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FEBRUARY COUNCIL MEETING

Future Council to have 29 members

The Council of the Royal Pharmaceutical Society has agreed that the future reformed Council should have a total membership of 29, comprising 17 pharmacists, two technicians (provided the Society proceeds to register technicians) and 10 lay members. The current Council consists of 21 pharmacists and three members appointed by the Privy Council.

The Council made its decision after considering a paper from the modernisation steering group, which had examined the 15 possible structures that would fulfil the Council's agreed criteria of 24–30 members in total, with an overall majority of pharmacists, two technicians and a lay membership of 30–40 per cent. The paper considered how well each structure would reflect the Council's remit and functions and how the different options would relate to the Council's supporting structures and workload, its effective functioning, its cost to the Society, the range of experience, views and expertise required and the views of stakeholders both inside and outside pharmacy.

On the basis of its deliberations, the steering group recommended a 26-strong Council, consisting of 15 pharmacists, two technicians and nine lay members. It also recommended that the Council should seek a mechanism to allow the reformed Council to request that its composition be changed if necessary while safeguarding the lay input required for a modern regulator.

When the paper came before the Council, the **PRESIDENT** said that the Council had discussed the topic on two reserve days. He felt that some background information should be given because some Council members might not believe that the recommendations were precisely in accord with what emerged from the previous discussions.

Effectively, the first recommendation was something of a compromise between the view of the modernisation group and the figure discussed by the Council at its "away-day". The group felt strongly that the Council should be as small as possible, recognising the demands on individual Council members. There were three rea-



MAIN POINTS

Reformed Council The future reformed Council is to comprise 17 pharmacists, two pharmacy technicians (should the Society proceed to register technicians) and nine lay members (this page). A procedure has been agreed for electing the two technician Council members (p245).

Benevolent Fund steering group A steering group is to be set up to improve the management arrangements of the Society's Benevolent Fund (p244).

Primary care steering group The way in which the Society supports primary care pharmacy is to change because of problems arising from the rapidly shifting environment in primary care and in pharmacy (p245).

OFT report The Council has adopted a statement expressing great concern at the findings of the Office of Fair Trading inquiry into community pharmacy (p245).

sons: first, a smaller Council was easier to manage in terms of effectiveness; secondly, the Council was a policy-making body and so the future might be different from what had been experienced in the past; thirdly, other individuals would be present at Council meetings (eg, the chief pharmacists of England, Scotland and Wales might be present, as might representatives of the Society

in Wales and Scotland).

The second recommendation, which the President said should be considered in conjunction with the first, proposed a mechanism by which the new Council could change its composition if experience showed that the initial make-up was not acceptable.

The recommendations had taken account of Council members' comments and anxieties, noting the views of the steering group but seeking to produce a robust recommendation, which would stand the test of time whichever way circumstances moved in the future.

PETER CURPHEY said that he did not regard the recommendations as a compromise. He regarded them as an absolute classic fudge. They fitted in the middle of what was said to be a need for a small Council and what Council had decided would fit the requirements of the Government. The Council's decision that the number of pharmacists should be about 16 or 17 had taken into account the political reality within the profession of reducing the number of pharmacists on the Council. To reduce the number to 15 would be seen by some pharmacists as an unacceptable carving up of the Council.

Mr Curphey said he was even more concerned about the logic in the document. The suggestion that they wanted a small Council had never been the Council's view. They knew that they had to fit in with national requirements, but they had never argued for a small Council, but just a smaller Council.

The document acknowledged that, among the structures already agreed by the Government, the lowest number of lay members was 10, a proportion of 34.5 per cent. Presumably anything less was not a good idea, but the paper proposed nine. Why had the group decided on that when the proposal from the Council was 10? The paper had also reported the view of the National Consumer Council that 34 per cent lay membership was insufficient. But what was the paper's proposal? Was it 38 or 39 per cent? No, it was 34.5 per cent.

Mr Curphey said he was disappointed that the group had not been robust enough to look at a figure of 28 or 29 on the Coun-

cil, with a good majority of pharmacists, not an overwhelming one, which took into account the membership's perception that they were carving up the profession and not leaving it to the professionals.

On the second recommendation, Mr Curphey suggested that implementing an "if" clause would not be the easy process implied but could be extremely difficult. If such a provision was to be put in place, then why not start with the Council's preferred constitution with the option of reducing the Council's size if it proved overwhelming and unwieldy.

The PRESIDENT said that the steering group had taken soundings from people from different backgrounds — from Council members and also from people who had knowledge and expertise in other areas who could add and introduce a different dimension. He was not saying whether it was a right dimension or a wrong dimension but it was a different dimension. But there was no question of a decision being foisted on the Council. Those who felt strongly that the figures should be changed should vote accordingly. The recommendation would be rejected. If the Council chose to reject the recommendations it could come forward with other proposals.

LINDA STONE said that she felt extremely uncomfortable with what was happening. The Council had had a constructive debate and most people had gone away thinking that they had arrived at a good consensus, a mature decision, after every Council member had had an opportunity for input.

David Lammy, Parliamentary Under-Secretary of State for Health, had told the Council that modernisation should strengthen the Society's professional leadership role (see p248). But reducing the number of professional members on the Council would not achieve that. It would undermine it and make it harder to carry the modernisation structure with the membership. She was also anxious about some of the assumptions about a small Council being more effective.

The PRESIDENT said that Mrs Stone had made the same points at the "awayday" meeting. He had heard nothing new.

Mrs STONE said that what was new was the paper before the Council, which totally disregarded those points.

The PRESIDENT said that the Council did not want to rehearse all points again.

Mr CURPHEY pointed out that the previous meeting had been held in private but the Council was now in open business, allowing Council members to express their views in public.

ASHWIN TANNA proposed that the motion be put to the vote.

Dr GORDON APPELBE seconded the proposal.

The PRESIDENT put the first motion, which was that the reformed Council should have 26 members, comprising 15 pharmacists, two technicians (provided that the Society proceeded to register technicians) and nine lay members.

The Council voted and the motion was lost.

The PRESIDENT asked for an alternative recommendation.

Mr TANNA suggested proportions of 18, two and 10.

Mrs STONE said that that at the Council's previous discussion the consensus had been 17, two and 10. That totalled 29. Mrs Stone proposed that accordingly.

Mr CURPHEY seconded Mrs Stone's proposal.

Mr TANNA said that having 17 pharmacists made Council elections difficult.

The PRESIDENT said that that had been debated at length, and it was not so. The Council should take a vote.

GERALD ALEXANDER said there should be an opportunity to discuss the matter.

The PRESIDENT said that the matter had already been discussed previously.

The Council then voted on the motion that the reformed Council should have 29 members, comprising 17 pharmacists, two technicians and 10 lay members. The motion was carried.

