



fit for the future

Professional leadership and development: what is it, and how should the Society do it?

A DISCUSSION PAPER ON FUTURE STRUCTURES

WHAT IS THIS DISCUSSION PAPER ABOUT?

The Council of the Royal Pharmaceutical Society has agreed proposals for the governing Council and the fitness-to-practise machinery for inclusion in the forthcoming legislation to modernise professional regulation in pharmacy. It is now starting to consider how the Society's detailed work could be undertaken in the future. Thought needs to be given to ensuring that the Society's professional leadership and development responsibilities, and its regulatory work, are properly informed and effectively discharged. Developing a broad outline structure that will support the Council and carry out this detailed work is a key step — this paper sets out initial thinking and seeks views on what is important and why.

WHY IS IT BEING LAUNCHED NOW?

As you will be aware, the Council of the Society has spent a lot of time in the past year or two thinking through the implications for pharmacy of the modernisation of health professional regulation, and developing the new Royal Charter. This was sparked by the Government's decision to introduce wide-ranging reforms of health professional regulation. You may have taken part in the many consultation meetings and other activities.

At the outset, it was recognised that the Society was both a regulator and the body responsible for professional leadership and development in pharmacy. But, because of the demanding timetable for drafting of the new legislation, this second role has, until recently, received much less attention than the former. In July 2003, the Council spent a day considering both functions and decided, as a priority, that the professional leadership and development aspects required more detailed work on the underpinning structures. The thinking has been developed further over the past two months.

In response, this discussion paper sets out what is at stake, sketches out some possible organisational models for the Society, and concludes with a list of issues for comment. Your views on all of this are most welcome. The results will be presented to the current Council in January 2004, and could also inform a paper to be presented to the new Council, once established.

WHAT IS PROFESSIONAL LEADERSHIP AND DEVELOPMENT?

Unlike modern regulation — the shape of which has been clearly defined by the Government — professional leadership and development (PLD) is for the profession to describe and define, and will be enabled by the new Royal Charter. So what do we want it to mean?

Several strands come together in the term PLD. First is a belief in the value of the profession of pharmacy, and all that that means in terms of serving the public and acting honourably. Second is a sense of responsibility for

PANEL 1: PROFESSIONAL LEADERSHIP AND DEVELOPMENT

As custodians of the profession, and in the public interest, to:

1. Provide strategic leadership for the profession of pharmacy
2. Promote and represent the profession of pharmacy
3. Set and improve standards for practice
4. Support practitioners in their practice
5. Promote and provide continuing professional development
6. Advise government, other professions and the public on health care matters
7. Promote scholarship, research and the advancement of knowledge
8. Foster collaboration with other relevant bodies
9. Provide a benevolent function for members
10. Promote pharmacy as a career

In all of these, to ensure that it takes no action against the public interest, and takes no part in representing individual parties in a disciplinary matter, or in campaigning on matters of a purely contractual nature

passing pharmacy on to the next generation in a stronger state than we inherited it. Third is a recognition that pharmacy is a diverse family whose strength lies in unity and, above all, a recognition that the future of the profession cannot be left to chance or to the whims of the government of the day — the profession must retain the capacity for self-determination.

The Council described PLD at its July meeting in terms of the functions set out in Panel 1.

HOW DOES PLD RELATE TO “MODERN REGULATION”?

PLD is the essential partner or complement to modern regulation, even sharing many of the same functions (such as standard setting and continuing professional development). As the Society discharges its regulatory role, it needs to take full account of the professional perspective, on matters ranging from ethics to pre- and post-registration education and development. Equally, PLD must be aware of regulatory requirements and public expectations. Acting together in this way, regulation and PLD should ensure the highest standards of care for patients.

