agha
Mr G Alexander	Mrs M Allan
Professor N Barber	Mr D Carter
Mrs D Drury	Dr C Duggan
Dr P Entwistle	Mr G Hall
Ms S Hikins	Mrs L Jacobs
Mr J Jolley	Mr A Kershaw
Miss Y Liddell	Dr T Learoyd
Mrs S Kilby	Professor B Michell
Mrs A Moore	Ms M Saunders
Mr D Thomson	Mrs V Turner

##### In attendance

Dr B Curwain, Chairman of the English Pharmacy Board, Mrs S Melville, Chairman of the Scottish Pharmacy Board and Mr M Donovan, Chairman of the Welsh Pharmacy Board.

Mr J Holmes, Chief Executive & Registrar

**Mr Steve Churton, The President:** Good afternoon Council.

##### 1. Apologies for absence

I have got apologies from Alan Kershaw this afternoon and Sandra Melville as well.

##### 2. Welcome to guests

First of all, can I welcome our guests at the back of the room, Timothy Barlow from Southampton and District Branch. Tim served on the Branch Committee for well over 20 years, it says here, Timothy. Is that right? A background in hospital and community pharmacy and presently a locum?

**Mr Tim Barlow:** A contractor pharmacist until recently.

**The President:** And a keen Yachtsman, I see?

**Mr Tim Barlow:** When I get time!

**The President:** Gemma is the President of the BPSA. Welcome, Gemma. During the course of meeting, please feel free to contribute.

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### **3. Declarations of Interest**

Can I ask Council Members to make declarations before each agenda item?

### **4. Minutes of the public business part of the Council Meeting held on 7 October 2009**

We have just one amendment to make.

**Ms Martyn Schofield, Head of Corporate Secretariat:** This is the obvious one! We were in York and I have listed it as Lambeth!

**The President:** Well spotted! Any more amendments? Does it accurately reflect the discussions and decisions that were made in York? **(Agreed)**

### **5. Matters arising from the public business section of the Council Meeting held on 7 October 2009.**

We have not been notified of any matters arising, so I assume there are none to discuss.

### **Professional Leadership Matters.**

#### **6. Transitional Working Group.**

Howard will give us an update, in terms of the red and amber initiatives on this report.

**Mr Howard Duff, Director of England:** This is the regular TWG update that the Council are asked to receive. I will concentrate on the reds and ambers as I go through, but will take any questions on matters. If myself or other TWG members cannot answer, we can take them away and get answers for you. Council will notice that there are no confidential parts. Three work streams that were in the confidential section, which were business planning, are now part of the normal budgeting process. It is an unusual year, but it is part of the normal business process. I think you had a good look at that this morning. The organisational developments workstream, the staffing restructure has been completed, although not all the recruitment has not been made. The process and the project has now been cooled down. The third-party workstream is now subject to the individual discussions between the people who own those relationships internally and those external stakeholders.

Moving on to the report, which you have on the A3 paper, we have a red section under the Information and Advisory Service. As you would have heard on previous updates, it has been subject to several issues. The most recent is the inability to find a project manager to run this. We have one who started on 16 November, and his priority will be to get the Information Advisory Service up and running. His name is Chris Sidra and he comes with a background in NHS and other bodies, call services and customer service response areas. So he has had a lot of good industry activity and background.

In terms of the number of posts we are still to fill in the area, we have eleven and-a-half posts. We have now recruited to seven and-a-half of those. Recruitment for the other four areas, one of which is the head of the team, is now subject to headhunting processes, as we have not managed to recruit through the normal advertising process or other headhunting processes. And some of the technicians involved in the call-handling part of it will be recruited for next week. We are turning the corner, but we are seriously behind plan at the moment. Chris, the new project manager, will be taking a plan to TWG next Monday about how we propose to further the next set of pilots for the Information Advisory Service going forward.

The professional support tools project is amber. This is subsequent to the project management recruitment, because that is the team that will be developing a lot of the practice support tools as we go forward. So we are amber.

The project manager's priority really is setting up the information advisory service, which will be his second area of priority. So probably in a month's time he will start looking at that.

That is timely with the appointment of the new Director of Developments Support, Dr Catherine Duggan, who I am sure will want to take that on herself anyway. We are not at risk externally on this, because we have quite a lot of products in the pipeline. So we are producing practice guidance. We have recently for sexual health guidance and we have a mental health toolkit coming out soon as well.

The other amber we have on here is the Vision for Pharmacy work. This is amber as we have a tight timescale to get this finished for the year end. We are now going through a process of ensuring we have the consensus of the profession behind the vision, which is why it is at amber, because we have not seen that yet.

The work is going out to some of the Boards. Two of the Boards have been actively participating in some scenario work, and the English Board will be doing so next week. I think there is a writing day involved on 18 December to tidy up a lot of the content of the vision. So that is a report on all the reds and ambers. I do not know if there are any questions.

**Mrs Sylvia Hikins:** Under local practice forums, I am bringing a comment to Council that was given to me during a meeting on Mersey. There was a conference on setting up a local practice forum. We had two representatives from the Society there who gave a very good presentation to the forum. But afterwards, someone came up to me and said, "There is £400,000 of branch funds out there. Use them." It was pointed out to me that in fact it is not so easy to use branch funds for local practice forums. If the branch wants it, that is fine. I wanted some clarification. I said that I would ask Council to clarify it, so I am passing a message on, if you like. It is under the viability bit. That is why I am linking it on here.

**Mr Jeremy Holmes, The Chief Executive & Registrar:** There is a largish sum of money in Branch funds. It is not quite as large as £400,000. First of all, it is the branches that are making the first wave of decisions to move into local practice forums. If they choose to take their funds with them, I would applaud that. Some of those funds are designated for particular purposes. If they have raised them themselves, for example, for social events, through local sponsorship or through people making donations specifically to the branch, then it is entirely up to them what they do with them. But we are encouraging branches, as they become part of local practice forums, to make use of those funds. Because we have to make every pound work for the members as hard as it can do, and it will not be doing that if it is sitting in a bank account.

**Mr John Jolley:** Howard, I do not know how you rank the colour scheme on this, but I attended the penultimate meeting of the Science Committee the week before last, and what I learned from the Science Committee bears no resemblance whatsoever to what you have here. In that there does not seem to be any continuity planned for science. There does not seem to be any organised structure for where we are going. Furthermore, the little bit at the end about the Academic Pharmacist Academy being integrated seems to be dead in the water totally. And furthermore, there does not seem to be the level of interest amongst the academic pharmacists, the Academy of Pharmaceutical Sciences, to even join the future even. We have only to see what John Gentle told us earlier today about the Academy breaking away from BPC. What I fear here is that with the various workstreams that have failed to really deliver on this particular issue, we are seeing a divergence of science for the first time in the history of this Society. It is more than likely that science will not feature in the new professional body. What are we doing about it?

**The President:** Have you raised those concerns with Jane Lawrence, who is the Workstream Leader?

**Mr John Jolley:** I have, and this was raised in open Committee. In fact, those members of the Committee I am sure will share my concerns. It is not my total concern.

**The President:** I only asked the question because the green rating here will have come from Jane.

**Mr John Jolley:** We did not talk about green rating, as we did not have this document at Science Committee.

**The Chief Executive & Registrar:** The fact that there is a workstream dedicated to science and research is a sign of the importance that the TWG and the process is giving to those two areas of professional activity.

It is true to say that it is half a step behind some of the other workstreams, because it only started in the summer of this year. But Jane has indicated she is well on track, and she is spending a lot of time engaging with the science community. We have had two very substantive and productive discussions in TWG on exactly her workstream, and what she is doing to engage with the science community.

I think there are two real thresholds we have to cross going forwards. The first is the new Assembly and professional body has to make a decision as to whether it wants to put to the day-one membership a new membership category for scientists who are not also pharmacists. The Assembly will make that decision, and if it wishes to put it to the membership, there will be a special resolution. I am hopeful that that will enable scientists who are not pharmacists to become members of the professional body, but it is not in our gift; it is in the gift of the Assembly, and the timing of that, as well as the decision whether or not to do it. That is one threshold.

The other threshold is what this new professional body ought to be offering to scientists, researchers and academics who are not also pharmacists. We are doing a lot of work on that. We are seeking the views of those groups. What would they like in this professional body that would best serve their interests? We are talking with APS, as with lots of other organisations in those parts of pharmacy, and that will mature along with Jane's work, over the next six or 12 months, such that we ought to get to a position, if it is decided that scientists who are not also pharmacists should be members, that we have a ready-made passage for them that we know is attractive to them.

**Mr John Jolley:** Eddy Frank was sat next to me at the Science Committee, and certainly in his view we do not accept that membership of the Academy of Pharmaceutical Science is necessarily the threshold through which we need to get them, because we do not have a concrete plan. There is no perceivable benefit from the Academy even gaining a membership category, because what is the group going to do? All we could talk about was virtual groups, and if the exercise that we had been subjected to within IPG of how a virtual group is going to operate, then forgot it, because it will not happen.

**Mr John Gentle, The Treasurer:** I understand John's concerns. Just to clarify something that perhaps I did not make entirely clear this morning -- the phrase John used about APS breaking away. What happened was that the set up we envisaged of the 2010 BPC did not fit with exactly what they wanted. It was around the number of science sessions and science streams. They decided to have their own conference. They have made it quite clear that they are still interested, should we desire it, that they would be involved in the science input into any conference that we want to run in 2010, and are quite happy to have a presence -- a stall, exhibition or whatever -- at their conference. So whilst we could not agree exactly on the nature of the kind of conference that we both wanted to have, and they had different wishes as to how it should be run to the ones we envisaged, it is not, strictly speaking, true to say that they have broken away from us. They have not declared some kind of IDU. We are still on speaking terms. We will still have an involvement in their conference, and they are still offering to be involved in ours. So just to make it clear that there is not a break with science in the sense that some people may have understood.

**Mr John Jolley:** My perception of BPC is that it is the pinnacle of the year's activities, and there needs to be a lot of dialogue going on about what is happening that is new. If the professional body is to be disjointed from the science community, if we are not going to have any input (albeit that the National Boards will vote for it in the first six months of their formation) that is more or less 12 months away. What we are seeing is a divergence which is occurring now.

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And once they have gone, they will be gone forever. It will then be more difficult to get people back, and we should be taking action which is what I thought. When I sat on the Science Working Group, in the days with Nigel Clarke(?), various suggestions were put forward, none of which have been implemented.

**The Treasurer:** I think it might be true to say that the danger of the scenario that John paints is possible. There is a danger of that happening. However, I am sure that we would be working to make sure that does not happen. I have said to Jane Lawrence on more than one occasion that I regard all pharmacists as scientists at heart (despite recent evidence to the contrary in sales of homeopathy and government inquiries!). But all pharmacists are scientists at heart, and whilst some practice in community, some in hospital, some in industry and some in academia, there is a science based, DNA strand that runs through all pharmacists when they qualify and which is hopefully maintained throughout their career. I, for one, would be very upset if anyone were to feel the Society has taken the view that those who call themselves scientists have no place in the new professional body. I would certainly counter that and say that is not what we are aiming for at all.

**The Chief Executive & Registrar:** I would say there is no stronger advocate of science than Jane Lawrence, which is why she is leading the workstream. I would encourage John, or any other members of Council who have strong views to get touch with Jane, so those points can be recognised in the work she is doing.

**Mr John Jolley:** I have, and we have had a long discussion. Jane's hands are tied in many respects. Jane can do no more than what she is doing, and she is working very diligently towards this end, but she is getting *no* support whatsoever.

**The President:** From...?

**Mr John Jolley:** From either the TWG or from the existing Executive. Martin was at the meeting and he knows full well what was said. I hope he has reported that to the officers. We have a problem which if we ignore, or wait to see something happening, then we are going to be disappointed. As I say, I am extremely disappointed because that group really determines the future of pharmacy, and without it pharmacy has no future.

**The President:** I am disappointed to hear Jane believes she is not getting support from TWG, as I am a member of that group. I think we have supported Jane very well, but I am very happy to speak with Jane offline about her concerns, if she has any.

