

September 26th, 2022

Notice Of Meeting

You are requested to attend the meeting to be held on **Tuesday, 27th September 2022** at **9:30 am** in **Back Hall, Society House**.

Agenda

1.0 Welcome & Apologies

Apologies received from:

1.

Welcome to:

1. Moore NI (External Auditors), Karin McLaughlin
2. Jenda McSwiggan, new Boardroom Apprentice
3. Steve Wright, PSA

2.0 Deputations

3.0 Conflicts of Interest

4.0 Tabling of Any Other Business

FOR APPROVAL

5.0 Minutes and Key Actions arising from last meeting

For Approval

Council is asked to approve and adopt the Minutes of meeting dated 28 June 2022 as a true and accurate record of events.

There are no outstanding actions.

 **Council - Public Meeting Minutes - 280622 - Draft.pdf**

Page 1

6.0 Annual Report & Accounts 2021-22

For Approval

Council is asked to

- reaffirm its approval taken via e-paper APP-Sept22-01 as set out in 6.1; and
- note the signing of the Annual Report & Accounts 2021/22 and the Letter of Representation as set out in 6.2 and 6.3.

6.1 Reaffirmation of Approval of the Annual Report & Accounts 2021-22

For Approval

___ Goal 2(b) was in relation to the HSC Reform programme and made note of Covid-19 and the lack of an NI Executive. DoH proposed that the first half of the sentence be removed. Council's decision was to retain the original wording relating to Goal 2(b).

 Council Paper - Re-affirmation of Decisions made via e-paper APP-Sept22-01.docx	Page 14
 Council Paper - Confirmations of Awareness - Annual Report and Accs 2021-22.docx	Page 15
 Pharmaceutical Society NI Annual Report and Accounts 2021.22 - Approved by Council 15.09.22.docx	Page 17
 LETTER~1.PDF	Page 100
 PSNI Report to Those Charged with Governance 2022.pdf	Page 101

6.2 Confirmation of the signing of the Annual Report & Accounts 2021-22

For Approval

Signing the Annual Report by the President, CEO and Moore NI LLP (Statutory Auditors). Following approvals _____

6.3 Confirmation of the signing of the Letter of Representation

For Approval

Signing of the Letter of Representation by the President. Following the approval of the Annual Report & Accounts

via e-paper APP-Sept22-01, the document was signed electronically.

 150922 - Letter of Representation - Moore NI.pdf	Page 110
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7.0 QUB IP Reaccreditation

For Approval

Council is asked to review the content of the attached papers and approve the reaccreditation of the QUB Independent Prescribing Course.

8.0 Council meeting dates - 2023

For Approval

Council is asked to review and approve the proposed dates for its meetings in 2023.

FOR INFORMATION

9.0 President's Report

For Information

Verbal Report

10.0 CEO's Report

For Information

Verbal report.

11.0 Internal Audit - ASM Annual Assurance Report 2021-22

For Information

Council is asked to review the content of the attached report.

12.0 High Court Extension - Interim Orders

For Information

Council is asked to review this paper and provide any feedback it considers appropriate.

13.0 Responsible Pharmacist/Superintendent Pharmacist - Update

For Information

Council is asked to review the content of the attached paper.

 **Council Papers Covernote Section 60 Orders Sept 2022.docx** **Page 143**

 **2022.07.29 draft RPSP commencement Order (002).doc** **Page 144**

 **2022.07.29 draft Hospital DE commencement Order.doc** **Page 146**

14.0 Community Pharmacy Closures

For Information

Council is asked to review the content of the attached papers.

 **PDA - Open letter - pharmacy closures.pdf** **Page 148**

 **150922 - Mark Koziol - PDA.pdf** **Page 150**

 **Pharmacy Closures - Statement PSNI 14.09.22.pdf** **Page 151**

15.0 Report on PSA "Safer Care for All" event - 07/09/22 - House of Lords

For Information

Council is asked to review the content of the attached paper.