The second recommendation, on the proposed mechanism for changing the Council composition, was carried.

ANDREW BURR said that he was concerned about the whole modernisation process. He had been critical of the steering group from the start. He had opposed the inequity in the way some decisions were taken. He was left with a feeling of railroading manipulation of events. The group would have to give urgent consideration to the way it presented itself to the Council. Council therefore needed to think carefully how matters were presented. He felt uncomfortable about some of the decisions that had been taken.

The PRESIDENT repeated that the ultimate decision was that of the Council. There was no railroading. The best solution might not conform with the ideal solution of individual Council members. When Council members were not happy with anything, they made their views clear. They were not shrinking violets. The reality was that the ultimate arbiter was the Council.

BENEVOLENT FUND STEERING GROUP

The Council agreed to establish a steering group to improve the management arrangements of the Society's Benevolent Fund. The group will consist of three Council members, including a past president (as chairman), the Secretary and Registrar, the Director of Resources, the Benevolent Fund co-ordinator (as secretary) and the director of Birdsgrove House. The criteria used in selecting the Council members will be an overarching understanding of the Society's affairs, experience in managing funds, an ability to think strategically and diversity in the representation. The quorum will be three, of whom two must be Council members. The group will meet twice a year.

DUTIES OF REGULATORY BODIES

The Council approved four recommendations designed to ensure that the

Society would in future comply with the common duties of health professional regulator to publish or provide certain information in the interest of transparency and accountability.

The Council had before it a paper produced by the modernisation steering group, which examined the professional regulators' duties to publish an annual report, to publish accounts, to publish or provide information and to co-operate with others. The paper noted that, although the Society already carried out these activities, the principles of transparency and accountability might require it to devote significant more resource in the future to collecting, analysing and providing information and to developing and implementing relevant policies.

Among other things, the paper noted that the Society's annual review currently did not include certain information that was likely to be required in future, such as statistical information relating to the Society's function to protect the public. On the publication of accounts, the paper said that it would be inappropriate for the Society's accounts to be submitted to the Comptroller and Auditor General, who certifies the accounts of public bodies. Although the Society performs functions of a public nature, it is not a public body.

On the publication of information, the paper suggested that the Society might in future increase its focus on providing information to the public about its work. On co-operation, the paper agreed that a duty to co-operate is reasonable but points out a number of potential difficulties.

The paper's recommendations were that, subject to various comments made, the Society should have a duty (1) to publish an annual report, (2) to publish accounts, (3) to publish or provide in such manner as the Council thinks fit, information about the Society and the exercise of its functions, and (4) to co-operate wherever appropriate and reasonably practicable with public authorities or other bodies or persons concerned with employment, education or regulation.

The PRESIDENT said that the Council had already debated the matter at considerable length. The recommendations were in accord with the discussion that had been agreed as a consensus elsewhere.

Dr GORDON APPELBE said he wondered why the fourth recommendation did not read "other bodies or persons concerned with health". Bodies concerned with health had been omitted.

CHRISTINE GRAY (project manager for the modernisation programme) said that it did not mean that the Society could not co-operate with other bodies as appropriate, but the Ministers specifically wished to see duty to co-operate with bodies concerned with employment, education or regulation included in the legislation for all health professional regulators.

The PRESIDENT said it was not restrictive but highlighted the fact that there may be obligation at some stage to co-operate, subject to caveats.

The Council approved the recommen-

dations.

ELECTING TECHNICIANS TO COUNCIL

The Council agreed a procedure for the election of two pharmacy technicians to the reformed Council should the Society proceed to register pharmacy technicians. The procedure reflects that already agreed for the election of pharmacists to the reformed Council.

It was agreed that the two places would be filled by a closed ballot using the "first past the post" system, with the election run on similar lines to the election of pharmacists and administered by the Electoral Reform Society. Candidates would have to be registered as technicians with the Society and be nominated by five registered technicians. Only technicians registered with the Society would be able to vote.

As with pharmacist Council members, the period of office would be four years. For the first election only, a ballot would be held for both places. The technician who topped the poll would be appointed for four years and the technician in second place for two years. Subsequent elections would be held every two years for one of the two places.

The Council also approved a transitional arrangement. For the first term of the reformed Council, from 2005, a panel appointed by the Council would select two candidates, preferably from different sectors of practice, to serve for two years. Reappointment for two further years would be then possible if it was not by then practicable to move to election under the permanent procedure.

During the Council discussion, LINDA STONE pointed out that in establishing new health care regulatory bodies the Privy Council had initially appointed all the members, both lay and professional. It might be seen as the Privy Council's role to be make the initial appointments of technician members of the Council. Perhaps the modernisation group should take soundings in case the Society's procedure was out of kilter with that of the other bodies.

The SECRETARY AND REGISTRAR said that the matter could be raised during the Society's regular discussions with the Department of Health.

PRIMARY CARE STEERING GROUP

The Council agreed to change the way in which the Society supports primary care pharmacy because of problems arising from the rapidly shifting environment in primary care and in pharmacy.

The Council made its decision on the recommendation of Sally Greensmith and Clive Jackson (Council members with strong primary care links). In a paper circulated to Council members, they said that the Primary Care Steering Group had been set up in 2000 with financial support from the Society. Its aim was to provide a forum for sharing views, experience and best practice in primary care pharmacy and to identify how the Society could best work with and support primary care pharmacists.

COUNCIL BRIEFS

Annotation of register for prescribing

The Council agreed to seek a Byelaw amendment to allow annotation of the Register of Pharmaceutical Chemists to indicate pharmacists who are authorised to prescribe as supplementary prescribers. If approved by the Privy Council, the amendment will give the Council general power to amend the third schedule to the Byelaws to allow annotation to indicate particular qualifications, specialist areas of practice or status, as determined by the Council or as prescribed by legislation. This wording chosen is intended to encompass other eventualities that might require register annotation in the future (see p251).

Attendance at committee meetings by President and Vice-President

The Council agreed to seek an amendment to the Society's Byelaws to delete a requirement that the President and Vice-President shall be *ex officio* members of all Council committees. The change is necessary to implement recent decisions of the Council, on the recommendation of its corporate governance group, that would result in those two Officers no longer being *ex officio* members of every committee (see p251).

Retention fees 2003 The Council agreed that the Benevolent Fund should meet the 2003 retention fees for 15 beneficiaries who are disabled or otherwise unable to practise.

Since the group's inaugural meeting, developments in the National Health Service had led to considerable change in the group's membership, and members had been unable to participate fully because of their own work pressures. As a result, despite the best efforts of all those involved, the group had failed to meet its core aims of producing an annual report and holding a seminar for primary care pharmacists. Furthermore, the NHS changes meant that the group's existing constitution and rules were no longer fit for purpose.