**Dr Catherine Duggan:** I just wanted to place this into a bit of context. I agree with John that there was an awful lot of work in the TransCom process to identify the fundamental place for science and research in the prospectus. Then the TWG picked up the strands of the work laid down by the prospectus, and perhaps that is where the confusion has arisen. There has been a little bit of a lag time before science and research were picked up subsequently. However, at Science Committee -- where we did have some very in-depth debates, and a bit of soul searching around the place of science moving forward -- we did agree (and I tried to chase up the minutes, so we would have some evidence of this) that the science and research work stream of the TWG would form the basis of the Science Committee strategy moving forward until the point of de-merger, which we think is only sensible, given the strains and pressures on staff. That allows Jane to focus on that, but it also allows the Science Committee to stand up and eloquently promote the place of science to the profession. That was one of the things that we came up with; that we had a body of work, moving forward, that we would all take ownership over from the Committee, where we would talk about the importance (as John said) but also about the importance of the work that is underway. And the offerings that the TWG is supporting Jane in developing with the profession, about what a pharmacist scientist -- an academic, for example, or an industrial pharmacist -- could expect from a PLB. But also, moving forward, what a non-scientist pharmacist could expect as well. I know we are in tricky times with negotiating partnerships with working relationships with other groups, but indeed Eddie was also very, very keen to share the partnership model that

APS has developed with the Royal Pharmaceutical Society over time with some of the other specialist groups as well. So there was a sense of soul searching about the meeting, but additionally we reviewed where we were, and thought we need some urgent action but we came up with some positive ways forward. Let us watch and wait, but I think we did.

**Mr Martin Astbury, The Vice-President:** Just to confirm there was a large and constructive debate at the Science Committee. There were obviously many concerns, but I am very happy with the report back that the Chair, in the appropriate way, has now given to Council.

**Mrs Sue Kilby:** Obviously I endorse all the work around science, because it does not matter which section of the practice you are working in, it is important to have science at the core of it. My concern is about what we will be doing for pre-reg tutors and pre-reg students and what contacts and networks we actually have with the academic schools at the present point in this. The reason is that a lot of this work has actually been done very ably by the education section, which was largely moving into the GPhC. At the Education Committee the concern was flagged up about how pre-registration tutors and students would be supported in the future, because it does create quite a significant chunk of work for the people on the education side. Unfortunately, when going through to GPhC it will not necessarily be within their remit. Therefore, it is really important that we do some risk analysis as to where the gaps are, and what work is actually moving through the education side, which will not be picked up when they are in the GPhC. I am looking for some reassurance that that will be managed effectively for the new professional body. Obviously, it is very apparent that we have the network within the schools of pharmacy and that we also support the pre-registration students coming in. At day one they may not be members, but I am hoping very soon after day one, they can be some sort of members. I do not care what the title is, but they will have some links. I think we also want the students to have links. But unless we have the network already established we will struggle. I want this piece of work looked at. At the moment, I can see there is something around pre-registration and it is really at level 3. I do recognise you have a lot of priorities, but I think this should be more than just left and forgotten about. It needs to be raised up the order of priorities and looked at before we split, not after.

**The Chief Executive & Registrar:** Thanks Sue. I think we are doing a lot of work on this. First of all on pre-registration; yes, it has got a priority 3, but we are looking to elevate that. It has been a bit of a slow starter, but we are looking to make further progress on that. In addition, as I think you know, we have established a very good level of contact with CUHOPS, so we are getting plugged into the early part of the education process. And the BPSA -- it is very good that Gemma is here. We have the bones of a very constructive relationship with BPSA from day one, even before a membership category for students and pre-regers is established within the PLB. And we are looking at how best the PLB can best influence education policy, because I take your point absolutely that most education work has been on the regulatory side to date. We are now looking at how the professional body can best influence the regulator in its development of education policy. As you know, the consultation on education and registration procedures is just out, and that has been added to the remit of the working group for Council and the Boards working group to respond.

So on all four fronts we are starting to pick up speed and I absolutely take your point that that is a crucial area for the professional body to exert its influence, and indeed to recruit future members.

**The Chief Executive & Registrar:** Thanks Jeremy and for the question; it is a very good point.

**Dr Tristan Learoyd:** When speaking with Professor Chris Rostrun, who chairs the Academic Pharmacy Group at the moment, he said that academia in pharmacy faces an uncertain future, and an uncertain future in the professional body. Now if the Chair of the APG is saying that, he has clearly got a well-versed opinion. I think that is worrying. And we are hearing that it is felt that science does not have a place. I am wondering whether there is an issue with effective communication.

Because at the moment with the APG, there is a series of consultations, but when consultation recommendations are put forward, they are not the actual opinion, or they are not the recommendations that academics have made. And the feeling is that academics are putting opinions forward, they are putting proposals forward and then these proposals are being altered and handed back as something completely different. And when looking forward to the future, there is nothing to look forward to. They do not feel as though there is any plan there. If we are going to be the professional leadership body we need evidence to become leaders, to propel the profession forward. Especially if we are focusing on clinical direction, and we need the evidence of academia. So therefore academia has to be central to the professional leadership body.

Yet academia does not feel as though it has a place. What is the plan? We have got three, four months out and we do not know where we are stand.

**The Chairman:** I think that is an assertion, Tristan. I think academia does have a big part and a big role to play in the new professional body.

**Dr Tristan Learoyd:** Where is the evidence? We do not know where we are going with this. If the Academic Pharmacy Group does not know where it is going, that is worrying, and there is no guidance there.

**The President:** I have not spoken to the Academic Pharmacy Group personally, and they have not spoken to me. So you are right in your assertion that there is a communication issue, if that is the case.

**Dr Tristan Learoyd:** Okay, so the communication needs to be dealt with, because it is not being fed down. As a member of Council I am unsure where it is going. If Professor Rostron is unsure where it is going, that is concerning.

**The Chief Executive & Registrar:** I think there are two issues here, if I may say. One is the Academic Pharmacy Group, because a number of those individuals are not pharmacists, and that leads to the question of future membership categories and what the PLB should do, in terms of enabling those academics who are not pharmacists to become members in the future, if the Assembly so decides.

That is one issue, and I can understand why members of the APG were not clear about the future, because it is dependent on a decision by the Assembly to hold a special resolution.

Then there is a separate question, which is how does the PLB secure the right expert advice and input on academic matters? I think that is crucial. We had a useful discussion some time ago which unfortunately Chris was not able to attend, but was invited to, with other special interest groups within the Society, to look at ways in which that kind of specialist expertise could be secured for the professional body, and those involved in those specialist areas could network more effectively amongst themselves. I am happy to pick that up with Chris and see how we can make best use of the expertise of the APG. And even aside from the question of whether the members of the APG might become members of the professional body in the future.

**Dr Tristan Learoyd:** You touched on a point there. You talked about new membership categories. But some members of the APG are not pharmacists as it stands. So groups in the future, even if there is no change to membership categories, you would assume that the purposes of academia -- if academics are not pharmacists -- that they would still have involvement, without a change to the membership categories.

**The Chief Executive & Registrar:** Well that comes under the second category, how we can best secure that expertise and have that advice available to the professional body, even if those individuals are not members.

**Dr Tristan Learoyd:** So therefore, should it be clearer at the moment that we should have

some sort of contingency plan in place. What is that plan?

**The Chief Executive & Registrar:** I am very happy to take that away and talk to Chris, but it was discussed at the meeting that I referred to which Chris unfortunately could not attend. I will take that up with Chris.

**Dr Tristan Learoyd:** It is not clear.

**The President:** Do you have any more recommendations to make, over and above those which Jeremy has outlined?

**Dr Tristan Learoyd:** The recommendation I would make is that there should be a clear identifiable pathway for academia just to be incorporated. I think if something is relayed to the Academic Pharmacy Group, then maybe to the Science Committee as well -- because the two are closely related -- that would be a move forward.

**The Treasurer:** Just to say that the Society has constituted the new Assembly, so it will have a CUHOPS member and it will have a pharmaceutical scientist on the Assembly. I do not think we can send a clearer signal to either group than that, that we will have reserved places for those two groups on that assembly, ostensibly to promote their interests. So I think that demonstrates how committed we are in the long term. Undoubtedly there will be teething problems in how these is representations of the special interest groups, as we go forward. There will be some teething problems in how that develops, but the appointment of those two people, or the reservation of two places on the Assembly, is the clearest signal we can possibly make.

**Mrs Sue Kilby:** We are in a difficult position so far as the APG is concerned, because the Chair of the group is not a pharmacist. He is an honorary member. He is an example of someone who has spent their whole life working for pharmacy and educating and training pharmacists and bringing them on. And just because he had not done his pre-registration he is not a pharmacist. But his contribution to pharmacy is far greater than a lot of other people who are perhaps actually on the register. I think that is why we actually recognised him. It must be very difficult for people like him, knowing what their situation is going to be in a few months time. I think we should not forgot that. He will not be alone in the APG, where we have had people who have served the profession very, very well.

**Mr John Jolley:** It was certainly clear at the last Science Committee that we were not sufficiently aware of what the latest position was with regard to the TWG. You could alleviate some concerns certainly by telling us what is going on, if all the members of the Science Committee and the academic group could be informed as to what the position is with regards to the TWG. Because all that was said at Science Committee was that there is meeting of TWG at some point after, and everything would be all right on the day! I am afraid this is not an area that we can go along with trust, without knowing precisely what it is that the TWG are suggesting.

**The President:** I think it is a good point. It comes down to communication again. At the end of the day, Jane is the workstream leader for this workstream. The Chair of Science sits on TWG. The documentation which TWG has is readily available on the internet. I am not sure what vehicle you suggest we could use to further advise you.

**Mr John Jolley:** I am not aware of information on the internet. Can we not just have a simple distribution to all members of the Science Committee of what it is?

**The President:** Absolutely.

**Mr John Jolley:** Because clearly communications have failed. It may be they have not, but there are some gaps. But every speaker has identified a concern about various areas where there appear to be gaps and issues we cannot allow to go to the demerger.

We have to take action now, which by leaving it until the Boards to decide we are in fact going to disadvantage those two particular groups.

**The President:** Just so I am aware, because I obviously was not at the Science Committee, have you invited Jane to give you a full update in terms of all the work?

**Mr John Jolley:** She was at the meeting.

**The President:** I am just questioning what more you require, John, because Jane is leading the workstream.

**Mr John Jolley:** For example, we could find no way, and Jane included in terms of how the Science Committee will progress under the National boards -- there is no provision within any of three Boards to make up the issues of science in order to be able to collect what is the current information. One of the things you put down here is: "Ensure that PLB becomes the first port of call ... **(reading to the words)** requiring information on science." There is no system within the PLB as we perceive it which will be gathering what are those key issues as they affect pharmacy. It is too fluffy.

**Dr Catherine Duggan:** I think part of that is because we have had a review about the status of special interest groups and committees. And until the PLB is instated, and there is a need for gathering that together, the role of the Science Committee will not, as it stands, automatically move forward, because the Science Committee is constituted under the RPSGB at present, which is not going to be the RPSGB moving forward. So that did raise a concern. But I think, in many ways, part of that is addressed by how we are going to interact, moving forwards, with the groups that exist within the profession already and outwith the profession. So that we ensure the non-pharmacist scientists are part of the process.

I think because we do not have a blueprint for how that will happen, it is causing consternation. But additionally, we did say at the Science Committee that once those gaps in knowledge were filled, that it was incumbent on members of the Science Committee to champion the role of science in the professional body moving forward, so that we would be equipped with the information to give to our colleagues who are raising the questions. So it was an in-depth discussion that was raising these as issues moving forward, that was seeking to find solutions for that, so that we could be the champions of science, because we are members of the Committee. I think it is really tricky at the moment, because lot of committees are going to change in their constitution and in their composition and in their support functions. That is what is causing the consternation; not the fact that we do not need science any more, but we need some kind of grouping in the new PLB that allows the scientists to come together and deliver the things the PLB should be delivering on science. Does it make sense?

**The President:** Yes, it does. I do not want to give the impression that science is not important here. It is clearly is important. We are a profession based upon science. But I liken it to growing pains. We have an awful lot to do and we try to prioritise workload as we move towards D-day. That is not to say that we need to let anything drop. But there is a degree of difference in terms of the attention we can devote to any particular point at any particular time. I understand where tensions are and I understand the comments that have been made. We will see whether we can redress those. But we must not redress those at the expense of things which have been prioritised as priority one here. We have to recognise there is only so much resource around here to take things forward, which is what we are trying to do as best we can. If we failing in that, then we need to know. You have given us that indication today and we will take it away.

**Professor Bob Michell:** It is a different point, but it also came from Science Committee. Unfortunately I was not at York and I had not seen the Council minutes when we discussed this in Science Committee. But in the Council minutes it records that the museum was put on hold for the moment, and I understand that.

But it also talks about “continuing to research the establishment of charitable status of the museum and its implications”. I would have liked to have seen the Science Committee minutes before I said what I am going to say, but there are plenty of people who can correct me, if I have got it wrong. It seems we are now, perhaps inadvertently, into chickens and eggs, because so long as the museum is on hold it is most unlikely that any further advance can be made with regard to charitable status. So if I am right about that, I think it is as well perhaps that we understand that is an unintended consequence of York.

**The President:** I was not at York either, Bob. I am looking at the minutes of what was said and agreed by Council.

**Professor Bob Michell:** I am not getting into a debate, but there seems to be an unintended consequence made clear at Science Committee.