The Society is unique among the health professions in having long carried out the dual roles of regulation and professional leadership and development. The medical profession, for example, has had the General Medical Council as regulator and the medical royal colleges for

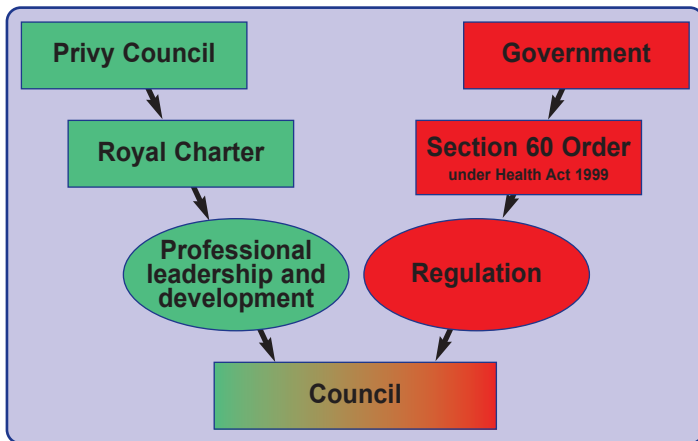


FIGURE 1: INTEGRATION OF LEGISLATION AND CHARTER STRANDS

professional leadership. For the Society, one strand flows largely from legislation, the other from the Royal Charter (see Figure 1). Such integration is a big advantage, and the Council has unanimously agreed that both roles should be retained.

The next stage is to describe — in broad terms — what structure within the Society could best deliver these integrated roles.

WHAT SHOULD ANY NEW STRUCTURE LOOK LIKE?

The decision to retain the integrated function was followed by three other key agreements by the Council¹ (Panel 2), which set the parameters for the rest of this paper and the discussion that follows.

WHAT MUST THE STRUCTURE DO? . . .

There are several answers to this question. One is the list of criteria that the Council agreed must be satisfied by any future structure (Panel 3).

Another answer is to look at the different types of work that the organisation must do, and think about what is required for each. Simplifying this a little, there are three broad elements of the Society's work — setting and prioritising the agenda, developing policy, and implementing policy. Each requires a different mix of inputs — from the Council as a whole, elected pharmacists, front-line pharmacists, expert groups, external stakeholders and the Society's staff (see Panel

PANEL 2: KEY PARAMETERS FOR DISCUSSION

1. Any structure adopted should allow the Society to discharge its roles of professional leadership, development and regulation in an integrated way, characterised by joined-up policy development. The Society must speak with one voice to the outside world.
2. The Society should be equally effective both as a professional body and as a regulator. To achieve this, the PLD functions should be substantial, credible and well-resourced.
3. If both the above are to be discharged in an effective, sustainable and credible way, the Society should have one over-arching governing body, accountable for all its functions, with a majority of pharmacists elected by the membership. Associated with this, there should be a structure that engages the leading experts in the relevant fields, together with a much broader cross-section of the profession.

4).

. . . AND WHAT MUST IT NOT DO?

To some extent, the answer to this question will vary from person to person — one person's effective leader of the profession is someone else's overbearing meddler! So the list of "must not do's" *might* include some or all of the following.

For example, the Society *must not become the domain of any self-selected cadres or particular groups within the profession*. Although the involvement of experts will be important (particularly in policy development), *all* pharmacists must be able to contribute to those aspects of its work that interest them. And even if they do not want to be involved personally, they must be confident that the Society is acting in the interests of the profession and the public and that they can change things if necessary by exercising their democratic rights.

For example, *the different parts of the Society — committees, working groups, staff groupings — must not work in "silos", effectively cut off from each other*. This may be difficult to achieve, given the complexity of most of the issues discussed, and the comfort that comes from only talking to like-minded people! But silo working will squander the great advantage offered by the integration of regulation and PLD, since most topics of any importance contain elements of both. The Society's policy agenda must reflect both strands and expert input must be provided to support both.

For example, *the Society must not become too introspective or protectionist*. Unless the Society understands the environment in which pharmacy operates, now and in the future, it probably will not make wise decisions about future direction. Also, although it must recognise the importance of standing up for the profession, leadership can also involve making some painful and unpopular choices. It must command the respect of external stakeholders, while remembering its prime purpose.

There are probably other "must not do's", as well . . .

ANY OTHER REQUIREMENTS?