On the recommendation of Mrs Greensmith and Mr Jackson, the Council agreed that the PCSG's constitution and rules should be revised to concentrate on core deliverables. The group in its present form would have no further meetings and a primary care virtual consultative group would be formed. The Council would continue to support the group financially until the future of special interest groups was decided during the modernisation process. The group's funding would be managed by the Society's head of practice, Nigel Graham.

The Council also agreed that the Society would organise public seminars at five sites around Britain to provide a forum to share views, engage primary care pharmacists with the Society and improve the communication link. In addition, a formal

one-day session was to be arranged at this year's British Pharmaceutical Conference.

OFT REPORT

The Council adopted a statement expressing great concern at the findings of the Office of Fair Trading investigation into "The control of entry regulations and retail pharmacy services in the United Kingdom". The decision followed a long debate which the President said would inform the Society's detailed written response to the OFT report.

The PRESIDENT said that after the report's publication on 17 January he had written to David Lammy, the Health Minister, and he and the Secretary and Registrar had put similar points to the Minister at a face-to-face meeting on 28 January.

They had emphasised to the Minister that the Society's concern was the safety, effectiveness and quality of the pharmaceutical service and that it had no commercial interest. They had communicated their initial reaction after considering the OFT report from the perspective of the proper provision of NHS pharmaceutical services and the report's compatibility with the aims and objectives of an integrated health service as envisaged by the NHS and the Government.

Mr Lammy had invited the Society to submit a more detailed response, and the President hoped that the Council's discussion would provide the basis for preparing such a response.

The President said that the points he had highlighted had related to the availability of pharmacies and the fact that there is currently national distribution in broad terms and pharmacies where people live, shop and work. The OFT recommendation could damage the existing distribution and that might disadvantage the most vulnerable groups in society — the elderly, young mothers, the poor and disadvantaged, who were the heaviest users of community pharmacies. They were not the wealthiest groups in society and may not have the wherewithal to travel to one of the 500 new pharmacies forecast, which happened to be in supermarkets and in out-of-town areas.

He had asked the Minister whether a free, commercial, competitive approach would achieve the objects of the NHS and the Government, and he suspected that the answer would be no. There was a place for supermarkets, but he believed the commercial imperative and the health service requirements could in some instance be in conflict. There was anecdotal evidence that primary care trusts had in the past had difficulty in persuading the stores to open and provide a community pharmacy service where the commercial imperative within the store suggested that the stores might close. An example he had cited was Christmas Day.

He had also highlighted that under the Medicines Act the superintendent pharmacist of the company should be the final decision-maker but from time to time there was a potential conflict of interest between the

commercial, professional and health imperatives. Typically pharmacy superintendents in some new larger organisations were not the ultimate decision-makers and were not on the main company board. He had also highlighted a recent report that a supermarket had withdrawn from a trial following shareholders' complaint at the company's annual general meeting.

The President had said that typically six pharmacists might be required to provide a service during a supermarket's extended hours. If there were to be 500 new pharmacies, then up to 3,000 pharmacists would be required, at a time when a national shortage of pharmacists was affecting community pharmacy and also pharmacy in primary and secondary care.

He had reminded the Minister that it was Government health policy that the nature and extent of health services should be determined locally, at least in England, by primary care trusts. Indeed 75 per cent of the funding would in future be spent by PCTs to meet local needs. It was difficult to see how that would be compatible with the purely commercial imperative, which seemed to be the basis of the OFT's report.

In summary, the President had said that as a Society they had considered the issue from the NHS perspective, seeking to fulfil the Minister's stated aims and the aims of the NHS of meeting local health needs, which were identified, determined and provided locally.

The Minister had asked the President whether he could comment or make any suggestions on the way that competition could be increased in the future. The President had replied that the Society would welcome competition that improved the quality of health provision but it was not the Society's role to identify how competition policy should be determined; its role was purely a professional and regulatory one and such policy was for others to decide.

GERALD ALEXANDER said that the Council had before it a proposal that it "views with great concern the findings of the Office of Fair Trading into the control of entry regulations and retail pharmacy services in the United Kingdom". He hoped the Council would support the proposal and give moral support to the 25,000 pharmacists working in this sector, who were gravely concerned, believing that ending the control of entry regulations for community pharmacy would be misguided.

Mr Alexander said that the public service that pharmacists contributed to the day-to-day lives and health care needs of the people of Britain was often understated within the context of health care and indeed the NHS. Community pharmacists and their support staff were a dedicated expert resource and workforce.

The OFT report acknowledged that the OFT had considered competition, but not health service planning considerations. OFT officials had openly admitted this in the stakeholder briefing on publication day.

Pharmacy supported competition. In fact, most patients currently had a choice of pharmacy, and people would choose by ser-

vice and convenience.

Community pharmacists wanted to see the pharmacy network integrated into local health services far more than has been the case until now. The Government, too, appeared to be committed to this objective.

The OFT report unfairly and narrowly portrayed pharmacists only as retailers, thus failing to take proper account of pharmacy's health care role — including future developments that would be blocked by the uncertainty, instability and likely changes in pharmacy location that would result from the adoption of the OFT report.

If OFT's recommendations were implemented, the number of pharmacies would soon increase rapidly, perhaps by as much as 10 per cent. Early expansion in numbers would be followed by a contraction. Smaller pharmacies particularly would be at risk, leading to a loss of service in neighbourhood locations. Investment would decline, and service cuts could also be expected. For many community pharmacies, survival would be extremely difficult.

The OFT report identified the high levels of consumer satisfaction with the present network and found no consumer pressure for change. It identified the costs of administering the present system, but crucially, not the costs of removing controls.

The OFT was not the right body to undertake this work, because it could not balance the benefits and detriments, which required intimate understanding of primary care and where it was heading. In particular, it did not have the expertise to evaluate whether the free market was the most appropriate way of ensuring that the best use is made of pharmacists' skills in enhancing health care provision to patients.

The public interest was best served by developing the services that community

pharmacy provided and meeting the policy objectives outlined in "Pharmacy in the future" (and the other UK pharmacy strategy documents). That required a stable environment, but the OFT recommendation would create enormous instability and uncertainty. Deregulation would frustrate the Government's plans for making better use of community pharmacy in health care planning and provision.

If the regulations were swept away, local communities generally would suffer, but there would be a particularly damaging effect on rural, isolated and socially disadvantaged areas. Planning guidance and the Social Exclusion Unit recognised community pharmacy as a valuable neighbourhood resource and its importance in supporting a community.

Implicit in the term "community pharmacy" was a close identity with, and a commitment to, the local community. Community pharmacies were at the heart of local health care, providing health care services and advice to patients where they lived.