**The President:** I think “to continue to research the establishment of charitable status” is what is happening. Is Bernard around? I think that has what is happening. So we are continuing to investigate and explore opportunities.

**Professor Bob Michell:** I think the bottom line on the research is that as long as it is in limbo, we will not get charitable status nor will we advance any closer to it, if I have understood what I have heard at Science Committee.

**Mr John Jolley:** We were informed that, subsequent to the decision that was made in York, there had had to be some cost reductions in that area, and various personnel had been put on short time. Until the museum can get into a charitable status, there is no way they can start seeking funds from other sources to be able to carry out many essential works necessary in maintaining that. So in many respects the creation of the National Boards is not going to be a controversial issue in setting up a charitable fund. The one request that was made was: Can we not go ahead with that, reverse the decision made in York, thereby ensuring that the museum could in fact seek funding from outside of the Society?

**The President:** Let us not reopen the debate of something which was decided in York.

**Mr John Jolley:** I am reporting what was said at Science Committee.

**The President:** I understand that, John. Jeremy, on the point that things have moved on or changed since this minute?

**The Chief Executive & Registrar:** A couple of prior observations. The first is that the organisational development work was put in place before this meeting in York and before these minutes. So the staffing change is part of the OD plan that Council was aware of in the summer. The museum has been really quite successful in a number of areas, including generating funds for the Ordinance Development Officer, for example, without charitable status. Charitable status is not absolutely straightforward. There are some tax implications. There are some governance implications. It is not an easy question to resolve. There are pros and cons which even the keeper of the museum recognises. It is not a straightforward issue. We are continuing to explore that. I would draw Council’s attention to the first point in the minutes, under 09/1/21: “Council agreed to support the museum remaining in the professional body if possible.” In the end, it will be a decision for the Assembly as to how that is managed. But I would not say we are in limbo at all. Council took the view, which I absolutely support, that it should remain within the professional body, if possible. And the ‘possible’ bit is for the Assembly to decide.

**Dr Catherine Duggan:** It was a point for information that the Society was given at our meeting, which was that a grant that had been pursued, if you like, had not been successful, and one of the points was that the future of the museum was not certain, which was the chicken and egg point which Bob wanted to raise. We wondered whether as a Committee we could perhaps more positively, instead of it being on ice, if you like, put forward the point

you have just mentioned, Jeremy, that we fully support the museum in doing its work and seeking such funds. It just seems that perhaps we had set the ball rolling in a direction we did not mean to; in that they went for funds and then the funding was not given, because it did not look like they had our support, which could have made them more independent, which could mean they were not dependent on the PLB moving forward. That was out debate.

**Mrs Alison Moore:** I was looking at what will it says on the TWG workstream paper on the museum, and noting that it appears to be different from the Council decision that was made in October.

Because the (iii) was, "to continue to research the establishment of charitable status for the museum," which was agreed in York. But under the museum section of the TWG paper, it says: "Following Council's decision at their October meeting to leave any future decision on the museum to the governing body, this project is now on hold." So that says something different to what Council actually agreed. Perhaps there needs to be some clarification to make sure that the project is not reported as being on hold, and that no reporting will continue, when Council actually asked for it to continue.

**The Chief Executive & Registrar:** I agreed that is not very well worded, Alison. It really picks up on (ii) in the minute from the October Council meeting: "to leave any decision on the museum's future to the governing body of the new professional body." That is what it was referring to, but it is not very well worded.

**The President:** It is not clear, Alison, I agree, so we will change that. It is clear, but it is different, and it is not correct.

We are going to move on now because we have spent 50 minutes on item 1. Thank you for the debate. If are there any questions on the green areas on here, the best place to direct those questions is to the project managers of those workstreams, and I am sure they will be able to help you. If I could request that item 7, the response to the GPhC standards for professional leadership and also item 9 on the regulatory response are considered together. There seems to be logic for considering them in adjacent items. I suggest we deal with them first thing tomorrow when Seema will be with us, as she has been leading the work on the professional response. We will take those tomorrow as the first thing on the agenda. We will go on to item 8.

*[Council  
i. received the report; and  
ii agreed that a strategy be developed to ensure that the expertise of the Special Interest Groups be maintained for the professional leadership body]*

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

This refers in paper 120A to supply chain issues. David will lead us on this.

**The Chief Executive & Registrar:** This paper was not in the original pack, so I hope everybody has a copy of it.

**Mr David Pruce, Director of Policy & Communications:** It is a relatively short paper. I will lead you through the thinking behind it. We have had reports in the pharmaceutical media and directly to the Society that there are increasing stock shortages on quite a wide range of medicines, and that there is a substantial increase in the number of medicines that are affected by supply problems over the past year. The main problem behind this is the weak Pound and the strong Euro. That has reduced the benefits of parallel importing and thus an increase for demand for UK medicines within pharmacies in the UK. Previously about one in 17 prescriptions were dispensed using parallel imported products. At the same time, it has become profitable to sell medicines destined for the UK in other European countries, so-called parallel exporting, which is, I must emphasise, a legal activity under European law. The UK has benefited from parallel importing to the detriment of countries like Spain and Greece, who have been some of the main suppliers of parallel imported material. The issue is complex and our assessment is that everyone is blaming everyone else in the supply chain.

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.

The ABPI claim that 11 percent of pharmacies were exporting medicines and this was creating shortages. When you actually look at the figures, they come from IMS, and IMS recently admitted that actually they are estimates of pharmacies that are undertaking trading activity, and that may not constitute exporting. However, it is obvious that some pharmacies have been taking part in parallel exporting.

The pharmaceutical industry are part of the cause behind it, because they have differential prices across Europe, and that makes it profitable simply to move medicines across a national border, if people can make quite good profits by doing that. It is more than just the pharmaceutical industry involved in that, and the differential prices are partly determined by the industry and partly also by the national government.

There have been also consistent rumours of wholesalers exporting medicines to Europe that were originally destined for the UK. Of course, one could say that the Department of Health has made quite a lot of money out of parallel importing through the claw-back system. So the issue is complex, but if we know the effect it is having on pharmacy. The ABPI has published figures showing that the number of emergency deliveries have gone up from about 6,000 in a five-month period in 2008 to 77,000 in the same period in 2009. The bottom line for pharmacies is that they are having to spend a lot of time trying to source medicines, arguing with companies that they have not exceeded their "quota", often having to fax prescriptions through to manufacturers to prove they have a real genuine need.

A lot of people have tried to sort it out. We put out a Law and Ethics bulletin. There was a joint bulletin put out by MHRA, ABPI, PSNC and various others, outlining the legal and ethical consequences of this situation.

What we would like now to suggest is that the problem is still there. It is affecting patients. It is possibly only a matter of time before patients are harmed, and pharmacists are spending an inordinate amount of their working lives sourcing medicines, which is something that, frankly, they could spend their time better on patient care.

What we suggest to Council is that now is the time to have an independent inquiry to really look at the evidence, look at the causes and, more importantly, look at the solutions, because each party blames everyone else. Perhaps now is the time for an independent inquiry by the Government to get this sorted out once and for all. That is what we would like to suggest to the Council.

**Mr David Thomson:** My understanding of the situation is that it is deteriorating; it is not getting better, in spite of slight economic recovery. I am aware that Pharmacy Scotland has done a lot of work trying to identify what the actual situation is, and they have sent representations to European Parliament and lobbied extensively as well. It might be more appropriate to lobby governments, rather than just the UK Government to get the point across. The other point on point 4, just to bring it home in reality, although it is put in the future tense, patients are suffering currently. There are examples of patients not getting vital medicines that they require. As a profession, as a Society, we perhaps should be expressing a concern about the standard of care that patients are likely to experience, rather than majoring in on the problems that pharmacy is suffering. It is wider than the local issue. It is a patient safety, patient care aspect, which is very much more important.

**The Vice-President:** I am actually amazed it has only rocketed to 77,000. Whether it be me, my pre-reg or trainee technician, it feels like I have made those 77,000 phone calls myself. Exactly as Dave has said, it is the patients at best who are being inconvenienced, and at worst many patients are going without their medication, or are having to be urgently sent back to the doctor. And unfortunately a lot of the medication that we are talking about is niche medication, very specialised medication to do with schizophrenia as just an example, and those medicines can be easily swished from one thing to another. So I totally support this approach and we need to lobby this as quickly as possible.

**Professor Bob Michell:** I fully support the objectives. But I wonder though, as we are an organisation in the red rays of sunset; the Government is an organisation in the red rays of sunset. And both the Government and the opposition loathe public inquiries anyway, although clearly it would not report until the sun had set completely. To me, if we want to get something done for patients in a hurry, I would wander much more in the direction of banging the drum with the Today Programme, a letter to The Times, a letter to the British Medical Journal and generate some aggro in that way.

**Mr David Pruce:** We are, is the simple answer. It was front page news in The Independent on Sunday this weekend, and we gave a statement to that, where I did suggest that there should be some kind of inquiry into it. We are also aware that there is a television programme being made about it, and we are going to appear on that. So whatever you decide today, we can implement tomorrow morning.

**Ms Yvonne Liddell:** I wanted to say what David said, that patients 'are' suffering. As someone who is in community pharmacy just now, having to make numerous calls just to get a drug that we have used our quota. And if you are a high dispensing branch, you do not know what your quota is. You do not get it for two weeks, you ring up the manufacturer and they say, "You have used up your quota." This should not have been allowed to happen in the first place. So can we not put something in that we stop sending drugs from the UK abroad in the short-term, until we have enough to cover our own patients?

**The President:** I think we have already issued a Law and Ethics bulletin on that very issue.

**The Chief Executive & Registrar:** Yes, absolutely.

**Dr Brian Curwain, Chairman of English Pharmacy Board:** Council may like to hear that I received a phone call this morning from my own Trust, saying that the Acute Trust that supplies my community hospitals is now out of stock of some of the emergency drugs that we have in our emergency packs. So there is a very real and imminent risk. All they can tell us to do is if the stock goes out-of-date, use it anyway, and that is not very satisfactory. So for David's information, I bring that to you.

**Mrs Sue Kilby:** David mentioned that part of it may be due to the differential pricing of the pharmaceutical companies for the different countries. Some companies actually try to adopt a process where they actually have the same price across Europe. That is why we actually have problems with some of the costs within the UK, and why we have things like risk sharing in here at the moment, because they are not in a position to actually lower the cost for certain drugs. So I think you have to be careful that it is not used as a standard statement. I am not sure what all companies, but some companies actually have standard pricing. You will get fluctuations because obviously the value of the Euro and the Pound goes up and down between the exchange rates. So you will get some variation. We will just have to be careful how we actually state this. You are absolutely right that there are an awful lot of issues involved here. It is not one simple issue. But our stance should be on patient safety and trying to ensure the patients get what they want and need for their treatment. It does [cost] a lot of lot of time effort in all sectors. Because even in the hospital sector they are constantly getting phone calls from people in primary care saying, "We can't get X or Y drug. Can you actually get a supply through the hospital?" Sometimes companies do have emergency lines, where you can get additional supplies. And sometimes that may be useful information that we should put out to our members as well, if we have not already done so.

**Mr Gerald Alexander:** I will start from a European perspective, because I know a little bit about it. The Greeks and Belgians have been suffering from shortages for years. If you just refer to the Code of Ethics, the 7 Principles: "As a pharmacist or pharmacy technician you must make the care of 'patients...' and it does not say your 'patient' 'but patients' "...your first concern." I do not remember hearing this learned Society being concerned about the patients in Greece and in Belgium over the last number of years, where they have suffered shortages at the hands of the arrangements that exist in Europe for cross-border trade.

Clearly our remit is the concern of UK or GB matters, so if we restrict our comments to that, but I am trying to put it in perspective, that this situation has existed prior to our concerns being raised.

I would take issue with the estimate the ABPI have suggested that only one in 17 prescriptions was filled by a parallel-imported product in 2006. I think from 2006 and before, the estimate would have been much higher. Therefore, if you could just assume that the figure I am going to quote now is incorrect, that it was 40 percent and not 5 percent; 40 percent of the market was supplied by parallel imported goods. That means that these days, 60 percent of total supply in the market came from UK manufacture and 40 percent came from elsewhere. The manufacturers have stated clearly that they are now producing 120 percent of the former amount that they used to supply to the UK market. If you work that out, that is 72 percent, which means there is still a 28 percent loss in the market.