 **Council Cover paper - PSA - Safer Care for All.docx** **Page 155**

16.0 Risk Register

For Information

Council is asked to review the content of the attached Risk Register which was reviewed at the last Audit & Risk Committee meeting.

 **risk register may 2022 MN.doc** **Page 157**

17.0 Report on Progress against Strategy

For Information

Council is asked to review the attached report. Executive Summary provided.

 **Corporate Strategy - Council Progress Report - September 2022.pdf** **Page 169**

 **Executive Summary - Corporate Strategy - Council Progress Report - September 2022.pdf** **Page 178**

18.0 Correspondence Log

For Information

Council is asked to review the content of the following correspondence:

1. 28/07/22 - Alan Clamp PSA to CEO
2. 04/08/22 - CEO to Alan Clamp, PSA

 220728 Letter to PSNI.pdf

Page 181

 040822 - A Clamp PSA.pdf

Page 182

TO NOTE

19.0 Hybrid/Resident Working Arrangements Policy

To Note

Council is asked to note the content of the attached policy.

 050 - Hybrid and Resident (Society House based) Working Arrangements Policy 2022.pdf

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FOR INFORMATION

20.0 Any Other Business

For Information

1. Council Communications - decisions

21.0 Date of next Council Public Meeting

For Information

The next Council Public meeting is scheduled for 22 November 2022 at 09:30.

Invitees

Ms June Alexander

Miss Sandra Cooke

Mrs Joan Duffy

Ms Colleen Duffy

Mr Ryan Duffy

Mr Brendan Garland

Mr Scott Gill

Mrs Laura Hughes

Mr Peter Hutchinson

Ms Chanel Jones

Mr Philip Knox

Dr Jim Livingstone

Mr Mark McCrudden

Mr Gary McMurray

Ms Jenda McSwiggan

Mr Barry Mimmagh

Ms Carol Moore

Professor Patrick Murphy

Mr Mark Neale

Mr Trevor Patterson

Mr Jonathan Patton

Ms Alison Ragg



Draft Minutes of the Council Public Meeting
Remote – Via Zoom
On Tuesday, 28 June 2022 @ 09:30

	Agenda Item - Present	Council Members: Dr Jim Livingstone (President) Mr Jonathan Patton (Vice President) Mr Mark McCrudden Ms Alison Ragg Prof Patrick Murphy Ms Carol Moore Ms Colleen Duffy Mr Brendan Garland Mr Philip Knox Mr Barry Mimmagh Mr Scott Gill Ms Chanel Jones Visitors: Ms Colette Higham – PSA In Attendance: Mr Trevor Patterson (Chief Executive) Ms Laura Hughes (Registrar & Director of Regulation) Mr Mark Neale (Director of Public Affairs) Mr Peter Hutchinson (Policy Standards & Engagement Lead) Mr Ryan Duffy (Interim Project Manager) Ms June Alexander (Executive Assistant)	Apologies Sandra Cooke Gary McMurray
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			Action
1.0	Welcome & Apologies	The President welcomed Council members and Colette Higham, PSA, to the meeting. Apologies were accepted from Council members Sandra Cooke and Gary McMurray.	
2.0	Deputations	The President was in attendance throughout. No deputation required.	
3.0	Conflicts of Interest	No conflicts of interest were raised.	
4.0	Tabling of Any Other Business	No other business was tabled.	
5.0	Minutes & Key Actions from last meeting For Approval	<u>Minutes:</u> Council approved and adopted the Minutes of the Public meeting of 17 May 2022 as a true and accurate record of events. Key Decision / Action: Council approved and adopted the Minutes of the Public meeting of 17 May 2022 as a true and accurate record of events.	Proposed by: Chanel Jones Seconded by: Alison Ragg
6.0	Retention & Destruction of Council papers For Approval	The DPA advised that the Audit & Risk Committee had discussed this matter at its recent meeting on the basis of a 15-year retention of papers. Following research into the retention policies of other regulators which showed that they had longer retention periods, the recommendation is for a 50-year retention of Council papers. It was confirmed that the cost of storage of documents was currently circa £2,000 per annum. Council was reminded that the retention proposal before them was for Council documents only and that the issue of the accuracy of records came to light during the fees and pension issue when	