The DoH needed to evaluate the extent to which unrestrained competition in providing pharmacy services would be detrimental to the improved services for NHS patients that could be offered by better use of community pharmacy. In addition, it had to assess whether adding to the existing competition would have any real benefits — and then decide whether they outweighed the detriments. The NHS interest had to predominate over non-NHS consumer interest. Indeed, it should not be forgotten that the NHS was pharmacy's principal "consumer".

Where competition could be introduced or controls relaxed with no detriment, then that should happen. A specific example was proposed in "Pharmacy in the future", namely, the relaxation of controls in major out-of-town shopping centres.

In summary, increased competition should support local health service planning, not frustrate it.

Professor BOB MICHELL said that, as a consumer and not a pharmacist, he unambiguously endorsed what had been said. It was horrific the degree to which the OFT regarded pharmaceutical products as if they were to be judged at the same level of competition as Nescafé.

LINDA STONE said that the OFT was clearly seeking to reduce costs to the Exchequer by increasing competition, but by its own acknowledgement £6.8bn of the £8.6bn that went into community pharmacies was actually for NHS dispensing and there was little room for manoeuvre to save money there. In fact, increasing the number of pharmacies would tend to force that up.

By undermining the stability of existing pharmacies, the OFT recommendation would not produce service quality improvements but would undermine existing professional developments. Being forced to cut costs, pharmacies would have to reduce their staff and services and therefore reduce the delivery of the enhanced roles envisaged in recent Department of Health papers. That reduction in staff could also lead to an

Attendance Those present at the meeting, which was held on 4 and 5 February 2003, at 1 Lambeth High Street, London SE1, were the President (Marshall Davies), the Vice-President (Dr Gillian Hawksworth), Gerald Alexander, Dr Gordon Appelbe, Hassan Argomandkhah, Andrew Burr, Peter Curphey, Sultan Dajani, Wally Dove, Digby Emson, Dr Phillida Entwistle, Alison Ewing, Christine Glover, Dr Nicola Gray, Sally Greensmith, Patricia Hoare, Clive Jackson, Professor Bob Michell, Helen Remington, Linda Stone, Ashwin Tanna and the Secretary and Registrar (Ann Lewis). Also present was the chairman of the Welsh Executive (Andrea Robinson).

Apologies for absence were received from the Treasurer (Kirit Patel), Hemant Patel, Professor Michael Schofield and the chairman of the Society's Scottish Executive (David Thomson).

Present by invitation were the following representatives of the Society's branches and regions: Robert Duncombe (secretary, Colchester branch), Janice Goundry (Scunthorpe branch), Dr Richard Sturgess (Mid Glamorgan East branch), Peter Jones (Edinburgh and Lothians branch) and Geoff Scott (Wessex region).

increase in errors and a compromise of patient safety.

Control of entry had led to a stability that facilitated innovations in patient care, many of which had been adopted as mainstream. Many such innovations had come from private contractors.

ANDREW BURR said that the report did a grave disservice to the Office of Fair Trading. At the end of the day the public would decide who provided a good service or a bad service. The OFT's view was not in the interests of health care.

He wondered if the OFT had thought about the damage that its report would do in terms of the motivation of the profession, which for years had striven to offer a first class quality service. The OFT felt that he was just a retailer, but he had chosen to be a pharmacist because of patient care and quality and ensuring that the patient received the best type of care.

HASSAN ARGOMANDKHAH said that the Council needed to make a good case as to why applying the OFT report in its entirety would damage the future delivery of health care in the community. A submission based on that would be seen and heard in a better light.

He urged Council members to make sure their local MPs signed the early day motion that his own MP was putting forward. This would make sure that the right people in the right places were briefed appropriately so that they could win the battle by other means, because challenging the OFT report would not achieve that.

The Society should not base its argument on supermarkets versus the rest. It should make sure that all its arguments were based on the delivery of good quality pharmaceutical care. It should emphasise that changing the regulations would destabilise pharmacy and remove incentives for pharmacy proprietors as well as individual pharmacists.

Primary care trusts were concentrating on rationalising and modernising primary care services in a planned and phased manner. Removing control of entry would play havoc with what they were trying to do locally. The NHS had to continue with its long-term plans and this could only be done if pharmacy, as one of the cogs within primary care, was not constantly undermined. Only with the stability and maintenance of the network could the NHS planners deliver what they really wanted.

ANDREA ROBINSON pointed out that the OFT report had gone to the Department of Trade and Industry, and it was that Department that would collate responses from different Government departments. This meant that the Department of Health, the National Assembly for Wales and the Scottish Executive would all respond independently. From Wales she had sent a letter similar to the President's to the Minister for Health and Social Services outlining the key messages of access, manpower and health policy in general. The Health and Social Services Committee was meeting the following morning to debate the OFT report and all of the members of

that committee had been briefed in anticipation of that debate.

DIGBY EMSON said that the OFT had started from the standpoint that everything should be a free market unless restrictions could be justified. It had built up its case by a series of well argued assumptions and economic theories. One had to go to the appendices to see that some of its assumptions were questionable. For example, it assumed that a surgery would not open its own pharmacy if there was one within 300m.

He said it would be wrong to give the impression that pharmacy was afraid of competition because competition did work in the public interest and in a sense community pharmacy had been competing for many years. It was also wrong to imply that the current regulations were inflexible: they were specifically designed to meet the changing needs of the population and labour forces.

The views of the medical profession would be important in terms of coming to an overall conclusion. He was not sure whether the Society intended to liaise with any elements of the medical profession in relation to sharing views on what action was to be taken. Would there be dialogue between the Society and the medical profession and the NHS Confederation?

The SECRETARY AND REGISTRAR said that a lack of time made it difficult. The Society had an outstanding arrangement to discuss a number of issues with the medical profession, but whether that meeting could take place before the closure of the consultation process she was not sure.

The PRESIDENT said that the OFT inquiry had been instigated by the NHS Confederation itself, via the Cabinet Office. He did not know whether the OFT had produced what the confederation had in mind, but it was important to recognise that the confederation, which negotiated on behalf of trusts, had actually felt that the matter should be examined.

SALLY GREENSMITH said that although competition improved services it should not be at the expense of the essential services that community pharmacists provided. From a PCT point of view she would support relaxing regulations to give flexibility in the delivery of service within the PCT area provided it did not undermine existing services in vulnerable areas. That was what she had hoped would come out of the report.

SULTAN DAJANI said that the OFT had accomplished what it had set out to do — to kick community pharmacy in the backside. He concurred with all that had been said. He asked whether the Society's response was to be put on its website and whether the Society would liaise with other bodies. He felt that it should examine every alternative route as well as the routes already discussed. It was a communication issue and one that the Society should turn to its advantage.