Manufacturers have applied quotas to pharmacies to receive certain amounts of goods, and those quotas are causing pharmacists and pharmacy technicians a great deal of difficulty in obtaining supplies. And patients are being put at risk by that reduction in the UK market supply. The Chief Pharmacist made reference to this matter earlier in the year when he was concerned about hospital trusts potentially exporting goods, and suggested that they must not do it. Whether they do or whether they do not, I have no knowledge, but clearly he would not have said it unless he thought they did. I think this is a governmental matter. I am very happy to support the action suggestion. The only problem with inquiries is that they take too long and action is never taken. I think the action needs to be taken by the UK Department of health, the three or four Departments of Health. They need to take action and decide on how they are going to deal trade across Europe, and there ought to be some inter-governmental relationship over this. The issue really is with the manufacturers making the matter worse by applying quotas. Applying quotas means that pharmacists cannot receive medicines to supply for their patients. I think there should be some naming and shaming going on. And the issue of pharmacists making the care of their patients their first concern is something that really is important to us. So as far as a professional regulatory body, we should say, "You should be thinking about your patients prior or in advance of your commercial activities." Clearly the relationship that we have by trading across borders in Europe allows the goods to be shipped from one place to another, and it is not illegal, and we have been the beneficiaries, as David said earlier, for some years. But there has to be a level playing field. Obviously there is too much UK stock being taken out of the UK market, because of the pricing of the Pound and the Euro. I think the issue should lie fairly and squarely at the Department of Health's door. It is the responsibility of the Chief Pharmacist of England, the Chief Pharmacist of Wales, the Chief Pharmacist of Scotland and that of Northern Ireland. They should be dealing with this and talking to their minister, and their minister should be coming up with appropriate solutions, talking to the ABPI and talking to manufacturers. We have actually discussed at PGUE the potential risk of director pharmacy schemes. Director pharmacy schemes are being looked at, and I think the NPA has actually considered putting the matter to the OFT as being an anticompetitive practice. So director pharmacy schemes, which are manufacturers' supply schemes to pharmacies, are potentially anticompetitive, and I think the whole issue should be dealt with by the UK government as a whole. I do not know whether setting up an inquiry to take steps that could resolve the issue -- because it would be about a year or so before it came to a conclusion. Although I support it, I really think it is down to the UK Government to take action appropriately. It is not really for the regulator to do anything other than to say to those who are regulated by the regulator to behave responsibly.

**Mrs Sylvia Hikins:** I would also like to point out the problems that are occurring in hospitals. A hospital pharmacist said to me last week that some patients cannot have certain procedures in hospital now, certain x-ray-type of procedures, because of the lack of the drugs required, in order for those procedures to happen. So it is not just the taking of medicines, but also investigative procedures that are being affected within the acute setting as well. So I think it is extremely serious. I take Gerald's point that setting up an independent inquiry will take time, so is it possible we could ask for two things. First of all, to lobby the Government to take immediate steps to alleviate the present situation, and (b) to set up an independent

inquiry that will put forward whatever, to resolve the current medicines supply problems that pharmacy is suffering in the UK. So it is two parts:

Look at it now to see what can be done now to fill the gap, and an inquiry to take a more long-term strategic approach on what changes need to be made.

**Mrs Lorna Jacobs:** As a layperson, I would like clarity on one issue. Gerald raised the point previously that there are shortages in other European countries and we have done nothing. Are we saying that the UK manufacturers are manufacturing, and they are only prepared to manufacture a certain amount at 'this' price (the price the UK Government will pay) but it is going abroad? Previously does that mean that there was an excess of supply in other countries, that was being exported or imported into the UK? Or is there actually not sufficient supply in the whole of the European Union, and now we are the ones that are suffering. In other words, is there not sufficient being manufactured?

**Mr John Jolley:** A point of information. Some 10 years ago, the UK was the second net largest exporter of pharmaceuticals in the country. We were a net producer and we were exporting to the world. We are now an importer. Most of the medicines -- the day-to-day medicines -- that we are using are being produced, particularly in those emerging countries, China, India and South Africa. Now what you will have is an import situation, not only to the UK, but to Europe. So if one country suddenly takes a significant increase in volume, not to excuse the problem but nevertheless what we are seeing is the traumatic change of going out of parallel importing. We are now not parallel importing -- or I cannot credit the sense of anybody who is parallel importing into the UK. We need to fill that hole of what we were parallel importing, and it can only come from countries which are the net producers of the drugs that we are using, and they may not necessarily be in Europe.

**Dr Tristan Learoyd:** Just dealing with another issue. It was the direct supply which came in probably about 18 months ago now. And from my own experience of when I go on locum on a Saturday, the ordering has probably increased my work day by 20 minutes, which has increased the workplace pressure. So it very much feeds into that issue and consequently has a double effect on patient safety. Not only can they not receive medicines in certain cases, but also they get extra pressure on the pharmacist.

**The Vice-President:** Just a statement that a number of times in the press there has been mention that a certain number of pharmacists, or a large number of pharmacists, are parallel exporting. I know now it has been quoted as "a number of pharmacies are doing it." Certainly so far as I am concerned, and as far as I am concerned for the profession, pharmacists do not. Exactly as you said, they have the best interest of patients as the top of the list of the Code of Ethics. It is not pharmacists who are parallel exporting. It is businessmen who are parallel importing, not pharmacists. If they are doing it, they are doing it in their capacity as a business person. It is not pharmacists who are parallel exporting.

**Dr Catherine Duggan:** I agree with the points that have been put forward about doing something now and doing something longer term. I wonder if we might wrap that up into the mix, because an awful lot of the press I saw over the weekend, if you were not a pharmacist, you would have gathered exactly what Martin was saying, that pharmacists (ie business people) are making money out of parallel exports and are leaving patients to suffer. I note the valiant point made by the Pharmaceutical Society in clarifying that on the Independent front page, but still, if I were a lay person reading it, I would have got the impression that pharmacists are at this point of time thinking about their pockets rather than their patients. We need to do something to say, as a professional body, we do not support this and as professionals we do not support it either. I think that would be hugely beneficial.

**The Chairman:** Thank you, Catherine. It is clearly an important issue for a large number of our members and, probably more importantly, their patients. That is something we should address. I get the impression that not only do Council agree with what is being asked of them in this paper, but also we should agree to lobbying hard whoever it is who can bring influence

to bear to address this situation in the short term as well, and also wrap up a PR publicity activity around this issue. Yes? **(Agreed)**

**The Chief Executive & Registrar:** Can I take this opportunity to thank David for bringing this to Council's attention. We have known about this issue for some time. It came to prominence when we issued the Law and Ethics bulletin back in July. It is a really good example of teamwork. It came to the professional leadership group, the executive team within the Society responsible for the professional leadership functions. I think Lyndon brought it to the group. David picked it up and said, "I can tell you what you should do". He went on to the front foot, talked to the Independent on Sunday and the paper has come to Council and I think we have had a really important, constructive and well-informed debate. This is David's last Council meeting, and I think it is great that he should go out on a high, demonstrating what his role is really about, and I would like to applaud David for that. Thank you. **(Applause)**

**The President:** I want to echo the comments made by Jeremy.

**Mrs Sue Kilby:** Taking this important issue up, because we do not want it to disappear. Is this going to be one of Catherine's challenges? We do need reassurance that there will be continuity.

**The Chief Executive & Registrar:** That is a good point, Sue. First of all, the country teams are being beefed-up, in terms of their policy and public affairs work. But we will also have a GB-scanning role, which will feed into the director of professional development to support, so we will not miss those GB-wide issues, even if they are not picked up at a country level in England, Scotland and Wales.

**The President:** And of course Charles Willis will also be heavily involved in this issue in terms of lobbying.

[Council  
agreed

*i. that the government be lobbied for immediate action to be taken to alleviate medicine supply problems; and that government be further lobbied for the establishment of an independent inquiry into steps that can be taken to resolve the current medicines supply problems]*

### **Regulation of Advanced Practice in Pharmacy.**

We have Andreas to present to us.

**Mr Andreas Hasman, Revalidation Policy Co-ordinator:** Good afternoon. I will say a few words about this paper and the background to it. Supplementary and independent pharmacy prescribing has been regulated in the UK since 2003. But other emerging areas of advancement in specialist practice have been brought into a similar regulatory framework. One reason for this may be that it has been difficult to formulate clear principles for the definition and delineation of advanced pharmacy practice outside of prescribing. It may also be that there is simply no need to regulate other kinds of advancement in specialist practice, because those areas of practice are of little risk to patients and the public.

In May 2009, the Society established an informal, in-office Task and Finish Group to consider these issues. It was an informal consultative exercise to determine if it would be appropriate to bring a proposal to Council to develop policy. The group consisted of 14 experts from across pharmacy practice, professional leadership and regulation. It met three times during 2009. A report was finalised in October. As the work of the Task and Finish Group progressed, the professional leadership body initiated its own project on advanced and specialist practice, under the leadership of Dr Carol Evans, head of professional development.

It became clear that the two projects were complimentary, and that a decision on the need for regulation could not be taken forward without the profession first creating a

framework for the recognition of advanced practice.

In a parallel development the four UK Health Departments commissioned the Council for Healthcare Regulatory Excellence (CHRE) to advise on regulatory bodies' handling of developments in advanced and specialist practice across all the health professions. The CHRE sent a recommendation which was published in July 2009 that regulation of advanced practice is not necessary in all but a very few specific cases. As you would have seen in the paper, this recommendation is consistent with the conclusions of the Task and Finish Group.

So we are now asking Council to agree these conclusions and that the report can be made available to the GPhC and other interested organisations. We would also ask that the report is made available on the Society's website.

**The President:** Thank you. Does anybody have any comment on the content of the paper to start with?

**Professor Bob Michell:** We are talking about the regulation of advanced practice in pharmacy, the task and finish report?

**The President:** Yes.

**Professor Bob Michell:** If we look at page 18 of 23, I think it is beyond belief that the primary responsibility for the governance of advanced roles should rest with employers. *Tesco! Asda!*

If we look a little further down at 4.10: "Relying on regulation by employers 'may' be problematic." That is the most *incredible* understatement! The conflict of interests is written up in neon lights!

Can one imagine that the advanced training of pilots would be left to Bangladesh Airlines and what they felt about it? Of course you need to regulate this sort of thing independent of employers, who have clear potentially and actual interests which may be in severe conflict with either the training of pharmacists, of the protection of patients who receive the results of that training.

**Mr Andreas Hasman:** Those points relate to CHRE.

**Professor Bob Michell:** I understand that, but I am just saying CHRE – Council for health care regulatory *excellence*. Is there excellence? It seems extraordinary to me.

**Mrs Dorothy Drury:** I am always a little bit worried when I see NHS, because you could have advanced practice in a private hospital, couldn't you?

**Professor Nick Barber:** I think it is a very good paper. I do not share the concern about employers. Regulation is a very, very rough tool. It is pretty ineffectual. Employers -- and I think all NHS pharmacists and independent hospital pharmacists for example -- have generally managed very well the quality of the work. In fact, the advanced work and all the best practice has come out of these settings where there has been good employer engagement. As a chief pharmacist for an employer, I was very clear what the boundaries were. That was my role. And when I started, the chief exec said, "It is my role to try and get you to do things, and sometimes it is your role not to do them as a professional." And that is quite right. That is what you are there for as a chief pharmacist. And what you are there for as a professional is to be able to resist those pressures and stand up for them. And in fact, you can get far better control of quality as an employer than you can as a regulator. We saw at the weekend the Dr Foster results were completely different to the CQC results. One form of regulation, and the other which could be a basis of regulation. Looking at work on care homes and the errors in care homes which were published about two months ago, the

regulatory quality of the homes on their reports was completely unrelated to that quality which we found from the research. So regulation has significant limitations, and I think we need to have a network of good employers, good professional practice, good leadership regulation, regulation and so on which interweaves to provide safety for patients and too advance quality of care for patients.

**The Vice-President:** I have no problem with the regulation within NHS hospitals, no problem at all. But I am glad that Professor Michell has pointed this out. I would have enormous concerns if we are sending out, or are agreeing to this document going out, that in any way we are saying that we believe employers should be regulating this. I am totally opposed to that. I think it is a very dangerous thing. It puts in jeopardy the professional's independence, in my opinion, because they can be in some way be beholden to their employer, which is a concern out there in the private world.

**Mr David Thomson:** On reading through the report a concern from my perspective is that we seem to cite Department of Health policy and the English White Paper as the reference point. But was consideration given to other policy documents in Wales and Scotland to inform or double-check that the implementation could be applied to other countries as well?

**The President:** Was that a consideration?

**Mr Andreas Hasman:** The starting point was that in the membership of the group we had representation from the group from Scotland and Wales, as I remember. The policy context in those other countries were discussed as well as part of this. I guess the recommendation from this work is that we do not need policy at the moment in this area. Had that recommendation been different, and if we had initiated a more comprehensive policy development process, we would have made it much more clear where all the underpinnings of that policy would need to have.