Yes, *whatever structure is agreed must be effective, efficient and affordable*. Almost everything the Society does will be funded by registration and retention fees and by income from commercial activities such as publications. The assessment of any proposition must include total costs.

WHERE WOULD TECHNICIANS FIT IN?

The Society will become the regulator for pharmacy

PANEL 3: WHAT CRITERIA MUST BE FULFILLED?

The structure should create an organisation that is:

1. Expert
2. Timely
3. Efficient and affordable
4. Effective
5. Capable of acting in a coherent way
6. Credible to all sections of the profession (with effective democratic control)
7. Credible to government, the Council for the Regulation of Health care Professions, and other professions
8. Credible to the public
9. Flexible
10. Robust and sustainable
11. Accountable

technicians but there is no intention that it will assume responsibility for their professional leadership and development. However, given the close relationship between regulation and PLD — and the integral role of technicians in the delivery of pharmaceutical care — there will clearly be a need for joined up working in this area.

ARE THERE ANY MODEL STRUCTURES TO LOOK AT?

These principles are important and it would be premature to debate structures without having thought through what the structure must do and how it must do it. But in the end, they are only principles — they must be translated into practice.

There is a bewilderingly large range of possible structures and permutations that the Society could adopt. But the task is made somewhat easier by two things. First, there is no need at this stage to dot all the I's and cross all the T's — the discussion can stay at the level of broad outline and key features. Second, three examples of model structures have been developed in the past few weeks, and are set out below.

None of these models is complete, none is perfect and, importantly, none has been assessed against the agreed criteria. Nor are they mutually exclusive — elements of each could be combined. They are simply offered here as a prompt for further thinking, to show some of the possible ways forward and to allow consideration of their respective merits. So, there is no need to decide on any one model now — in fact, the best outcome would be to invent another that improves on these!

Model One: clinical and practice senates, and academies This is a refinement of the model presented at the British Pharmaceutical Conference in 2002, adapted to reflect some of the features of Model 2 and responding to points raised in the Charter consultation. In this case, a total of five PLD bodies would be created under the Council (Figure 2). Two academies would address issues of education and learning, and science and technology, respectively. Participation in each would not be on the basis of membership (like the faculties in Model Two) but might be a combination of appointment on the basis of

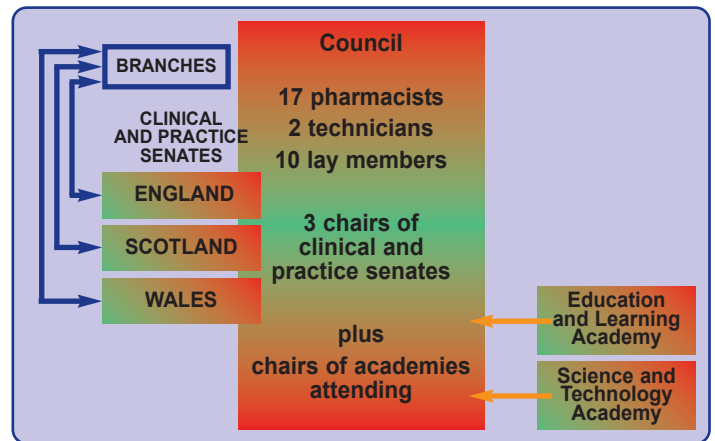


FIGURE 2. MODEL ONE: CLINICAL AND PRACTICE SENATES, AND ACADEMIES

expertise, together with some shared membership with the Council — and perhaps some direct election. The clinical and practice elements of the Society's work would be addressed by three clinical and practice senates — one for each of England, Scotland and Wales, to reflect the importance of devolution in areas of professional practice, and each linked into the branches. Senate members could be elected using a system to reflect devolution and diversity of practice and avoid excluding smaller but important sectors of the profession. The chairmen of the senates and the two academies would attend all Council meetings but not have a vote. The bodies under the Council (the senates and academies) would contribute to all three stages of the policy cycle, with the senates taking the lead in much of the relationship with the Scottish Parliament/Executive, the Welsh Assembly/ Government, and English MPs/Department of Health (where it has responsibility for English health policy). *Ad hoc* working groups could be drawn from the Council, senates and academies, with additional expertise being co-opted.