Dr NICOLA GRAY said that it was ironic that the OFT was trying to place the

future of community pharmacy services in the hands of those consumers who could shop around for the best deals. But big groups of the population relied on the NHS to support their access to equitable health services. The OFT would not be standing up for these people — they were not even on their radar.

HELEN REMINGTON said that pharmacists would have an uphill struggle to persuade the Government that their significant interest in this area was not personal interest. The report should be examined with critical analysis and not opinion. The OFT had particular terms of reference but the Minister had a completely different responsibility for health care strategy. The Minister had a responsibility to look at the whole. In recommending the removal of regulations the report said that new remuneration was needed and a continuation of the essential small pharmacy scheme. The regulations should not be removed without the other half of this.

CHRISTINE GLOVER said that the response must talk about three health plans and not just one. Also it must not just talk about trusts because the Scottish and the Welsh health plans were also predicated on networks of existing pharmacies. The Scottish plan particularly aimed at using the network to deal with minor ailments in a more focused way than in England.

The response should also talk about the support that community pharmacy gave to public health, largely unsung, because issues such as that were vulnerable if the OFT had its way.

The VICE-PRESIDENT said that the Society had a great resource in its practice research division to provide evidence to underpin what it said in response to the document. Many of the points made were based on belief, but there was actually much supporting evidence. Everything the Society said should be backed by evidence.

CLIVE JACKSON said that the Department had to respond to the OFT report and the Society should help that process positively. It needed to consider the impression given in the report to those who are less directly aware of pharmacy's importance to the NHS, and that was particularly relevant to some of the arguments that the report used.

He wondered whether the likely outcomes could be predicted as confidently as the report suggested. Being able to predict the outcome would be difficult in the present state of flux. Therefore if the Society was going to help the Government respond effectively, it needed to think more widely. It seemed that local pharmaceutical services (LPS) already had potential effects on entry and configuration and would have more effect as time went on. He wondered whether LPS could be one of the arguments that might be used to help deliver some of the more beneficial elements of the OFT report in a more planned way, which would be a benefit to patients and pharmacy.

WALLY DOVE felt that Council members had to take a reality check because he was a bit worried about what he had heard

around the table. First, he was absolutely against digging through the evidence at the back of the report because that was not what it was about. It really was a question of whether they could influence, in particular, Alan Milburn (Secretary of State for Health) to come off the fence in their favour. It might be hard, but it was something pharmacy had to try to do.

More importantly, David Lammy was to be a guest at that evening's Council dinner, and Mr Dove implored Council members not to moan at him because that would not work. They had to take a positive approach but at the same time remember that Alan Milburn was behind Mr Lammy. Pharmacy could get through this difficulty but they had to work at it and be positive and not whinge.

Dr GORDON APPELBE said that he believed the deregulation would take place and when it did the Society should not just leave it there but should say that if the Department of Health wanted the benefit of a good distribution in pharmacy then it should look again at the controlled distribution of the opening of pharmacies rather than a restriction of the contract. There should be geographical distribution of pharmacies without discrimination between pharmacies. All pharmacies should be able to supply a full pharmaceutical service in a competitive field. In some European models that worked well, it was only the pharmacy that was controlled. Pharmacists were not told that they could only supply some pharmaceutical services because a government would not give then a contract for providing other services.

PETER CURPHEY said that the Society should try to persuade the Department that things had to be done in the right order. To disintegrate the system and then try to find a new way of paying people was absurd.

When talking to the Government the

first thing to do was to offer to solve its problem and not complain about something that was bothering you. The Government did not need convincing that it could not deliver the pharmacy plan in a market place that was in turmoil. Pharmacy needed to make it clear that the profession wanted to change and that it was not protectionist and not simply trying to preserve the status quo. However, it should not be done by commercial attrition but by health needs in local communities.

The Society should make use of its comprehensive survey on patient demand for pharmacy, which highlighted that patients wanted their pharmacies near where they worked, shopped and lived. It should use that to show that there had a good distribution of pharmacies for the current situation. Its offer should be that pharmacy wanted to change but they wanted to do it in co-operation and not under the threat of attrition.

Minister sets out vision for a modernised Society

Modernising the Royal Pharmaceutical Society as a health professional regulator in line with Government expectations should strengthen its roles as a leadership and advocacy body for pharmacy, according to David Lammy, Parliamentary Under Secretary of State for Health, David Lammy.

Speaking on 4 February at a dinner for some 80 guests hosted by the Society's Council, Mr Lammy said that he was aware of the progress the Society is making in its reform programme.

He said: "The Society already embraces many of the elements of modern professional regulation, such as professional leadership and supporting professional development, as well as the more traditional fitness to

The PRESIDENT thanked all who had contributed to the debate. He said that the Society's response should be positive and constructive and looking for an effective way forward for the profession. Every effort would be made to produce a response speedily on the basis of what had been said in the discussion, and taking into account Mr Alexander's proposal. Although time was short, he hoped that a draft could be circulated to Council members.

practise functions. But, as you have acknowledged, you too need to make changes so that there is greater transparency, accountability and public involvement in your processes."

"I have listened to the debate in pharmacy and I want to take this opportunity to state clearly that our vision is of a reformed Royal Pharmaceutical Society which, in its strengthened role as a modern regulator, continues to operate at arm's length from Government. Equally important, we expect the reforms to enhance the Society's ability to provide strong, independent leadership and advocacy for the profession as a whole in taking forward the agenda for pharmacy with patients, Government and the NHS," he said.

LAW AND ETHICS BULLETIN

An occasional feature, prepared in the Royal Pharmaceutical Society's Professional Standards Directorate, to highlight problems and inquiries currently being handled. Previous bulletin items can be found on PJ Online at www.pjonline.com/lawandethics

Sale of substances included in Schedule 1 to the Poisons Rules

Pharmacists are reminded of the need to exercise caution when requested to supply a substance included in Schedule 1 to the Poisons Rules.

Schedule 1 poisons may be sold only if the purchaser is known to the pharmacist as a person to whom the poison may properly be sold or if the purchaser presents a "certificate for the purchase of a non-medical poison". This certificate must be signed by a householder, certifying the purchaser to be a person to whom the poison can be properly sold. If the householder is not known to the pharmacist as a responsible person of good character, the certificate must be endorsed by a police

officer in charge of a police station. The pharmacist must retain the certificate for two years from the date of supply.

A pharmacist may not supply a Schedule 1 poison until an entry has been made in the poisons register and the purchaser has signed it. The poisons register must be kept for two years from the date of the last entry.

Where a purchaser requires a Schedule 1 poison for his trade, business or profession, the pharmacist may accept a signed order in lieu of the purchaser's signature. The pharmacist must be satisfied that the purchaser carries on the trade, business or profession stated and that the signature is genuine.