**Mr John Jolley:** I was disappointed in this paper in that I felt it certainly did not address all of those issues, as covered in the Government White Paper. I was particularly concerned by its focus on NHS activity. Last month I attended the last meeting of the IPG at which various concerns were raised about the inordinate number of new regulatory regulations coming into force which affect members working within industrial practice. And we were assured at that meeting, "Ah! There is a structure for the advanced specialist practice coming along. You will see some marvellous issues!" When I look at the membership of this group, there is absolutely nobody with any industrial practice. Now this regulation is becoming more and more involved. There is no mention here at all in terms of pharmacists working within industrial practice. What sort of regulatory support are they going to receive? I accept it is outside the remit of the Department of Health. We need to take the blinkers off. I would certainly not recommend any adoption of this until such time -- if we are going to invite industrial members to become members of the new professional body, we should at least have some policies and procedures which will impact on them.

**Ms Marcia Saunders:** I actually thought this was a more generic paper than that, and I really thought it was an extremely good paper. I wanted to pick up on the point that both Bob and Nick addressed earlier. First of all, you referred, Nick, to the difference in regulation and actually epidemiological and scientific information, and the battle that is going on now between Dr Foster and Care Quality Commission is a good example of that. But I think the problem that Bob refers to arises because we get into some loose language sometimes, and regulation by employers is a piece of loose language. What we are really talking about when we say there is a balance of responsibilities between employers and regulatory bodies is that there is regulation, on the one hand, and there is contract management, performance management or direct management on the other. And as an employer, which I am, I am not a regulator and I have never thought for a second I am a regulator. So it came as a surprise to see that the CHRE was thinking in those terms. They are wrong, but it is not, frankly, a huge issue. I do not think many employers are abused by that. It is certainly issue as it appears here, but I do not think we ought to allow it to creep into the language.

And I think in our discussion we should be quite clear that we are not talking about a shared regulatory responsibility across regulatory bodies and employers. That is not actually what is being shared. There is a responsibility for ensuring performance, on the one hand (that is the management responsibility), and assuring it on the other, which is the regulatory responsibility.

**Mrs Sylvia Hikins:** First of all, can I reassure my learned Council member that there was actually somebody from industry on the group, because I have worked in industry, and I was also talking to IPG members. We did consider the QP and we also considered the role of pharmacist in ABPI sign-off as well. I am actually very closed. I know it has Peter's name on it, but I know that Andreas was heavily involved in pulling together this paper.

I think he should be thanked for getting all our thoughts and views and coming up with something that we can basically sign up to. It needs to be tweaked here and there, but actually I think it is a very good paper. What we were very keen to try and do was actually try and reduce, or not introduce additional regulation unless we absolutely had to. I think there were several people on that group who argued vehemently that we did not need to have additional regulation for each additional bit of work that we actually did. Okay, we have got it on where there is an annotation on the register for prescribing, but that is something different. Actually, I think what John is thinking about is the piece of work that is actually going on the professional side, which is looking at advanced and specialist practice, and what the competencies are that are actually required to actually achieve that. That is actually a different piece of work. This piece of work was looking and helping to advise the regulatory side as to whether they needed to include additional regulation for the different levels of practice, and if we could actually identify what is specialist practice. I think we have quite clearly said: "Look, we do not need to do it at this point in time," and actually I think the profession should be quite relieved that we have come up with that. And I thank Andreas, Peter and the rest of the group for coming up with that consensus view.

**Dr Catherine Duggan:** My points have been covered by Marcia and Sue. This was an advisory group for the regulation of advanced practice. As you said, Andreas, there is a lot of work going on about the professional development and support that is needed to develop knowledge and skills to advanced practice, and that you were taking a watching brief on the work of the PLB moving forward, in order that regulation is mindful of those developments and that anybody who is practising at an advanced level does not do so without being adequately skilled and appropriately knowledgeable in a recognise, structured and supported way, so patients are not put at risk. I think there are many in our profession who practise in that way but do not have at this time -- how can I say -- the 'badge' to prove it. That might need to come from the professional body first off, and if they are particularly risky longer terms, maybe that is the point at which the regulatory would step in. I understood that to be the work of the group. I have to say, in backing Sue up, that it is a confused area out there. We have never really debated it in a unified way before, and I think the variety of views and approaches, and a lot of the work that has been done by specialist groups outside of the Pharmaceutical Society, was brought in under the umbrella, and I think you should be congratulated about thinking of regulation in such a progressive way. I wanted to pick up Marcia's point, that it should not be about regulation by employers, but that employers should be, one might say, aware of the need for somebody to be appropriately knowledgeable and skilful, if they are going to be treating patients who are perhaps more complex, or who have complex medicines needs. That might allay Martin's fear and perhaps employers who have not been mindful of that before should be.

**Mrs Alison Moore:** Following on Catherine's point, it was Martin's comment about being worried about employers regulating, I think from how I read this report, chapter 5 is what we are recommending; chapter 4 is what CHRE said. Chapter 4 was the bit where maybe you and Bob had concerns. What we recommend in 5.3: "Existing regulatory arrangements such as the requirement to practise within competence and employers' responsibilities to assure patient safety are sufficient to control any additional risk." I do not think there is anything we could not sign up to with regard to that.

**Professor Bob Michell:** It is a lovely mantra, but let me give you a specific example of where it just is not so. The Veterinary Pharmacy Group -- and we can debate whether it is specialist or advanced, but it is sure as eggs (in the clinical sense) not in the basic curriculum, in most cases. Now, so far as companion animals are concerned, which is where the lack of training is the most severe problem, some of the supermarkets have indicated that they want to move into this area. And the reason is that there are a small number of veterinary medicines, usually to do with parasite control, that are pretty profitable. Most veterinary medicines are not, because the market is small.

And the idea that existing regulatory frameworks, ethical duties and practice within their competence is somehow going to deal with that situation is naive. The supermarkets want to sell those medicines.

The pharmacists in the supermarkets, in all probability (with a few exceptions), will have had no relevant training on the clinical aspects of companion animal medicines, as opposed to the legal aspects. Where is the incentive to break out of that conflict of interests? The employee wants to sell medicines because they do not want to lose their job. The supermarkets want to sell the medicines because they are profitable. Who other than the regulator (currently us and next to be the GPharmC) can do anything to rectify the situation? And yes, they may have four legs, but they are patients.

**Mrs Sue Kilby:** I hear what Bob says, and we could debate all day as to whether there is enough or not enough within the MPharm at the present point in time. There is variation across the schools of pharmacy as to how it is covered and in what depth. Yes, I think there is a need for people to have some knowledge and understanding about veterinary pharmacy. Like I also think there is a need for them to have some knowledge and understanding about management and leadership skills, and there is a need to have some knowledge and understanding about clinical pharmacy, and probably tableting technology, if you are working in that area. The problem is that we are facing a situation where we are really signing up for life-long learning.

And once you have done your MPharm does not mean that you have actually finished your training these days. If you are in a hospital, then you sign up normally to do your certificate. Then you move on to your diploma. Then you probably do some specialist thing in some other area. We also know that we have the Certificate for Companion Animals, and I believe now you also have your MSc for Veterinary Practice that is being set up as well. I believe that if people are working in this area of veterinary pharmacy, then they should be prepared to sign up and do some additional training in these areas. And I think there is a role for the professional body to support and endorse and encourage people to undertake this additional training. And it is one of the useful resources we can have within the professional body to give direction as to where they can go to get these additional skills and training.

**The Vice-President:** I accept and am aware, as Andreas has pointed out, it is a CHRE report. But my concern is because it is one of the chapters that is in there. If it was an appendix at the end, that is not a problem. But when it is part of a report that you have produced, and it is in there, that is where I still think -- although you have put the other bits -- that is a concern. I have really been impressed with what I have seen so far with the work or TWG on how the new professional body are looking, trying to take us forward with advanced and specialist practice. I am totally wed to the fact that the standards will be set by the new professional body. And I believe the only people who should be able to take that away from you, if you have reached that standard, would also be the new professional body. Therefore, that is how I see, if anyone was regulating it -- and I dread to say the new professional body should regulate anything -- the only one who could take it away from you would be the new professional body would take away your advanced section and not your employer.

**Mr Alan Kershaw:** Turning to the report, I wanted to bring us back to what we are being asked to do, we are being asked to allow other people to see the work that has been done, and I think it is absolutely right that we should. The report is good, as far as it goes -- and when I say that, I mean so far as it could go. Because looking at its remit, it was about: was there a pressing case for introducing the regulation of advance and specialist practice?

One of the central things to emerge from discussions very early that was we do not actually know what those are, and they vary from one place to another. Some very important things were found out by the group about what is going on, one of which is that whatever you do, you cannot base the regulation of this on professional titles. It is about the role you are performing.

It is very easy to say whether someone is a prescriber or not. It is not so easy to say all these other things, and the work needs to be done by the professional body, which is in the lead. This is a classic example of where the professional body and the regulator need to work in harmony. Because if the regulator is going to use the opportunity to annotate the register, in ways that the law will allow them to, where else would they go but to the lead professional body to find out what those roles are, what their content should be and how to identify the people who should be worthy of that annotation. In just the same way as you come on to the register in the first place.

It seems to me that that is a major contribution in this, to identify the fact that advanced and specialist practice means a whole lot of different things in different places, and that needs to be carefully analysed by the role you are performing, and the significance of that, in terms of patient safety and beyond that. That is work we could not possibly do in this timescale, or even within the lifetime of this Council, but it is work for the professional body to do, and they should, and then be talking to GPhC about which of those, if any, require special annotation on the register. I propose that we move to the questions and agree that we can put this report out for wider discussion.

**The President:** Are Council content for Andreus to make any minor textual amendments to this to reflect this discussion, and perhaps to give consideration to Martin's suggestion of moving chapter 4 as an appendix, to avoid uncertainty and misunderstanding. **(Agreed)** And to making the report available to interested parties. We will break for 15 minutes.

*[Council  
agreed*

- i. the report of the task and finish group, subject to additional clarity being made in the report that Chapter 4 was from the CHRE and the tightening of language relating to regulation and the employer responsibility; and*
- ii. that the report be made available to interested parties.]*

**(After a short break)**

**Mrs Wendy Harris, Deputy Registrar & Director of Regulation:** I am not going to repeat the paper that you have in front of you, which was the update on actual regulatory activity which was provided to PRLOG. If you have any questions, I will take them offline. This is just a verbal update following the PRLOG update on 5 November, which was the last meeting of PRLOG. The Chief Executive, Council members and Chairman Designate of the GPhC were all in attendance. There was ceremonial baton passing on, as Ken Jarrold has referred to. Batons were purchased and passed on, ready to hand over the introduction of GPhC to those designate people. They cannot take that on in full, because the Pharmacy Order has now been laid in both the Scottish and the Westminster Parliaments, but has yet to be made. The process that will happen is that they will be debated in Scotland and in Westminster during this month, following which they move to the House of Lords for debate, and then to the Privy Council for approval. Then following that, the GpHC will become a legal entity. Simultaneously there has also been a constitution order for a very rapid consultation, which follows on from the advice to PRLOG on the governance arrangements for the Council, and our Governance Committee have responded on our behalf for that.

That is all there is to say really. The standards and rules are at the consultation, but there are separate papers coming to Council for discussion tomorrow on that. And it is still on course for a Spring date opening.

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But until we know the progress of the debates which are the, Scottish part of Westminster Parliament due for this month, we do not know whether there will be further delay. We are certainly likely to miss the December Privy Council.

There is not a Privy Council until February, which is why there may be talk of this slight delay, but we do not know until the debates are held.

**The President:** Are there any questions for Wendy on the PRLOG meeting? **(None)**

*[Council  
i. noted the update and the business continuity information.]*

### **11. Transition Planning Update.**

**Mr Bernard Kelly, Director of Commercial Services & Resources:** Jeremy asked that I try to give an update to Council on the planning for the transition, for the passage of regulatory responsibility to the GPhC. As you can probably imagine, there is a huge amount of work to be involved in this. We have been working on it for quite a long time. The DH has been working on it for quite a lot time. The people seconded to the DH have been working on it for quite a long time. And as Wendy has just indicated we are nearly there -- or at least we think we are -- but we are not holding our breath that is actually going to happen tomorrow.

You will probably come up with quite a few questions, because it is a large and fairly wide ranging subject matter. I will do my best to answer where I possibly can, but quite frankly, on the finer nuances on regulation of pharmacy, I will probably have to call upon my colleagues, and particularly Wendy, to help in relation to this.

Let us start and say where have we got to. The Draft Pharmacy Order has been published. The full impact assessment has been published and the response to the consultations has been laid before the Scottish and Westminster Parliaments. Subject to parliamentary approval, which is not expected to be withheld, the Order is expected to be made at the next full meeting of the Privy Council in early 2010. The Constitution Order and the Appointments Directions will also be made at the same Privy Council meeting. The Constitution Order will then be laid in both Parliaments for negative resolution, which basically means that unless someone votes it out in its entirety, it is actually going to happen. There will be no debate on the subject. Once that has happened, then the appointment of Council members and the Chief Executive can be formalised. We already know who the Chief Executive is going to be and we know who the Council members are, and they are busy working in designate status at the moment. But until that actually happens, they do not have any formal status, and at that point in time the GPhC acquires legal status, which is a stepping off point for what it then can actually start doing.