Model Two: the pharmaceutical senate This is the model that was first briefly presented at the Council discussion on 2 July. For the primary discharge of the PLD

PANEL 4: THE STAGES OF THE POLICY CYCLE

STAGES OF WORK	KEY FEATURES	WHAT IS NEEDED
<p>Stage 1: Setting the agenda <i>This is a crucial stage: issues that fail to get on the agenda will never be addressed</i></p>	<p>This is about looking forward, to anticipate future issues and to lead, as well as responding quickly to problems and opportunities in the present. There are far too many issues to handle effectively, so there must be agreed criteria and a transparent process for prioritising them.</p>	<ul style="list-style-type: none"> ● Input from a wide cross-section of all pharmacists ● Input from expert groups in pharmacy ● Horizon scanning ● Views from other professions/NHS ● Overall democratic control
<p>Stage 2: Developing policy <i>Most new policy involves aspects of both regulation and PLD and they must be addressed seamlessly</i></p>	<p>Much of this is detailed, back-room work, to be carried out by the best available experts. It needs to be co-ordinated to take account of the realities of everyday professional practice and, ultimately, to be endorsed by the Council.</p>	<ul style="list-style-type: none"> ● The best available experts, from pharmacy and elsewhere ● Co-ordination and direction ● Democratic approval
<p>Stage 3: Implementing policy <i>The Society implements its own policies (on standards, CPD, etc), and seeks to influence how others (eg, governments) implement their policies</i></p>	<p>Much of this is about the impartial, effective and efficient implementation of policy already decided by Council. Lobbying and persuading others is also part of it. But implementation will also reveal weaknesses and gaps in current policy — something for Council members to consider. This then feeds back into Stage 1.</p>	<ul style="list-style-type: none"> ● Competent staff and procedures ● Appropriate resources ● Awareness of possible gaps and weaknesses ● Democratic oversight

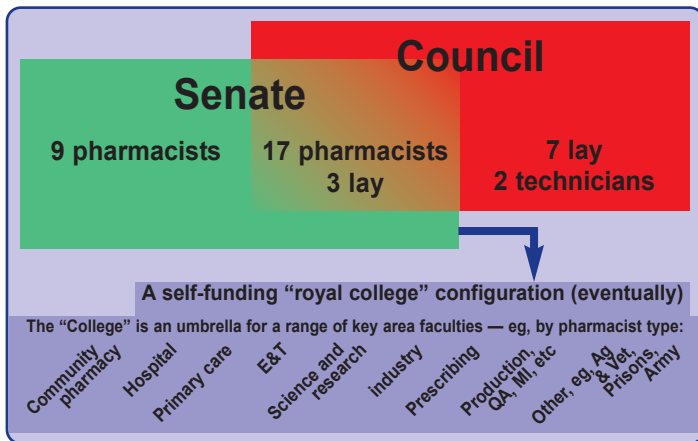


FIGURE 3. MODEL TWO: THE PHARMACEUTICAL SENATE

function, it envisages a senate, subordinate to the Council, with most members drawn from the Council, plus others from the chairmen of a number of “faculties” (Figure 3). Each faculty would include pharmacists working in defined sections of the profession (to be discussed and agreed). Figure 2 provides examples, which are purely illustrative at this stage. Each pharmacist could opt to belong to one, or maybe more, of these faculties which, as in Model 1, would undertake and influence work at all three stages of the Society’s policy cycle — advising the senate and Council on the future agenda, helping develop detailed policy as relevant (with final endorsement by the Council), and influencing (or perhaps assisting in) implementation. Each faculty would democratically elect its own officers, and the chairman would serve on the senate. In time, all faculties would come together under one umbrella, analogous to a medical royal college. The Council would retain ultimate authority and accountability for the work of the senate, which would have a significant range of delegated responsibilities including co-ordination of the PLD work of the faculties. Efficient and effective co-ordination of all the Society’s responsibilities — including both the PLD and regulatory agendas — would be ensured through the Council, helped by the substantial common membership of Council and senate.