A signed order need not be dated, but the entry in the poisons register must be dated and must include the words "signed order" in place of the signature. The entry must be identified by a reference number. In an emergency, the supplier can deliver the poison on the undertaking that a signed order will be furnished within the following 72 hours, although in practice it is unlikely that this situation would arise.

Further information on the Poisons Rules and examples of permits and certificates can be found on pages 55 to 58 of the current (26th) edition of 'Medicines, ethics and practice: a guide for pharmacists'.

Your views wanted on mandatory CPD

The Royal Pharmaceutical Society is seeking views on mandatory continuing professional development for pharmacists through a survey form distributed with this week's *Pharmaceutical Journal*.

The survey is a follow-up to the consultation document produced by the Society's CPD implementation committee, which was published as a centre pull-out in last week's *Journal* (and also summarised on p205).

The survey form is being distributed with all copies of *The Pharmaceutical Journal* sent to members with registered addresses in Britain. Further copies of the form can be downloaded from the CPD page within the education section of the Society's website (www.rpsgb.org.uk/education). The form bears a Freepost address and is designed for posting without the need for an envelope.

For members resident overseas, who are also affected by the proposals, *PJ Online* is offering a version of the form that can be completed online (www.pjonline.com/survey). Others are welcome to respond by this means should they so wish.

The closing date for responses is 17 March. The responses will be summarised

The survey form

in an article in *The Journal* on 29 March and will be considered by the Council at its meeting in April.

The survey form need not take long to complete. It asks for views on six specific matters and gives respondents the opportunity

to add additional comments on these or related matters.

The questions on which it seeks specific views are:

- 1 Which pharmacists should mandatory CPD should apply to?
- 1 What should be in a pharmacist's CPD record as a minimum requirement?
- 1 Should the Society restructure its register to have "active" and "inactive" categories?
- 1 If so, should pharmacists in the "inactive" category be required regularly to sign an undertaking not to engage in any form of pharmacy practice?
- 1 What title might be appropriate for those in the "inactive" category?
- 1 Should CPD records for those who acquire prescribing rights (or some other clinical responsibility in the future) include CPD specifically related to that responsibility?

Before completing the survey form, members may wish to read the answers, set out below, to a number of questions that have been addressed to the CPD implementation group since publication of the consultation document.

Answers to questions about the CPD consultation

Who does the CPD implementation committee hope to hear from in the consultation?

The committee would like the views of a representative cross-section of pharmacists and pharmacy organisations, and a good number of other stakeholders, such as other health professions, patient advocacy groups and the National Health Service.

The committee is aware that individuals and groups potentially falling in Group 2 and Group 3 are particularly concerned about the impact of mandatory CPD on their membership of the Society. The committee wants to hear from them and from the large number of pharmacists in Group 1 who will be committed to meeting the Society's CPD requirement.

Where will the line be drawn between what are referred to as Groups 2 and Group 3 in the consultation article?

This question is really about the scope of Group 2, ie, which persons should or could fall within the description "a pharmacist undertaking a pharmacy or health care job(s) for which s/he does not actually have to be a pharmacist"? The answer is anyone active in the broad science or practice of pharmacy.

The implementation committee has not provided a definition because the committee favours putting the onus on the pharmacist, with suitable guidance from the Society, to declare — and justify if chal-

lenged — a statement that he or she is "not active in pharmacy (science, practice, or say, management)". By making such a statement a pharmacist would fall within Group 3 and have the option of joining the inactive class within the register, thereby avoiding the CPD requirement.

Is it not inevitable that many industrial and academic pharmacists will choose to leave the Register?

The implementation committee believes that many industrial and academic pharmacists are highly active in their CPD efforts as a requirement of their employment and that it will not prove onerous for them to record their CPD, to meet the Society's requirements. The implementation committee and the Society's CPD team are committed to making record keeping user-friendly and genuinely useful to the pharmacist. However, the committee recognises that some pharmacists may choose to leave the Society rather than meet the CPD requirements when the regulations for mandatory CPD become effective.

Can Group 2 pharmacists opt to be on the inactive register if they choose not to carry out CPD and sign the non-practising statement?

If this were allowable for Group 2 why not for Group 1? This would be disallowed under the current proposals for CPD. A member who works in a position in which

they use their knowledge of pharmacy will be expected to comply with the CPD requirements. The inactive register would be for members who have retired or do not work as a pharmacist in any way.

Why should those whose jobs have nothing to do with pharmacy, eg, accountants and landscape gardeners, be allowed to continue to have a say in the way the Society is run, while those whose jobs have a pharmacy or health care connection are to be forced to leave the Society if they do not undertake CPD?

At present all pharmacists are equal on the register, whatever their pharmacy or non-pharmacy work. Correspondence about the introduction of CPD has made it clear that retired pharmacists, and others, value their membership of the Society and wish to retain their membership. If they are to remain members of the Society what should be the benefits of membership, eg, receiving *The Pharmaceutical Journal*, access to the library, voting in Council elections?

One purpose of the consultation is to determine whether the membership at large think that this is reasonable. It may well be that the profession as a whole believes that pharmacists listed on the inactive register should have more or fewer benefits of membership than this.

Non-compliance with the CPD requirement is a separate issue. Any pharmacist who has trouble meeting the CPD

requirements will receive support and guidance from the Society. However, if a pharmacist in Group 1 or Group 2 chooses not to send in CPD records when requested, after reasonable reminders, the Society will have no choice but to remove that person from the register. A pharmacist who is active in the broad science or practice of pharmacy cannot be offered movement into the inactive class.

Why does the CPD implementation committee think that CPD is enough for pharmacy when other health professions are setting up revalidation schemes?

The implementation committee would like to see how revalidation schemes wider than just mandatory CPD work out in other health professions. The Society is not being pressed to produce a revalidation scheme at this time, so we can take the time to reflect on the experience of other professions

Will there be any difference in what an individual needs to undertake to move from the inactive to the active register and what is required if you are already on the active register (but have no patient contact) and want to move from, say, pharmacy journalism, to hospital pharmacy?

There is commonality of the two cases in the Code of Ethics requirement to prepare oneself for practice or changed practice. In the case of the pharmacist in the inactive class, there may well be a requirement to submit an appropriate personal development plan for the move into the aspect of pharmacy concerned. In the case of the pharmacist in the active class moving to new employment, the requirements of the Code of Ethics will apply, as now.

In the case of supplementary prescribing, where a pharmacist's role as a prescriber will be recognised by the Society, the initial qualification and subsequent continuing

professional development are likely to be monitored.

If you have a job where the pharmacy component is small, eg, a managerial job, who decides what records you must make that relate to pharmacy in general, ie, would you just pick an area that you were interested in or would the Society expect specific things to be covered?