We have heard about some consultations already this morning. The Standards Consultation is being conducted by CHRE. There follows a rolling programme of consultations on a wide variety of matters, starting off with registration and fees, fitness to practise, Statutory Committees an advisers, appeals, registration and education appeals that is), premises and CPD.

That is an awful lot to get through, but until that consultation has been gone through, and those new rules have been adopted by the GPharmC, there would be no new rules from which they would operate.

However, because the Civil Service anticipated that would be quite a difficult situation with a new regulator from a standing start, they have made transition provisions within the Pharmacy Order. And they allow for transitional arrangements to apply to committees, the information on the register (which would be passed to the GPharmC), register applications (in other words, if someone is in the process of having an application to be registered with the RPSGB, but by the end of the time that they go through that application process, it is assumed that they can continue to do, even though they might start with the RPSGB but they finish with the GPharmC).

There is again the transitional provisions to allow appeals against registration, or failure to register, to be continued to be handled as smoothly from one regulator to the new regulator. Similarly for fitness to practise cases. The aim of all these transitional provisions is to actually allow business to continue on a day by day basis, and not to have a complete disruption to the regulatory process as a result of the GPharmC coming into existence. The same thing applies for accreditation.

If a school of pharmacy or a school is trying to apply for accreditation, it starts with the RPSGB. It may finish with the RPSGB, but if the timing is unfortunate, then it will finish with the GPharmC.

Then we have grand-parenting for technicians. Information and records to the GPharmC, in other words their provision within the order for the minister to effectively state: You will hand over this information. Again, it is in the interests of maintaining the smooth transfer of regulatory activities. We have transitional provisions for the TUPE transfer of staff, property rights and liability, ability for the minister again to make the provision for grants or loans to the GPharmC, premises. I am sure some of you will be relieved to know it is not about transferring number 1 Lambeth High Street to ownership of the GPharmC. It is about information in relation to premises who are subject to the register of premises. Similarly for pre-reg tutors and pre-reg trainees. Again, it is smooth transfer wherever possible until the new set of new rules, standards, or guidance are applied. The assumption would be that the existing processes under which regulation has been conducted by the RPSGB will continue until replaced by others.

So what have we been doing against all that background? Well, quite a lot of work at a fairly detailed level. Quite some high stuff at a higher level as well. You will be see tomorrow I think -- provided we do not get on to it today -- the budgets for 2010, and of course the GPharmC itself has been looking at what holds for it beyond 2010, as does the PLB. There has been a lot of work done on IT, records, office space, Tupe and finance issues. So the initial GPharmC budgets were established by the impact assessment. That was not work carried out by ourselves, but carried out by people working on behalf of the Department of Health, and the basis under which the impact assessment went with the consultation.

Based on the impact assessment we have an understanding at the moment on revenue sharing for 2010 to be established. We do not have the fine detail -- that has yet to be determined. But we believe we have an overview as to how we think that revenue could be shared, and shared on what was considered to be a fair and equitable basis. But the starting point of it is the regulatory fee revenues, that is assumed the GPhC will need to establish itself in its first year.

There has been a huge amount of work on IT. We started work over 18 months ago and the work still continues. And the closer we get to the detail of what is involved with the GPharmC, and the closer we get to the timetable, the more we realise that there is more to be done. So what have we done so far? We duplicated things like service and software, certainly for the register, which is the most important plank in terms of software, using Concept, which is the database we have used for quite a long time. We have also spent quite lot of time and effort introducing a new case management system, which I did not actually list, but I should not miss that off, because it has been a tremendous piece of work. I will interject at this point -- because I am sure someone will ask us -- that was all paid for by monies provided by the Department of Health.

We have been very successful, and in all honesty I think the DH has been very willing to provide money to ensure that any work that needs to be done, and expense incurred in actually bringing the GPharmC into existence shall be provided.

We have developed the provision for new registration numbers and cross referencing to existing numbers, so that at the point in time of separation, there will be a new register which will be the GPharmC's property, which will contain the new registration numbers, once they have decided upon what the format of that might be, but with a cross-reference back to the RPSGB's reference for historical purposes, and to ensure that there is continuity of record keeping.

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We are basically at the point where we have unzipped, in the background, the email systems, so that all we need to do is overlay what will be a new GPharmC email address and domain name over the existing regulatory staff. That is all stuff that has been done in the background, so there is a huge amount of work there. There is already a GPharmC website which is under development. There is a lot of work to be done in terms of transferring information from the existing RPSGB website on to the GPharmC website. Of course that is information specific to regulatory matters.

We have had a long running project on electronic document storage and separation. This project, which again is funded by the GPharmC, has been running 12 months. Where we have got to so far is that we have effectively now an electronic record and catalogue of all the documents within the RPSGB that are deemed necessary to be stored and carried forward for the future. We have those documented and split, ready to be transferred to GPharmC where relevant, and for where relevant to be retained by the PLB. All paper records have been catalogued and stored, and we hope get to a situation where we introduce a destruction policy soon. Because, as you know, with paper if you do not do something about it, it just accumulates and accumulates. I do not know if you have ever cleaned your loft out recently, how many boxes do you find from the last time you moved? It has been extremely useful for me, as I have had a new kitchen built. I went through the cupboards to find the stuff I could not store any longer, and I was amazed by the dates on them! We need to put a 'sell by' date on our records and actually just bin it at some point in time. Because we cannot carry forward the level of records that we have been storing in the past. That applies to the PLB and the GPharmC and to publishing as well. We just accumulate. We have so much off-site storage, it is unbelievable. It is cheap, but it never seems to shrink. It just gets bigger and bigger. Paper is a thing of the past. It has to be electronic and it has to be filed once and once only, so we do not have duplication of records. We had a little problem electronically a couple of weeks back in the Society when the file and print server went down. It did not affect the day to day operations, just that if you had stored a document and you went looking for it, you could not find it. We were offline for about two days on that. It did not stop emails coming in and out. It did not stop the Concept system. It did not stop the publishing systems. All our systems were operating. This was just the server where documents were filed, and they had to basically reconstruct it. There were one and a half million documents in the server, and that is apart from the case management systems, etcetera. That was just people keeping copies, and there are probably something like 400 or 500 copies of the same document. That is the sort of discipline we need for the future.

There has been a huge amount of work on HR, as you can imagine. People are any organisation's main asset. All I can say is that the 'main assets' in this organisation are feeling pretty fragile and under a huge amount of pressure. We have been living with the prospect of change for a long time and we know it is not going to happen tomorrow morning. So we have got to live through the next stage or phase. So we have gone through a phase one restructure. We have been through a phase two restructure and now we are about to start a phase three restructure. We have had a fairly large turnover of staff, but considering the stresses that are imposed on people because of the uncertainty of the future, I think we have done remarkably well to keep things running as well as we have done.

So what are we looking for in HR? We want to provide outsource services to the GPharmC, and I think the GPharmC wishes to take those outsourced services, but we have not got down to nitty-gritty negotiations yet. But we have tried to produce an SLA for consideration to an outsource service model. We are working on TUPE and have been doing so for quite a long time. I think Society staff are a little tired of being consulted. We have had employee consultations, restructuring consultations and TUPE consultations.

And we will continue to have them, because we have to continue to talk to people and ensure that we do our job, and do it legally, in the best interests of the Society, the GPharmC in the future and the staff at the moment. So that means individual and collective consultations. So the HR department is working very, very hard and has done a hell of a lot of work with individual members of staff and groups of staff.

We have had to prepare due diligence materials. Employee and consultants -- that is people who are not on a strict employee contract. We have a lot of people, such as health and medical assessors, medical advisers, question markers and question setters, who are not strict employees, but they provide services and they need to be continued and carried forward as smoothly as possible for the sake of the on-going activities.

We will eventually get to a finalised staff consultation arrangement, and in preparation of the TUPE consultation which will lead to the TUPE transfers. This is all stuff to be done in the future.

In the finance area we saw this coming some time ago, so we have started separation of our ledgers some time ago. We have now completed it. So we have separate ledgers for publishing, commercial services, the PLB and regulatory activities. And with ledgers go the balance sheets. We are in the process of trying to prepare ourselves for completion statements and we are preparing an SLA for services to be supplied. We have not yet with the GPharmC, because there has not been anybody to talk to yet as to exactly the extent, depth and breadth of those SLAs, in terms of the services that will be supplied, but we will hopefully get there soon. We have prepared a task list and plan for establishing banking arrangements for the GPharmC, when it acquires legal status. Until it acquires legal status it cannot open a bank account. It cannot do anything. It has no legal authority. So the week, day or minute (whatever it is) after the GPharmC acquires legal status, we will be knocking on their door saying, "Please can we have a copy of your utility bill? Can we please have a copy of your passport?" and we will take those down to the bank and say, "Here we are. This is what we do. Can we have a bank account, please?" Then they will go through their money laundering procedures, etcetera. Then we will get to the stage where someone will allow the GPharmC to write a cheque, to pay into a bank account, to pay us for the services we are providing them with.

Building services. Again there has been considerable work over the past two years. If you think what this building used to look like two years ago, compared to what it is now. The third floor, the professional leadership body; the second floor, entirely regulatory activities. The fourth floor is publishing. Then on the first floor is rag tag of mongrels, who do a bit of everything for everyone! **(Laughter)** We have to think about the detailed things, like the GPharmC will want their own budgets. They will want access control for their areas that are unique to them. And visitors badges accordingly. We have already designed those, and some people are walking round with the GPhC badge on, even though GPharmC has no legal existence. Catering, taxes, mail and couriers. "How am I going to get my post? It is going to be delivered to what address? Is it going to be delivered to me or reception?" Detailed stuff. We are all working on that sort of stuff, which is taking place in the background. It is the nitty-gritty of stuff that just has to happen for a building to work, and for every organisation to continue to operate. That is about it really. That is an update on what we have been doing, where we are have got to and the work ahead. Does anybody have any questions?

**Mrs Sue Kilby:** My question is about the register. Obviously it will go with the GPharmC, but we will need a list of people that are in the professional body. Will we keep a copy of that register? I know it will go out of date fairly quickly. The other element of that is when we were filling in our fees for this year, we went through a whole long list of declarations, but there was nothing on there on what sector we were working in.

Bearing in mind we are in the process of having board elections, and people are having to stand in sectors, I wondered why we could not have had something on there which actually helped to determine which sector everybody was actually in, if we were filling it in online. Perhaps you could clarify where we will be with the register, because obviously once it goes to the professional body, if we do manage to keep a copy -- and I do not know what restrictions are on it -- it obviously will not be a register. It will be referred to as the list, will it?

**Mr Bernard Kelly:** At the point of transfer there will be two copies of the register. Once will be handed over to the GPharmC. It will be stripped of anything which is membership information and which is unrelated to regulatory activity.

The other will be the traditional Society register, which is a mixture of professional information and regulatory required information. We will not be able to maintain the list, that register, forever. It is our responsibility under the Data Protection Act to write to those people on the list and say, "We hold this data on your behalf, which we have collected under our previous arrangements as the regulatory and professional leadership body.

If you wish to stay a member of the professional leadership body, we would welcome you into our membership and we will retain this information. If you do not wish us to retain this information, please let us know and we will then, as a requirement under our obligations under the Data Protection Act, have to destroy that information." We collect it for one purpose. People have an option to tell us whether they want to stay on the membership list or not.

**Mrs Sue Kilby:** I think we need to agree what we are actually going to call it. Are we going to call it a list? **(Inaudible)** ... it will not be a register because it will not be a legal document.

**Mr Bernard Kelly:** It will not be a register. It will be a list of members. As regards the declaration, I understand it was quite extensive this year. Although I understand that it is no different to the previous years, but it asks you the same questions but individually rather than collectively. There was nothing on there about which area of practice you were in. We have always asked that people update their personal information on that type of activity through the website, and we continue to do so. It has never, to my knowledge, been an actual part of the actual retention fee return exercise. We do wish people to update that online, where possible.

**Mrs Sue Kilby:** It has always been a major issue that they have not had access to information, and it would be helpful if we could have it on the form; if you could direct people to update information.

**Mr Bernard Kelly:** I think there is always a difficulty with the retention fee exercise to try and pack a hell of a lot of information into what has to be necessarily a limited size form, otherwise you end up with a piece of paper where people get fed up or tired of reading, before they get to the end of it. It is something that has to be treated seriously, and therefore has to be as concise as we can manage it. It is not perhaps as concise as people would like.

**Mrs Dorothy Drury:** How long will it take to give registrants the new numbers, to get the new numbers?

**Mr Bernard Kelly:** Do not take this as gospel, because the detailed planning has not been finalised yet, but the idea is that they would be allocated a number, once the GPharmC takes over and then informed of what that number is.