	boxes of documentation were retrieved from storage but their contents did not match the inventory. The importance of having a searchable resource was noted and the President asked the Senior Management Team to price the digitisation of all other records and advise Council. The CEO advised that the next stage was to start the destruction of documentation that had exceed its life expectancy under the current retention policy. The President proposed that those documents that had exceeded their life expectancy be destroyed prior to the pricing of the digitisation of the remaining documents. Council noted that there was an argument for not destroying all papers as some may be historical in relation to pharmacy in NI and ROI which may be of interest to researchers in the future and that it may be a worthwhile exercise to liaise with the Public Records Office in relation to Council documents of historical interest. The Vice President advised that the volume of documents and the resultant storage costs would increase year on year and, therefore, the digitisation costs should be reviewed by Council prior to a decision being made. It was agreed that the ease of access to the correct documents was imperative and that the process for managing the accurate storage and retrieval of documents should be clearly delineated. In response to a Council query about a 50-year retention being excessive, Council was advised that the retention period for registration and fitness	
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	to practise documentation was 100 years. The recommendation for a 50-year retention period was purely for Council documents. The CEO advised Council that irrespective of how documents were stored, Council needed to decide on the retention period. In terms of the possibility of aligning retention periods, the DPA advised that there were different levels of retention for different reasons, for example, staff and financial records were retained for a period of 7 years. It was agreed that, if Council decided on a retention period of 50 years for Council documents, this could apply to both digitised and paper documents. Council agreed the following: 1. Council documents, going forward, would be retained for a period of 50 years; and 2. The Senior Management Team was requested to return to Council with the costs for digitising documents to enable the organisation to dispense with the cost of document storage and to ensure that documents were more easily accessible. Key Decision: Council approved that documents, going forward, would be retained for a period of 50 years. Action: The Senior Management Team was requested to return to Council with the costs for digitising documents to enable the organisation to dispense with the cost of document storage and to ensure that documents were more easily accessible.	Proposed by: Mark McCrudden Seconded by: Brendan Garland Proposed by: Brendan Garland Seconded by: Scott Gill
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7.0	IP Consultation Report For Approval	The CEO directed Council's attention to the consultation report in the papers provided. He advised that the IP regulations stipulated a number of things about the qualifications that pharmacists must have before being entitled to an accreditation. Departments of Health across the UK have stated that, by 2026, they would prefer that pharmacists enter onto the Register as IPs. He noted that this was a high-level policy consultation to see if there was a general consensus for changing the regulations for 2026 and for recognising that there was a large legacy workforce. The following five recommendations were highlighted: Recommendation 1 To inform the Education Reform Implementation Group (ERIG) that, based on the response to its consultation, Council agrees in principle to remove from the 1994 Regulations the requirement that a person is only entitled to have an IP annotation where they have been registered as a pharmacist for a period of two years. Recommendation 2 The PSNI is to engage with the GPhC and relevant stakeholders in the development of Guidance (to be approved/endorsed by Council) to further define the requirements for course entry in advance of the changes being introduced. Recommendation 3 The findings of this consultation should be presented to the ERIG at the earliest opportunity.	