It is up to the individual pharmacist. The interpretation of "pharmacy in general" will be broad. The guidance in support materials from the Society and other bodies will lead pharmacists to reflect, plan, act and self-evaluate CPD that is relevant to their work, not consciously distinguishing between pharmacy-related and other CPD. Clearly, the pharmacist in the case given will have to consider from time to time the need for a pharmacy slant to the CPD he or she is undertaking and recording.

Welsh Executive sets out public affairs programme

The Welsh Executive of the Royal Pharmaceutical Society has announced a wide-ranging public affairs programme for 2003. Its focus will be liaison with the Welsh Assembly on the strategic future of the pharmacy profession in Wales. Other activities will include briefing politicians on pharmacy issues at national and local level, attending political party conferences, briefing local health board pharmacists, increasing interaction with relevant patient groups, and presenting the public affairs programme in a Welsh medium to relevant Welsh audiences

Andrea Robinson, chairman of the executive, said: "Pharmacy in Wales is developing on a daily basis. It is an important role of the Welsh Executive to make sure politicians from all parties are fully briefed on key issues such as patient safety, risk management, facilitation of automated dispensing and manpower issues."

As part of a commitment to increase branch involvement in the public affairs pro-



At the Welsh Executive dinner, Eleri Ebeneza and Geraint Morgan, chairman and chief pharmacist, respectively of Ceredigion and Mid Wales NHS Trust

gramme, representatives of the Society's local branches were invited to a dinner hosted on 28 January at the Garden of Wales (the former National Botanical Garden). Branch members from Ceredigion, Penfro and Bro Myrddin joined local health representatives, including: chief executives and chairmen of the new local health boards and local NHS trusts. Also invited were representatives of patient groups and local pharmacy development groups.

Andrea Robinson said that the dinner had provided an excellent opportunity for branch members to network with local politicians and key influencers. "If anyone can convince decision-makers that pharmacists have an increasingly valuable contribution to make to the health agenda in Wales, it is those who are actually making that contribution", she said.

"Through these events, branch officials and the Executive can join forces to influence key local opinion formers and decision-makers in Wales."

Leaflet promotes pharmacists' primary care role in Wales

A new leaflet, "Pharmacists' contribution to primary care in Wales", has been launched by the Welsh Executive of the Royal Pharmaceutical Society.

Aimed at providing information to the emerging local health boards, the leaflet examines the way in which pharmacy fits into the agenda for improving health in Wales. As well as prioritising issues that are important at local level, such as the real value of the local contribution of pharmacy services and manpower availability, the leaflet also includes a range of case studies that illustrate the success of innovation in pharmacy services.

The four-page leaflet says that pharmacists are currently an untapped expertise resource for local health and social care services in Wales. It points out that pharmacists are an acceptable, trusted and

accessible source of advice for a wide-ranging public. It adds that pharmacists have a proved contribution to primary care — among other things, by preventing unnecessary hospital admissions, improving patients' use of medicines and supporting other health professionals in medicines management.

The leaflet says that LHBs, National Health Service trusts and social services could do much more to make pharmacy expertise available as a professional resource

The Welsh Executive chairman, Andrea Robinson, said that the leaflet aims to achieve a greater understanding of the total contribution pharmacy can make to local services. "Although there is a willingness within trusts, and the political health arena generally, to recognise the value of pharmacist's contribution in primary care, the full

scope of pharmacy skills and expertise can still be overlooked by service providers."

The executive hopes that the leaflet will help LHB pharmacists increase understanding among their board counterparts. "LHB pharmacists are in a prime position to help their colleagues understand the full contribution that pharmacists can make to local health services," Mrs Robinson said. "It is in the interest of patient care that pharmacy expertise should be an intrinsic part of improving health in Wales."

The leaflet is available in both English and Welsh versions. It can be downloaded from the Welsh Executive section of the Society's website (www.rpsgb.org.uk/wales) by clicking on "News" and selecting "Briefing papers". Those without internet access can obtain copies from the executive's office (tel 02920 412800; e-mail wales@rpsgb.org.uk).

Communications to the Royal Pharmaceutical Society of Great Britain should be addressed, except where otherwise stated, to the Secretary and Registrar, Royal Pharmaceutical Society of Great Britain, 1 Lambeth High Street, London SE1 7JN (tel 020 7735 9141; fax 020 7735 7629). Official Notices also appear in the Notice-Board section of PJ Online (www.pjonline.com/notices)

Alterations to the Byelaws:

Register of Pharmaceutical Chemists
Notice is hereby given in accordance with Section XXVIII of the Byelaws that the Council of the Society has approved proposals to alter the Byelaws concerning the Register of Pharmaceutical Chemists (Section XXI) as hereunder and that it intends to make such alterations after the expiry of 60 days from the date of this notice, subject to such amendments as the Lords of the Privy Council may require.

SECTION XXI

Add the following new paragraph — “The Council may by resolution amend the third schedule to the Byelaws to enable the annotation of the annual register to indicate particular qualifications, specialist areas of practice or status as determined by the Council or as prescribed by Regulations.”

ANN LEWIS
Secretary and Registrar

Note: The intention of the Byelaw amendment is to allow annotation of the Register to indicate pharmacists who are authorised to prescribe as supplementary prescribers, but the wording will encompass other eventualities that might require register annotation in the future (see p245).

Alterations to the Byelaws:

Council committees

Notice is hereby given in accordance with Section XXVIII of the Byelaws that the Council of the Society has approved proposals to alter the Byelaws concerning the Council and meetings of Council (Section VII) as hereunder and that it intends to make such alterations after the expiry of 60 days from the date of this notice, subject to such amendments as the Lords of the Privy Council may require.

SECTION VII

Paragraph 10 — Delete the final sentence.

ANN LEWIS
Secretary and Registrar

Note: The effect of the Byelaw amendment is remove the requirement that the President and Vice-President of the Society shall be ex officio members of all Council committees (see Council report, p245).

Statutory Committee inquiries

The Statutory Committee will meet at the Royal Pharmaceutical Society of Great

Britain, 1 Lambeth High Street, London SE1, at 10am on Monday 17 February, Tuesday 18 February and Wednesday 19 February:

Monday 17 February

1. To announce the decision following the hearing of an inquiry into a complaint by the Council of the Society against a pharmacist proprietor and his locum pharmacist which alleged that the sale without prescription of a quantity of co-proxamol tablets amounted to misconduct. The complaint against the pharmacist proprietor also included allegations that the failure to account, by means of valid prescriptions or emergency supplies, for co-proxamol and Rohypnol supplied from the pharmacy and failure to ensure that all medicines possessed for the purpose of sale or supply are properly licensed, amounted to misconduct.
2. To hear an inquiry into a complaint by the Council of the Society against a pharmacist which alleges that practising as a pharmacist on 43 occasions between 14 May 2001 and 27 October 2001 while unregistered, amounts to misconduct.
3. To hear an inquiry into a complaint by the Council of the Society against a pharmacist which alleges that a dispensing error made by the pharmacist amounts to misconduct.