**Mr Gerald Alexander:** Just a little question, President. Bernard, perhaps you can answer this. Transition planning and continuity planning run side by side. If there is slippage in time on the date (which we hope there will not be) what is the continuity planning for the current organisation, in the event that slippage takes place, and is that part of the audit process or is it not?

**Mr Bernard Kelly:** It is basically business as usual, Gerald. That is exactly what we are doing. We are doing all this stuff on top of the business as usual. We all have day jobs, which we continue to actually do. And we continue to actually supply that, in accordance with our contracts of employment.

So we are trying to keep both the regulatory and professional leadership activities running, while at the same time we know there are a number of parallel workstreams. We will continue to do that until such time as the actual split and transfer of regulatory responsibilities happen.

**Mr Gerald Alexander:** Presumably the slippage would only be very minor, but if it were for longer than anticipated, would there be a risk to the organisation's current function?

**Mr Bernard Kelly:** I think the only risk comes from staff fatigue, more than anything else. I think we have proper processes in place. Regulation has never failed in the Society. I think it has been an exemplar for a good few years now, which is reflected in the CHRE reports. Business happens day in, day out. If it were to slip seriously, then I think the only thing we can say is that it is just fatigue on the part of staff and -- and I must involve you in this -- fatigue on the part of Council members, who are looking forward to a point in time when their responsibilities will finish. But if it slips, you are still going to be responsible. You are still going to be the Council of the RPSGB, and you will have to continue discharging your duties as such.

**The Chief Executive & Registrar:** And just to confirm for the record, we take our current responsibilities, as I know Council does, very, very seriously. We are just going through the first part of the self-assessment exercise for the next CHRE review, which is sitting on my desk right now. And are taking that seriously, and intent on business as usual, whatever the date of the transition to the GPhC is to be.

**Mr John Jolley:** A simple question, Bernard, which I have been asked many times. What is the basic reason for bringing forward the closure date for submission of annual fees?

**Mr Bernard Kelly:** Just purely to be smarter administratively and more efficient. We were very, very lax many years ago. When I first joined here, if I remember rightly we were striking people off for non-payment of fees in July, when the fee was due in January. Obviously, because we know we have the transaction arrangements coming up, we would not want that to be extended so that for some reason or other someone had failed to pay and transferred into the GPhC without the record being updated. We are trying to keep it tight. We have brought it forward so that people who do not keep themselves up to date on the register were struck off for non-payment by the end March last year. We are trying to bring it forward to the end of January. The fee is payable on 1 January, and failure to pay on 1 January, according to the rules and regulations, means that you will be struck off for non-payment.

**Mrs Valerie Turner:** One thing I would like to clarify. With regard to the signing of the declarations and the payment of fees, are you going to do like ... **(Inaudible)** and ignore [the fact] that if you have not done the declaration by 17, December that the direct debit will be cancelled? Because I know last year that did not happen.

**Mr Bernard Kelly:** I am struggling to have the detail of this, but I will try my best to answer it. Wendy will correct me if I am wrong. To allow us to collect the direct debit, which I think goes out at the end of the first week in January -- the date is in early January anyway -- we have to be able to give the instructions to the bank, and the bank then passes it through its processes, which allows us to call the direct debit. We cannot actually do that unless we know that the member has actually made their declaration. It is exactly the same process that one would go through, if paying online. But just because it has gone through the direct debit system, we have to have an earlier cut-off point in time.

**Mrs Valerie Turner:** That is fine, but what I mean is you put the date in -- say somebody is thinking there is a direct debit that they do not want to go through; they want to pay it in another way -- and they think "Right, I will let the declaration slip, and then send a cheque in or whatever afterwards?" Will that direct debit be cancelled, because what I am saying is that last year it was not?

**Mr Bernard Kelly:** Can we take that one offline? It is quite a detailed question.

**Dr Tristan Learoyd:** Just a point about backing this up into December. This has created a lot of financial hardship, especially for younger pharmacists, including myself. Because before we would have the leeway to be able to pay that through the January salary. I am now having to pay for it with the Christmas salary. It is creating mayhem. This is a really miserable Christmas now because of this.

**The President:** Can we thank Bernard and the team? Thank you for your hard work.

### **13. Patients and public involvement**

**Mrs Sylvia Hikins:** The reason I am presenting this paper to you is that Ray, who was Chair, is no longer on Council, so you are stuck with me. What you are asked to do is to note the progress in the delivery of the Society's PPI strategy and, subject to your comments, approve a report prepared by Vanda Thomas, our PPI manager. You can see by the text of the report there has been wide-ranging, proactive discussion and contribution by the Public Liaison Group to both consultative and strategic documents and reports. Some of the responses have been that of critical friend. Others have added weight to the Society's position. This is exactly how a public liaison group should work. But that, of course, is just the start. I suggest that the GPhC will be differently focused once in action. The Society's Public Liaison Group has been seen, essentially, as being professionally focused, dealing with the issues of pharmacy and pharmacists. For example, the draft pharmacy vision document, the Section 60 consultation and so on. The shift with the GPhC will be a patient and public focus, with standards and outcomes all set to achieve or maintain patient safety and public protection. That means all the good work undertaken by the Public Liaison Group needs to be built on and extended, which will include adequate resourcing and capacity building. Patients and the public are legitimate stakeholders within the details of the Pharmacy Order, which I suggest places an obligation on the GPhC to consult with them. With that in mind, I hope that once the annual report has been finalised, a courtesy copy will be sent to Bob Nicholls for information.

Finally, I would like to thank Vanda and her group of members of the public, who have given their time and energy to engage with us. Thanks especially to Ray Jobling, who has chaired the group over the past year.

**The Chairman:** Thank you, Sylvia. I know Council are appreciative of the work done by Ray and Vanda and the team. Do we have any comments?

**Mrs Kay Blair:** I have one general comment and a couple of comments on the document. One of the challenges of PPI is not only the involvement, but actually determining what the success criteria are, and what the outcomes and measurement of its effectiveness is. Because I think it has been a great challenge to get the public and patients involved. I think people have the perception that the public and patients are queuing up to get involved, and they are not. So trying to get a fair representation, etcetera, is very important. I really welcome the views that the next stage is actually looking at measurement criteria and the outcomes of all of this. Because to me, that is the bit that has been missing. That is my general comment. I did have a couple of comments on page 4, under the Responsible Pharmacist. I thought the last sentence needed amplification: "There is not much confidence in 'it' at the moment." I thought that needed something. And I also thought under counterfeit medicines, the first paragraph, second to last sentence, "patients would only really discover that drugs were counterfeit if they had no effect." But presumably also if they had adverse effects, which might be even more important. I thought that should be added in.

**Mrs Dorothy Drury:** Just on page 6/7, the name and registration number of the Responsible Pharmacist also needs to be displayed in the pharmacy. So we are doing that. But I think the public want to identify the person on duty who is the pharmacist. I think Bob will back me up, that we have asked for clear name badges, perhaps using the restricted titles. You can have some name badges that you do not know who the person is, and you cannot always relate to a certificate on a wall, and so on. And sometimes things like "pharmacy manager" might not be the pharmacist. And you can have other titles.

**The President:** Are there any more comments?

**Mr Gerald Alexander:** Not on the paper, but for the next time they look at it, I think perhaps they should be looking at the supply issues in pharmacy as another bullet point for them to look at.

**Mrs Sue Kilby:** Just a general comment. Are you focusing just on community pharmacy, or are you also considering patients' perspective in the hospital sector as well? It seems to be focusing on the community sector, rather than hospital. But pharmacy is a whole range of areas where they would actually come into contact with patients.

**Ms Vanda Thomas:** We do actually focus on all areas, but mainly, in the first few years, focus has been on what staff have been bringing to us -- particularly projects the Society has been looking at. We have been focusing on staff and mainly in that way we would be moving on to develop other things, specifically coming from the liaison group members that they would identify areas that they would like to concentrate on, working with the public, but mainly with the supporting policy and development of the Society.

**Mrs Sue Kilby:** Obviously pharmacists have contact with patients and the public in hospital and also primary care and industry as well. It might be useful to consider those aspects, as well as looking at the pharmacy profession.

**The President:** Are Council content to approve publication of the report?

**Professor Bob Michell:** Could I reinforce Dorothy's point? It really is relevant. If you bear in mind the main reason we could not have a retired register was that the Department thought that people might be confused as to who were 'real' pharmacists and who were retired pharmacists. I said then -- and it was not the first, or the last time -- much more important was that, confronted with a row of faces in the pharmacy department of a shop, patients wanting to speak to a pharmacist, someone who can give additional clinical advice, should know which person that is. So it is jolly depressing to see that "more thought is needed as to the best way to identify which person on duty is the pharmacist." It needs a millisecond of thought. There should be a unique and distinctive badge, as there has been for a veterinary nurse for about 50 years. It does not need more thought.

**The President:** I am going to ask a question, in terms of the future of this work. I do not know, Sylvia, if you could resolve this for me. Is this a GPhC work piece, going forward, or is it to remain PLB?

**Mrs Sylvia Hikins:** It is GPhC work.

**The President:** Okay. Could I ask Council to approve publication of this report? (**Agreed**) Thank you, Vanda.

*[Council*

- i.       **noted** the progress in the delivery of the Patient and Public Involvement (PPI) Strategy and;*
- ii.       **approved** the annual report for publication.]*

### **15 and 27 English Language Competency of EEA Pharmacists**

If we could take item 15 combined with 27, papers 126 and 134, the English Language competency of EAA pharmacists, as probably the last item of the afternoon.

**Mrs Wendy Harris:** The purpose of the two papers is, first, to update you in terms of activities that have been achieved more recently, and the second is to suggest ways forward with this. I think for the purpose of this meeting, given that this is matter that has been an issue I have brought to Council on a number of occasions, it is helpful for me to finally précis for you everything that has been achieved over the last few months to make it a matter of record.

We first brought this to Council's attention in March with the response to the Section 60 Order for the GPhC, where the current Pharmacists and Pharmacy Technicians Order, which does

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.

not permit us to routinely test applicants from EEA countries for their competency in English language, has been rolled into the proposed Draft Pharmacy Order. Our response was to say that we were not content with this, and that we wished to have it as a two-stage process, one which recognised the qualifications of those applicants from the EEA countries, and secondly that if we believed there was a necessity to check for language competency, because it was poor, or lack of competency had been revealed in the application process, that we should be able to do that on the grounds of patient safety and public protection. Council supported that and we responded accordingly to the Department.

That was not then subsequently included in the next or subsequent iterations of the draft order. So to press this further forward, we took legal opinion from Queen's Counsel on whether our interpretation of the EU directive was correct, that it was permissive, and did allow us to check language competency, as long as that was not systematically undertaken, which was indeed the opinion we received. We were told by the Department that their view was that this was a matter for employers and not for the regulator, and that the employers should test for language competency from anyone they employ. So we surveyed all the employers and those results have been reported and published in the PJ. We met with the Department of Health to further press the case, and we are told by them that it may be of assistance, if we gained the support of all of the other regulatory bodies, that they viewed the matter equally, and also if we could bring to bear any evidence of fitness to practise cases that involved lack of competency with English language of EEA applicants. This was also raised with the Chief Executive of the steering group on a monthly basis, either by Jeremy or myself, to alert those other regulators to it and to try and bring them online with us. We shared our legal opinion subsequently with them as well, so they could see the very question and the nature of our concern. Gerald assisted us with the PGU, who undertook a survey of all the other European countries to determine whether they tested for language competency, and that has been provided. Then there was a report in the PJ covering all of this, with a report of the survey.

At the last Council meeting in York Council asked that the President write to his counterpart, the chairs of all the regulators, to see if those Councils could also debate this subject. We did send a letter which went from the President, but we only sent to those regulators who had not come on board with us. We did not think it appropriate to write to those who had already said yes, they were aligned with us. We have now received one letter of response back from the GDC, who have discussed and set some action in train of their own to look into the matter further. We have received a consultation from the Department of Health, which is a guidance document being issued by the EU which actually states our position that there can be a two-stage process, and that the EU does believe that testing, where it is necessary, or rather the evidence of competency can be requested, again as long as it is not undertaken systematically.

And finally, following another paper which was received at York, David Pruce has also written to the Care Quality Commission and primary care organisations pointing out the need for language testing. So we have been very, very thorough in collating the information and evidence to show the need for this. We still continue to believe that we do need to be able to ask for evidence of competency with English language from some applicants, and we are now at a point where I am asking Council for the way forward. There are some options open to us, which are contained in the second paper, which is to say: Do we provide all of this information to the Department of Health and ask that they revise the Draft Pharmacy Order that is currently in front of Parliament awaiting debate? Do we go wider than to the Department of Health, other Government departments, who will have an interest in the mobility of professionals from other EU and EEA nations, and other regulators, such as the Care Quality Commission? If we are not able to have amendments to the order, might this Council send a legacy policy issue to the GPhC Council to ask that they consider introducing rules that allow and introduce this two-stage process, and to seek evidence? And might you want also to go to professional bodies of the other professions, to see if they would act in concert with you?

