CONTROLLED DRUGS

Are the funds and the workforce available?

From Mr I. G. Simpson, FRPharmS

I was pleased to read that primary care trust chief pharmacists and pharmaceutical advisers have been authorised to witness the destruction of Controlled Drugs (*PJ*, 21 September, p383).

In my previous post as a health authority pharmaceutical adviser, this was something which I did quite often under the authority previously issued by the Secretary of State,[1] and I regarded the work as an important contribution to pharmaceutical public health. Unfortunately, not all of my colleagues in health authorities around the country viewed the activity in the same light, and it remains to be seen what degree of priority our successors in PCTs will give to it.

Your news item states that PCT pharmacists have been given authority to witness the destruction of CDs in general practitioners' surgeries, and the Department of Health paper on which it is based[2] is entitled "Destruction of Controlled Drugs in GP practices". However, the letter of authority which accompanies the paper makes no reference to general practitioners' surgeries, or indeed to any other location. From this, I assume that PCT pharmacists may witness the destruction of CDs, wherever they may be located, as was the case for pharmacists acting under the 1997 authority.

I should like to raise a few points for discussion, based on my experience as a health authority pharmaceutical adviser until the end of last year.

The locations to which I was most frequently called to witness the destruction of Controlled Drugs were the hospital pharmacies of my local NHS trust. I know that EL(97)22 gave authority to chief executives of NHS trusts and senior officers in the trust responsible for health and safety, security or risk management, but none of these officers was ever available to carry out the work. Perhaps the NHS chief executive should be asked if he really expects trust chief executives to do this work, and how often he did it when he was a trust chief executive. If NHS trust chief executives do not regard it as a priority, will PCT pharmacists be called upon to witness the destruction of CDs in NHS trusts?

The second most frequent call on my time came from hospices that held stocks of CDs under the exemption granted to charities, or by Home Office licence. I combined this activity with inspections carried out under authority of the Registered Homes Act. This role has now been taken on by the National Care Standards Commission, but pharmacists employed by the Commission or contracted to it do not have authority to witness destruction. Will PCT pharmacists also be called to these locations?

I was required to witness the destruction of CDs in a GP surgery on only two occasions, and both of these were unusual situations. One situation was when a dispensing practice, which was run single-handedly, closed down, and the other was when there was a fire at a dispensing practice and most of the medicines were subjected to heat and smoke damage. Although I was received courteously on both occasions, it was made clear to me that I was there by invitation, and not because I had any right of entry. Will PCT pharmacists exercise their authority in GP surgeries only by invitation? If the emphasis on destruction in GP surgeries is meant to be an "anti-Shipman" measure, I would suggest that the responsibilities of GPs and PCT staff require further clarification. Otherwise, we risk the possibility of a PCT pharmacist or doctor being made a scapegoat, should another disaster involving the use of CDs occur.

Finally, I note that the new Department of Health paper[2] states that it is good practice to have the destruction of CDs returned by patients witnessed by an authorised person. This advice differs from that given by the Royal Pharmaceutical Society,[3] which states that the destruction of CDs returned by a patient should be witnessed by a member of staff. If the DoH advice is to be followed, it will lead to storage and logistical problems in both hospital and community pharmacies, and a considerable increase in the workload of authorised persons. If the brunt of this work is to fall on PCT pharmacists, one must query if there is the workforce available to do it, and how it is to be funded.

Ian G. Simpson
Old Marston,
Oxford

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2. Department of Health. Destruction of Controlled Drugs in GP practices. Available at www.doh.gov.uk/pricare/cddestruction/index.htm. London: The Department; 2002.
3. Medicines, Ethics and Practice — A guide for pharmacists. Number 26. London: Royal Pharmaceutical Society; 2002; p26.

ADVICE FOR CORRESPONDENTS

Letters for publication can be posted, faxed, or sent by e-mail to letters@pharmj.org.uk and should not normally be of more than 400 words. **The Journal** *reserves the right to abridge letters and to edit them for clarity and style. Pharmacist correspondents should supply their membership numbers and a contact telephone number should always be given. Women correspondents should specify a preferred title otherwise "Ms" will be used.*

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Letters that are critical of individuals, organisations or companies may be sent to the person or body concerned so that they are given a simultaneous right of reply. In these instances, the authors' identities will not be disclosed until publication, and publication will usually be delayed.

Anonymity will only be accepted in exceptional circumstances. These circumstances will be at the discretion of the editor and the decision made in consultation with the correspondent.

CPD

A loss to the community

From Mr D. Clayman, MRPharmS

I write regarding my concerns about continuing professional development.

I sold my pharmacy some six years ago and have since been doing regular locum work. During this time I have always attempted to keep up to date regarding new drugs, for example, looking up references, taking courses as well as reading many articles for continuing education and completing some distance learning courses. Furthermore, until I sold my business, I was part of a once weekly or fortnightly meeting on updates attended by doctors, nurses and representatives of drug companies. I know many of my colleagues do the same, not entering anything into a diary, but just regarding it as normal professional behaviour. I, like most of my colleagues, fit these in around my non-professional life.