	Recommendation 4 We should engage with GPhC on the post-registration assurance of practice group as it considers any further requirements as part of its initial work, whilst ensuring appropriate engagement with local stakeholders. Recommendation 5 Subject to the cross-reference with the GPhC on final wording of the changes to the Standard for Education and Training of pharmacist independent prescribers (2019), Council is asked to endorse that: a) the two-year requirement for entry onto stand-alone pharmacist independent prescribing courses, containing the Standards for Education and Training of Independent Prescribers, replacing it with an assessment, by course providers, of competence to enter the course. b) the requirement to have relevant experience in a specific clinical or therapeutic area be removed and replaced with the requirement to have relevant experience in appropriate clinical setting(s). The CEO advised that the Department had asked PSNI to set up the ERIG; the group is an advisory group to Council. The group's proposals and recommendations to amend regulations and standards would be brought to Council . It was noted that the term "clinical setting(s)" provided a wider range of areas in which pharmacists could operate and would more easily facilitate the legacy workforce. The CEO advised that currently approximately 800 of the 3,000 registered pharmacists were IPs. There would be a need for more pharmacists to have training in clinical settings. As IPs moved into community pharmacies, training settings would develop and increase the options for the legacy workforce. Before new IPs enter onto the Register in 2026, Council will need to think about a support framework for these	
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	pharmacists in the early part of their career, perhaps as part of post registration education and training. It was hoped that the proposed legislation would be in place before 2026. This would be dependent on a functioning Assembly as it may require ministerial approval of the Departmental approach. The CEO advised that the Department and other colleagues in ERIG were keen to progress work. The PSEL advised that some of the feedback was on post-registration ability to immediately practise, particularly in the community pharmacy setting where the provision of services is much less developed. It is hoped to regularise and support the sector in terms of education and training. There was also feedback in relation to the role of employers in ensuring that pharmacists are fit to provide services. These will form part of the work that will be undertaken in conjunction with GPhC. The CEO advised that the timeline for IPs providing services in community pharmacy will be a matter of contract with the Department and those independent business providing the service. It will be influenced by the availability of suitably qualified and experienced IPs. He advised that there are lots of task & finish groups in the Department working on this and ERIG is involved in its development. The Registrar assured Council that the ERIG was fully across the wider and particular detail of this work including funding and the fitness for purpose of clinical settings. The President noted that the five recommendations sat naturally together as an entity and proposed that Council consider them as such when deciding whether or not to approve.	
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		Council approved the five recommendations as set out in the papers provided. Key Decision: Council approved the five recommendations as set out in the papers provided.	Proposed by: Barry Mimmagh Seconded by: Philip Knox
8.0	Appointment of new Scrutiny Committee Member For Approval	The DPA advised that Mr Colin Kennedy's eight-year tenure as a lay member of the Scrutiny Committee ended in June 2022. Ms Jennifer Knappe was the next ranked lay reserve on the Scrutiny Committee 2020 reserve list. She had been approached and had confirmed that she was willing to assume the role of lay member of the Scrutiny Committee, if approved by Council. He confirmed that the reserve list is for three year and can be extended for a further year and that the list would come to Council next year to consider such an extension. Council approved the appointment of Ms Jennifer Knappe as lay member of the Scrutiny Committee and the President confirmed that he would send a letter, on behalf of Council, to Mr Colin Kennedy thanking him for his service and valuable contribution to the work of the Committee. Key Decision: Council approved the appointment of Ms Jennifer Knappe as lay member of the Scrutiny Committee Action: The President is to send a letter, on behalf of Council, to Mr Colin Kennedy thanking him for his service and valuable contribution to the work of the Committee	Proposed by: Mark McCrudden Seconded by: Jonathan Patton

9.0	Safe Staffing Levels - Update For Approval	The CEO advised that this was in relation to those persons responsible for governance in pharmacy taking account of appropriate factors when deciding staffing levels. He noted that the following: • there was little available in terms of guidance, regulation and standard for employers; • Whilst Council was primarily responsible for registered staff, legislation did give Council leave to set standards for non-registered staff. The Inspectorate had advised that they would require a benchmark against which to inspect this aspect of premises standards. He advised that the Premises Standards, which do include provisions to ensure adequate staffing levels, had not been commenced by the Department as yet, pending the completion of an inspection regime. At a recent meeting, the Department advised that they had not yet developed their IT requirements, somewhat reducing the urgency for the publication of standards. He advised that Council may wish to take some time to consider the proposals and get some reassurances and that the consultation could be brought to Council in September. This would not delay the Premises Standards coming into operation. The President noted that the Department was not advancing quickly, he was inclined to delay to allow fuller consideration. It was noted that there were no recommendations for GP practices – only for pharmacists within a community team and it was agreed that a well-constructed checklist/assessment framework would be useful for practitioners.	
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		The Vice President advised Council that it was making big changes and taking more time would result in a better decision. Council agreed that it would not make a decision at this time and instructed the Executive Team to bring this matter back to Council in September 2022. Key Decision: Council agreed that it would not make a decision at this time and instructed the Executive Team to bring this matter back to Council in September 2022. Action: The Executive Team is to bring this matter back to Council in September 2022.	
10.0	Removal of Names from the Register For Approval	The Registrar advised Council that she required its approval to remove from the Register the names of those pharmacists who had been issued with a demand for payment of retention fees under Article 15 of the Pharmacy NI order but who had not paid by 15 August 2022. The Registrar advised Council that pharmacists who had not paid their retention fee and who were also non-compliant with the CPD Framework would be removed for non-compliance with the CPD Framework. The CEO advised that the statutory process was well documented. A statutory demand was posted to the registrant's current address, as held on record, in line with legislation. The burden of proof of posting sits with the organisation and postal records are kept accordingly. He advised that a few payments may possibly be received before 15 August as some registrants did not pay until they had received their "red notice". Council	