**The President:** Thank you, Wendy, for all of the above.

**The Vice-President:** The Royal Pharmaceutical Society has been a gold standards regulator for many years.

And I am very proud that our profession is leading this charge on this patient safety initiative. It beggars belief that any regulators could not support this. Your registrants have to be able to communicate in the language in which they are speaking to their patients. It beggars belief that is the case. And I think now it is definitely the time we have to go and speak to the other professional bodies and share this information with them, and then they too can speak to their regulators and hopefully persuade some common sense down that approach. I also support all the other things you were suggesting, in directions of travel. I do hope the GPhC will champion this in the future, as I am sure the new Royal Pharmaceutical Society will as well.

**Mrs Sylvia Hikins:** I find it extraordinary that if you become an under-graduate in this country to take an MPharm, you have a language requirement. You must have achieved up to a C grade at GCSE English language or the ELTS level 6, preferably preliminary level. So isn't it extraordinary that here we have an arrangement where an undergraduate must be able to communicate to learn the practice of pharmacy, and yet there is not a language requirement in actual practice of pharmacy in this country. I think that is an extraordinary contradiction. Extraordinary too, I think, is the lack of response from the GMC, particularly now following the Take Care Report; although I note it is an interim report, so they still have plenty of time to make a noise. And I think that we ought to gee up some of the other regulators. Maybe it is on back boiler, because they have so much other work they are doing, but I think we need to up the ante there, and try and get at least some of them on board with this issue.

But what we have found in the paper is that in fact there is something about access to the profession within EU law, and I think that is the peg that we need to hook it on. And that okay, the recognition of professional qualifications within the EU is one thing, but the requirement for access to the profession is another separate one. I do think that because this is a public safety issue, I think we ought to set up some questions with some of the MPs that we know will be on our side here, and work on them, so that if they can actually do anything about the Pharmacy Order, so be it. But I think we need to be very proactive there. And yes, I think we do need to strongly put a legacy policy together, so that the GPhC will pick this issue up, because I am sure it will not be solved within the next few months.

**Mrs Lorna Jacobs:** First, I would like to declare an interest, as a Council member of another regulatory body, the NMC. I would like to comment most specifically on the fact that this has been in the Section 60 Order, and is going to be in the Draft Pharmacy Order, which seems a strange thing legislatively, in that my understanding usually is that good law is enabling and not disabling.

And it seems bizarre that something should be restricted that could, for different professions, prove to be useful in protecting patients. That is clearly that regulators should have the option for doing what is right for their professionals, but to have legislation that inhibits them in general would seem to be not a good thing.

**Dr Phillida Entwistle:** I would like to support Sylvia. We have done all we could be expected to do as a gentlemanly profession, and now the time has come to lower standards to try and get out there and fight this, wherever we can. If that involves MPs, certainly our key speaker at BPC, says "Anything I can do to help you, just tell me and I will do it." He will be a great lead on this. It is not just him, but there are other places like the press we can go to. **(Inaudible)** ... the evidence is not just a document about the danger to patients and other pharmacists. It is a real danger, and if people have suffered we need to have the evidence printed.

**Mr Alan Kershaw:** Imagine the situation were the other way round, and we had had to live for years with an EU requirement that we impose language testing, and now we had a proposal saying, "You can dispense with that if you want to." Which responsible regulator

would dispense with it, given that it is fundamental to everything we say about fitness to practise that individuals should be trained in and able to practise effectively using a full range of communication skills?

Our job is not to ensure that people can pass exams, but to ensure that they are fit to be in a profession, including the exercise of their skills, and I find it quite staggering other regulators -- one in particular, the GMC -- if I had a penny for every time when I saw at the GMC I heard someone say, "If only we could have language testing," I would have retired long since and not been any trouble to anyone. The fact is that it is an easy one to hide behind for the Department and any regulatory. It is not an easy one to crack necessarily.

We make this requirement of anyone else coming from outside the EU, we make it of our own undergraduates and MPharm students, and I cannot see any logic -- especially given that, as we now know, at least two other countries are imposing these tests with no harm done and no apparent challenge in the courts -- why should we not be going the same way. So please press ahead.

**Mrs Sue Kilby:** We have to be careful in the way that we put this forward. Being able to speak English and being able to communicate with a patient who is English speaking are two different issues. Because we have all been in situations where we have had patients, who have gone to see the doctors, who in theory can speak English, but actually when they come out they have not the faintest understanding of what they have been in to see that individual about. So it is not quite the same as actually being able to speak English and being able to communicate effectively with patients. That said, I still think that if you cannot speak English, and you are trying to communicate with the patients, you are not going to be able to do that very effectively. So from that point of view, I am totally behind what Sylvia, Phillida, Alan and Lorna are recommending. It is very interesting that it is lay members who are pushing this forward and encouraging us to take this forward as well. I think we should listen to our lay members on that.

**Ms Marcia Saunders:** And I sort of agree, but I am a lay member with a slightly different take -- not a different take, but a different slant on it. David Pruce has always been very careful about the way he uses the media, and who he uses in the media. I am conscious that you cannot control the media. I would not really want to play into the xenophobia that is so strong, and it can actually become tied into other issues. Just a note of caution there, that you cannot actually control that. It is a question of where you start and which organ, if you like, you give it to as a mission to deal with. That was my first point. My second is a more practical point. Elsewhere on the agenda we have general standards consultation for the General Pharmaceutical Council. The section on proficiency, which I think is Annex C, is a good place to feed in this issue, and our concerns about it and our proposals. It can be subsequently built into the rules.

I suggest that if we do agree to do that, we should actually let the General Pharmaceutical Council in waiting know almost immediately, because they also will be meeting to consider their response to the consultation. And also I noticed from something I think on their website, or somewhere, that they have done some very good work so far with locums, and talking about registration of locums. That is actually somewhere where we are perhaps a bit different from other regulators, in that we do have a high number of locums, and that does make reliance on the employer, if that were an appropriate route (which it is not on the whole) even more difficult in our case.

**Mr Gerald Alexander:** I would propose that -- and the actions that are written here, you cannot disagree with any of them -- we widen the distribution of our concern, and however that may be attained, we take such steps as are necessary that our concern is raised with the Department of Health urgently and immediately, and that the Department of Health receive the legal advice that we have had since April 2009 from James Flynn QC, our Counsel. We know that the Department of Health know that we have raised this issue, and we still see clause 9-6 in the current Draft Order, which has been laid before Parliament, which actually is a continuation of the present Pharmacy Order 2007, prohibiting language testing by a

regulator, by this regulator in particular. It is quite bizarre when we think that there were fisheries wars that took place between Member States some time ago over whether fishermen could fish within the limits of sovereign nations, because the EU prohibited fishing.

The reverse is true here.

The EU directive 2005/36, when we have interpreted it through our QC and through our suggested two-stage process, makes it absolutely clear that proportionate and appropriate language testing is reasonable, should it be necessary. It is quite bizarre to think that a UK Government should prohibit that activity by a regulator. So I think the UK Government need to be lobbied very heavily to think again about bizarre practices which are contrary to EU law. And I think we should use every means at our disposal, potentially sequentially, to lobby the UK Government. If necessary, we will ask opposition parliamentarians to raise questions, if necessary we will ask newspaper editors to carry information relating to patient safety, raising our concerns. We have gone down this road and all of the above in this paper is to be commended, and I think we need to raise our concerns. Our profession has a particular difficulty. Pharmacists need to convey information relating to medicines. It is a little different for other professions, but clearly we need to fight for our corner and I think it is about time we did so.

**Professor Bob Michell:** I would like to make very briefly three of the points I made this morning. First of all, I think before we go high profile we should try and find out from doctors' representatives, as opposed to the GMC, whether there is a problem with language. The second point is that we need to emphasise that the EU is built on free movement of goods and services, but this is an instance where patient protection should take precedence over free movement of goods and services. And in my interpretation, it is also consistent with another major plank of EU attitudes towards safety, which is the precautionary principle. That is why I think it is wrong that we have to provide evidence of why we need to language test. The precautionary principle would say that your default position would be that it would be manifestly unsafe not to be able to test language competence where necessary.

**Mr Steve Acres:** If I have understood it correctly, one of the options on the table was to potentially hand this over as a legacy issue to the GPhC. We might, to use a Bill Scott expression, be in the dying embers of our tenure, but I would see that as a failure of this Council, if we did not do all we could to try and resolve this before we hand over to the GPhC.

**Mrs Sylvia Hikins:** Just picking up on what Marcia said, I hope that we would go cross-party in posing questions for MPs. I think it is a cross-party issue. I think you will get MPs on all sides of the chamber who, regarding patient protection, would actually want to champion this cause. If we can get it cross-party, it has more chance of effective change. What we do not want it to become is a party political issue, with them banging against each other in debate. Secondly, although I do think we should go higher profile, I think we must beware of the tabloid press, where we could end up with egg on our face. We want reasoned argument here. I think we should stick with the lawmakers and the people who can effect change. We have had in our paper here, it is clear that the EU Commission is not against language testing. I think that is the thing to push with Parliament, that we are not creating something illegal with this.

**Mr David Thomson:** We are aware of the problem, the scale of issue we can determine more accurately, we are aware of the problem. If we do not take decisive action to deal with it, we are failing in our responsibility to protect patients, in that if something drastic happened, where do we sit and how do we hold our heads up, as an organisation, if we do not take effective action now to deal with this?

**Ms Marcia Saunders:** I am sorry if this is naive or unrealistic, but actually if there was a simultaneous move by the regulatory body in one of major European countries, to say the same thing, it might actually strengthen our position and make it sound less xenophobic.

**Dr Tristan Learoyd:** Just to feed into Professor Michell's point, Article 39EC is the one about the freedom of movement for workers, and there are a series of non-discriminatory restrictions you can put in place. One of them is membership restriction. To add weight to that, it has to be the Member State that would normally approach the matter, so that is getting all the regulators to work together to build an effective lobby. So the EC regulations, in a way, can help us through these three categories of non-discriminatory restrictions.

**The President:** We are in danger of agreeing here, I think! **(Laughter)** I know it is a rare occurrence! I suggest we ask Wendy and the team to take account of everything that has been said today -- there are lots of good ideas -- and mandate the Society to do everything within its power to expedite resolution of this issue as soon as possible.

**Mr Gerald Alexander:** There is one further option that could be placed on the agenda, but I am not suggesting it is at the moment, but it should just be laid on the table and left there. That is that we judicially review the Government over this.

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

*[Council  
agreed*

- i. that such steps as necessary to raise the concern of the Society regarding English language competency of EEA pharmacists be taken (set up questions with MPs; lobby the UK government; press involvement; contact professional bodies for support).]*

#### **14. Fitness to practise disclosure policy**

This is just for noting. I have received no comments on that.

#### **16. Chief Executive & Registrar's Report**

**The Chief Executive & Registrar:** This is to receive the minutes of the confidential committees and to seek ratification of Council on the appointment of Alan Kershaw as Chairman of the GPhC Standards Working Group.

**The President:** Are Council content with the recommendation to ratify the decision to appoint Alan as Chair of the Working Group In paper 127? **(Agreed)**

*Council  
ratified*

- i. the decision that Alan Kershaw be appointed Chair of the Standards Working Group to develop the Society's regulatory response to the consultation on draft GPhC standards.*

**The Chief Executive & Registrar:** There is also paper 127A. This is the recommendation of the officers on the GPhC constitution order. Advice was sought from Governance Committee, and two responses were proposed from Governance which relate to question 4 of the consultation. The reasons for disqualifying a person from appointment as a member of the GPhC Council, and question 10, which was the quorum of the GPhC. Governance proposed that we should disagree with question 4, the reasons for disqualification. That is to say a person who is a member of a profession regulated by another health regulator should be allowed to be appointed as a lay member. The experience and expertise that this person could bring from being regulated in another profession could be highly beneficial. But that a lay member should not be appointed to the Council or more than two health regulators. In question 10, Governance proposed, and the officers agreed, that we should agree with that, with a qualification that the quorum should include at least two lay members and two registrant members, rather than just one of each.

**The President:** Are the Council happy to ratify that submission? **(Agreed)**

*Council  
ratified*

*[i. the consultation response to the GPhC (Constitution) Order 2009.]*

**19. Council update. Paper 130**

This item is for noting.

**20. Appointments Panel Report. Paper 131**

This is to note the appointment of Nick Barber to the executive of RPS Publishing. Thank you, Council.

*[Council*

*noted the report attached at 09.12/C/131]*