Tuesday 18 February

4. To hear an inquiry into a complaint by the Council of the Society against a pharmacist which alleges that the submission by the pharmacist of prescrip-

tions to the Prescription Pricing Authority claiming payment for a full month's supply per prescription when only one week's supply had been dispensed against each prescription amounts to misconduct.

5. To hear an application from a person seeking registration with the Society. Following the hearing of the inquiry in January 2001, the committee had directed that the applicant's name should not be registered until the committee otherwise directs.

Wednesday 19 February

6. To hear an inquiry into a complaint by the Council of the Society against a pharmacist which alleges that the submission by the pharmacist of documents, which he had falsified, to a health authority, for the purpose of claiming payment to which he was not entitled, amounts to misconduct.

M. B. PAWLUCZYK (Mrs)
Secretary to the
Statutory Committee

Council election 2003

Nominations for election as members of Council should be received by the Secretary and Registrar of the Society on or before 18 March 2003. Each nomination in the Council election must be signed by at least 10 members of the Society, of whom at least five must be from the branch of the member nominated.

Nominees who are accepting nomination to the Council are asked to enclose with the nomination form their biographical details, photograph and financial declara-

tion, as indicated on the back of the nomination form.

ANN LEWIS
Secretary and Registrar

Nomination forms are available from the Secretary and Registrar or from the "About the Society" section of the Society's website (www.rpsgb.org.uk/society). Nominations can also be made by letter.

Community Pharmacists Group
committee election 2003

The seven elected places on the Royal Pharmaceutical Society's Community Pharmacists Group committee fall vacant at the end of May 2003. Nominations for election to membership of the committee are invited from group members and should be received by the secretary to the group by 14 March.

Each nomination must be signed by at least five members of the group. Those accepting nomination as a candidate are asked to enclose with the nomination form their biographical details and a statement of policy amounting to not more than 200 words. Nominations are available from the secretary to the group at the Society's headquarters and from the CPG section of the Society's website (www.rpsgb.org.uk/society).

The election will be conducted using the single transferable vote system. Voting papers will be sent to the members of the group in April. The closing date for the receipt of voting papers will be noon on 9 May.

Those elected will serve for a period of three years.

ANN HARRINGTON
Secretary to the Community
Pharmacists Group

DIARY

HEADQUARTERS MEETINGS

The following meetings take place at the Royal Pharmaceutical Society's headquarters, London

Monday 17 February
Statutory Committee 10am

Tuesday 18 February
Veterinary Pharmacists Group
Committee 9.30am
Statutory Committee 10am

Wednesday 19 February
Statutory Committee 10.15am

LOCAL MEETINGS

Events listed below are meetings of branches or regions of the Royal Pharmaceutical Society. Details of all future meetings notified to The Journal appear in the Diary section of PJ Online (www.pjonline.com/noticeboard)

Monday 17 February
Bury "Role of primary care trust: the pharmacist input" by Vivienne Ben-David (prescribing adviser, Rochdale PCT). Village Hotel, Waterfold Business Park. 8pm.

Tuesday 18 February
East Metropolitan "Update in cardiology: terminology, tests and treatment" by Dr Sandeep Gupta (consultant cardiologist). Churchill Room, Wanstead Public Library.

Northamptonshire "Practical aspects of obesity" by Amanda Cardall (Roche). Monsoon, Kettering. 7 for 7.30pm.

Plymouth "Drug treatment of depression" by Dr Steve Pearson (consultant in old age psychiatric medicine). Postgraduate Medical Centre, Derriford Hospital. Buffet 7.15pm, meeting 7.30 for 8pm.

Reading "The treatment of epilepsy" by Dr

Matthias Koepp (consultant neurologist). Postgraduate Centre, Royal Berkshire Hospital. Buffet 7.30pm, meeting 8pm.

Wednesday 19 February
South East Metropolitan "Update on modernisation" by Sultan Dajani (member of the Royal Pharmaceutical Society's Council). Clarendon Hotel, Blackheath. Refreshments 7.30pm, meeting 8pm.

Thursday 20 February
Bradford "Improving the status of pharmacy" by Dr Malcolm Brown. D4 Lecture Theatre, University of Bradford. Buffet 7.30pm, meeting 8pm.

Halifax "Introducing continuing professional development" by Dr Peter Wilson (CPD adviser, Royal Pharmaceutical Society). Learning and Development Centre, Calderdale Royal Hospital. Buffet 7.30pm, meeting 8pm. Joint meeting with Huddersfield branch.

Huddersfield See Halifax.

Hull "Primary care and emergency planning in the NHS" by Dr R. Mark. Postgraduate Education Centre, Hull Royal Infirmary. 7.30 for 8pm.

Lanarkshire "The Royal Pharmaceutical Society's Statutory Committee" by Lord Fraser of Carmylie, QC (chairman of the Statutory Committee). Hilton Strathclyde Hotel, Bellshill. 8pm.

Friday 21 February
Isle of Man "Cholera in the Isle of Man" by Bethany Clague. Postgraduate Medical Centre. Refreshments 7.30pm, meeting 8pm.

Monday 24 February
Cambridge "POM-to-P switches" by Amanda Williams (Medicines Control Agency). Addenbrookes Hospital. 7.30pm.

Southampton "Hormone replacement therapies" by Dr Caroline Sadler. Solway Healthcare, West End, Southampton. 7.30 for 8pm.

LISTENING FRIENDS SCHEME

The Listening Friends Scheme exists to offer free confidential help to pharmacists suffering from stress. The scheme has been set up by the Royal Pharmaceutical Society but operates independently so that help can be sought in complete confidence. The service allows any pharmacist under stress to talk to a fellow pharmacist who has insight into the particular pressures that apply in pharmacy. The service is not, however, restricted to work-related problems, but offers help with all causes of stress, such as family problems, illness and bereavement.

The service is run by a team of volunteer pharmacists, all of whom are mature and experienced in their field of practice. All have been trained in listening skills and many have counselling training and experience. They are able to direct pharmacists under stress to sources of specialist help where needed.

Contact with the Listening Friends is made initially by telephoning the scheme's automatic answering service on 020 7572 2442. Callers will be given brief details of the service and asked to leave their name, the area in which they live, a contact telephone number and a convenient time to call. A Listening Friend will then call back to discuss the details of the pharmacist's problem in complete confidence. Further contacts are usually by telephone.

Information about the scheme is available in the form of a leaflet that can be obtained by contacting the help-line number. Funding for the scheme is provided by the Society's Benevolent Fund.

Advertisement