Model Three: standing and *ad hoc* groups, plus networking This model takes a slightly different approach to the others. It envisages a combination of standing bodies and *ad hoc* groups (Figure 4). The former would have oversight (under the Council) for substantive areas, concentrating on agenda setting, co-ordination and review; the *ad hoc* groups would be set up for particular purposes, with a “task and finish” brief. The standing groups should be as few as possible, to reduce the burden of being a member, to reduce cost, and to provide a way for busy experts to become involved in issues about which they really care. In addition to this formal structure — and to some extent even more important — it also seeks to emphasise the importance of networking. This is not a loose process of social interaction — a nice thing to do when the real work has been done. Rather it is a deliberately planned and co-ordinated attempt to bring together the appropriate individuals and groups, at the appropriate time, to focus on particular aspects or issues of policy. It would involve a new way of working, far less rigid and bureaucratic than a committee-dominated structure. It seeks to break down silos by having an ever-changing kaleidoscope of different working relationships, to suit the task at hand.

Other models Remember that the models outlined above

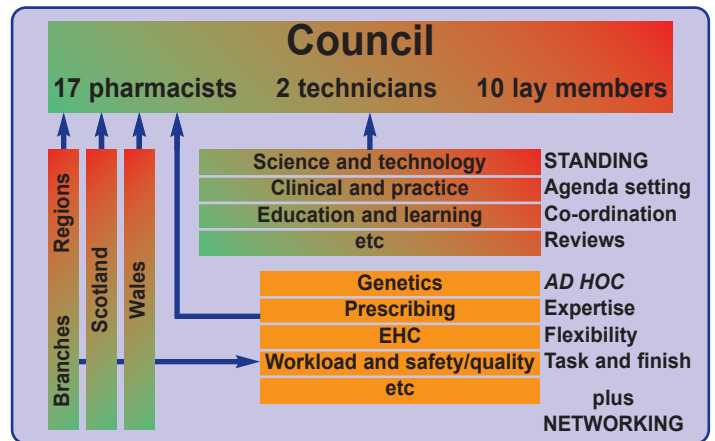


FIGURE 4. MODEL THREE: STANDING AD-HOC GROUPS, PLUS NETWORKING

are only three of many possible approaches.

WHAT ISSUES DO WE NEED TO THINK ABOUT NOW?

This paper has outlined some of the key aims, desiderata and contraindications of any new structures. The three models give a flavour of how it might all come together. But there may be other aims or criteria not discussed here and there are certainly many other possible structures (or variations).

Your views on these issues are now being sought. Here are 10 key questions that need to be addressed:

1. How should democratic accountability be reflected in each of the three stages of the policy cycle (Panel 4)?
2. How can we overcome silo working and ensure that regulation and PLD are properly joined up?
3. What sorts of arrangements are most likely to attract the necessary input from leading experts?
4. How should the impact of devolution be reflected in the structures?
5. To what extent are standing groups required, and where are *ad hoc* arrangements better?
6. How should technicians fit into the PLD structures?
7. What role should the lay members of Council play in PLD for pharmacy, beyond their role as members of the governing body accountable for all the Society’s functions?
8. How should the PLD and regulatory activities be funded?
9. What are the advantages and disadvantages of having shared membership between the Council and its subordinate bodies?
10. How can we ensure that the needs of all sections of the profession are properly addressed?

YOU MAY ALSO WISH TO RAISE (AND ANSWER) OTHER QUESTIONS . . .

Please send your views by letter, fax or e-mail to Christine Gray, Modernisation Programme Project Manager, Royal Pharmaceutical Society, 1 Lambeth High Street, London SE1 7JN (e-mail cgray@rpsgb.org.uk; fax 020 7572 2501) by Monday 1 December 2003.

Thank you.

REFERENCE

1. Royal Pharmaceutical Society. Report of the Council’s discussion on possible organisational models for the future Council. *Pharm J* 2003;271:66–8.