I have another life, including participation in sport and involvement in a wide variety of interests within the community at large. I also have a family with grandchildren. Taking into account the new Government initiatives, such as clinical governance, I wonder when pharmacists will have the time to fulfil these myriad tasks. I suppose those working in hospitals, or larger multiples, might be given time off during the week, while the others will have to give up what is left of their "leisure" time, quite possibly at the expense of their family. I cannot envisage our medical colleagues agreeing to be so governed.

From a personal point of view it is difficult to see where I can continue to develop personally, especially after a working lifetime in the profession.

It would appear to me, from all I have read of CPD, that there will be a choice between being a practising community pharmacist or a communally active person with no part to play in the profession (ie, not registered).

The loss, I fear, will be to the community for the vast amount of voluntary work undertaken by pharmacists, or to community pharmacy — which already appears to rely on locums — for

the loss of people who will choose not to be even more tied up with the bureaucracy of staying registered than they are currently with the practice of community pharmacy.

David Clayman
Leeds

BPC

Community pharmacists were conspicuous by their absence

From Mrs E. E. T. H. Hopkins, MRPharmS

I have just come back from the British Pharmaceutical Conference in Manchester. From the list of attendees, two of us shone like beacons, as independent community pharmacists.

It has cost us in the region of £1,500 for locums, accommodation and travel, etc. There were members attending the conference from industry, academia and social services. There were pharmaceutical advisers, members of various NHS trusts, pharmacologists and biochemists, but if there were any other independent community pharmacists who attended, I would be interested to know.

Yet this group — independent community pharmacists — is the most vulnerable and most affected by the conference. For example, supplementary prescribing will only be allowed with the agreement and co-operation of local general practitioners, so do independent community pharmacists really stand a chance? There were also issues raised about local pharmaceutical services, discussions on law and ethics, on new innovations and on new drugs that, as the retiring president of the Academy of Pharmaceutical Services said, community pharmacists will have to persuade patients to take — yet we were conspicuous by our absence.

Taking all of this into account, perhaps the answer lies in the scientists organising the next conference. The pharmacists and anyone else involved in the health of the nation could then attend if they so wished. The conference fee would then be much lower.

E. Hopkins
London W5

CAVE DRAWINGS

What is the point of preserving them?

From Mr J. Balshen, MRPharmS

Onlooker's paragraph concerning the drawings on in the caves of Santander (*PJ*, 21 September, p418), suggests that the only means of preserving them seems to be to exclude human visitors. If this is the only way of preserving them, what is the point?

J. Balshen
Chesterfield, Derbyshire

DAILY NEWS

For a daily news service, visit *PJ Online*, *The Journal*'s website, at www.pjonline.com**.**

THE COUNCIL

How many pharmacists on GMC and GDC?

From Mr T. N. R. Horsfield, MRPharmS

I read with interest the various articles in *The Pharmaceutical Journal* of the 28 September. In particular, I noted the editor's enthusiasm for having a "leading member of the Royal College of Physicians" on our Council.

In the report of the September Council meeting (p464), Christine Gray compared the actions of the General Medical Council and the General Dental Council with those intended for the new Royal Pharmaceutical Society Council. This appeared to put the status of all three Councils at the same level. This leads me to wonder how many pharmacists are serving on the medical and dental councils.

T. N. R. Horsfield
Sandbach, Cheshire

Advertisement

THE COUNCIL

Changes that do not reflect members' wishes

From Mr J. Ferguson, FRPharmS

The Council has decided by "an overwhelming majority" (although no voting figures were given) to propose changes to its constitution (*PJ*, 28 September, p426). Its reason for the proposed fundamental change is said to be to meet the requirements of a "modern regulator" as set out by Kennedy in his report. The Council's proposals, if implemented, would not be confined to changes for the regulatory function of the Society. They would represent a profound alteration to the professional body itself.

The constitution of the Society's Council is established by Royal Charter, currently the Supplemental Charter of 1953 as amended in 1975 and 1988. This makes it clear that the Council comprises 21 elected members plus the three Privy Council nominees, currently appointed under the Pharmacy Act 1954. It is now proposed to change the Charter to replace this Council by one comprising up to 30 members, increasing lay membership to between 30 and 40 per cent, with two technician members if the Council decides that technicians are to be registered by the Society.

The Charter contains provisions designed to prevent a Council from making changes to the Charter that do not reflect the wishes of the members. It requires any proposed change to command a majority of three-quarters of Council members and confirmation by a majority of three-quarters of the members attending and voting at a Special General Meeting.

Until recently, this was the only means by which changes could be made to the Charter. But the Health Act 1999 includes a power for changes "modifying the regulation" of the profession to be made to the Charter by order in Council. The Council's proposals are not confined to "regulation". In my view the Council will be on very unstable ground if it seeks to make its proposed changes by using an order, ignoring the safeguards for the members included in the Charter itself.

There are alternative ways of meeting the requirements of Kennedy without altering, so radically, the composition of the profession's governing body. One possible alternative framework was put forward by the Young Pharmacists Group, supported by the National Pharmaceutical Association and the Pharmaceutical Services Negotiating Committee, and there are other possibilities. The Council appears to be refusing even to listen to any alternative to its own proposals, raising the spectre of the Council for the Regulation of Health Care Professionals. Two of the main functions of this council are "Comparing and reporting on a regulator's performance to promote continuous improvement" and "Promoting co-operation and sharing of good practice". The Society has no reason to fear a review of the way it has, over many years, discharged its regulatory function. Fine-tuning would meet all the Kennedy requirements. And perhaps some of the Society's structures and processes would be promoted to others as "good practice".

In all the circumstances, the members will surely expect that the original Charter provisions will be followed for the suggested alterations to the provisions of that Charter.

John Ferguson
Haywards Heath, West Sussex

Change to Byelaw is prejudicial

From Mr A. Tanna, FRPharmS

At the Council meeting held on 8 September, it was approved by a majority present to alter Byelaw 3, concerning the reimbursement of locum expenses for Council members engaged on Council business, in order to allow the director of a private limited liability company to claim locum expenses and remove the ambiguity which exists in the current Byelaw.

The alteration is as follows: replace "A member of Council who personally incurs expenditure in employment of a pharmacist to take personal control of registered retail pharmacy premises in order to comply with the requirements of the Medicines Act 1968 whilst the member of Council is engaged on Council business shall be entitled to reimbursement of sums expended not exceeding £200 per day" with "Where expenditure is incurred in employment of a pharmacist to take personal control of registered retail pharmacy premises in order to comply with the requirements of the Medicines Act 1968 while a member of Council normally present on those premises as sole pharmacist and registered proprietor of those premises is engaged on Council business, entitlement to reimbursement of that expenditure shall arise for a sum not exceeding £200 where that sum is incurred either by a private limited liability company of which the member of Council is a director or by the member of Council personally."

The Council is well aware of my feelings regarding the reimbursement of locum expenses. I therefore, through your letters columns, wish to tell the membership to be aware that the effect of the amendment will be that a large company that allows a pharmacist to join the Council will not be able to claim locum expenses for a replacement pharmacist while that Council member is engaged on Council business.

Shifting the goal post in this manner is prejudicial to members of the Council who are employed by large companies since their employer would be within their rights not to pay such locum expenses incurred and therefore the member would be unable to attend Council meetings.

Ashwin Tanna
London SE26

WORKFORCE CENSUS

Upset at being profiled by ethnic origin

From Mr A. C. Patel, MRPharmS

I take offence at receiving your enclosed "Pharmacy Workforce Census" 2002, which I refuse to complete on the grounds that the Society is trying to sort me out by my ethnic origin, especially since it is not an anonymous survey.

I am wondering what a learned Society like ours is trying to do with this information. One of the reasons forwarded in *The Journal*, implementing race relations legislation (*PJ*, 14 September, p378), does not hold water — the Society is not the Government. Would the practice research division care to elaborate? As a member of an ethnic minority I have access to an abundance of Race Relations Acts and Laws — we do not need any more legislation.

As a member of the Society I have several questions: (1) Who would have access to the results of this census and in what form? (2) How does the Society plan on protecting this data? (3) Where would this data be stored and in what format? (4) Does the Society under the Data Protection Act have to make the Data Protection Agency aware that it is conducting such a survey?

Another question that comes to my mind is how the ethnic origin survey of pharmacists is going to help plan the future of the pharmacy profession? I think it is important to focus on enhancing the image and the morale of the Society and its membership.

I feel extremely upset at the thought that I am being profiled by my ethnic origin. I am currently seeking legal advice as to whether the Society can conduct surveys/census that are based on racial/ethnic profiling of its membership under the Race Relations Act since the profiling does not enhance, benefit or further contribute to the learnedness of the membership.

Ashok Patel
London E1W

ZOE WHITTINGTON, research manager, pharmacy practice research division, Royal Pharmaceutical Society, replies: The question of why the Society collects data on ethnic origin has been responded to previously (*PJ*, 14 September, p378 and 28 September, p439).

The aggregated results of the census will be published and therefore be in the public domain. The data are secured by ensuring that access is only for statistical analysis and to support the regulatory and professional functions by named individuals in the Society. It will not be possible for external organisations to review individual records. The data will be stored on a secure server folder at the Society. This will only be available to authorised users and for authorised purposes, eg, research into the changing work patterns of pharmacists. The collection, processing and disclosure of these data are covered by our Data Protection Registration (mmc652, 25 June 2002). Analysis of our registration confirms that we have registered all data being collected, processed and disclosed for the purposes of this research project.