	was, therefore, asked to give approval for the removal of those names who had not paid at the cut-off point of 15 August 2022. The Registrar advised that the removal of a pharmacist's name from the Register was the last resort. The current position was that 68 pharmacists had not paid the retention fee, 27 of whom were also non-compliant with the CPD Framework. Therefore, if the current position did not change, on 16 August 2022, with Council approval, 41 pharmacists' names would be removed from the Register for non-payment of retention fees. The remaining 27 pharmacists would be added to the list of those to be removed for non-compliance with the CPD Framework. Council asked that the relevant numbers of those to be removed for non-payment of retention fees, non-compliance with the CPD Framework and those who fell into both categories, be clearly tabled for next year. Council directed the Registrar to remove names of those persons with retention fees remaining unpaid two months after the date of the statutory notification, except for those subject to current Fitness to Practise and non-compliance with CPD submission requirements. Key Decision: Council directed the Registrar to remove names of those persons with retention fees remaining unpaid two months after the date of the statutory notification, except for those subject to current Fitness to Practise and non-compliance with CPD submission requirements. Action: Council asked that the relevant numbers of those to be removed for non-payment of retention fees, non-compliance with the CPD Framework and those who fell into both categories, be clearly tabled for next year.	Proposed by: Jonathan Patton Seconded by: Brendan Garland

11.0	President's Report For Information	The President advised that the Council recruitment process was proceeding and that he expected an announcement of appointments to be made in August.	
11.1	Membership of post-registration assurance of education & training group	The President advised that he had joined this group and attended a meeting which was hosted by GPhC and PSNI which had secured three places on the committee. It was a difficult meeting with 29 attendees, 28 of whom were registered pharmacists. It was expected that this important group would meeting monthly and will be based on Task & Finish groups addressing individual issues. The President asked for two registrant representatives to attend the group. Those appointed may have the opportunity to draw in other colleagues from Council.	
12.0	CEO's Report For Information	The CEO advised that papers were in the In Committee agenda in relation to a recent CEORB discussions around the DoH reforms and the status of regulatory bodies. In addition, he advised that he had received an email from the CPO advising that the near-final version of the Pharmacy Technician Consultation Report was imminent. He believed that it would be positive and would be favourable to moving on with the registration of pharmacy technicians.	
13.0	Report on Progress Against Strategy For Information	Council reviewed the content of the report presented and noted little change since the last Council meeting, with no additional amber or red ratings. The CEO advised that anything related to pharmacy technicians would probably change status prior to the next Council meeting. It was noted that the Corporate Strategy Addendum was available on the organisation's website.	

14.0	Fitness to Practise Manual To Note	The DPA advised that, following the FtP training course and subsequent feedback– which went well, there are no real changes to the FtP manual.	
15.0	Correspondence Log For Information	None.	
16.0	Any Other Business For Information	In the absence of Carol Moore, Chair of the Council Learning & Development T&F Group, Philip Knox advised that, since the last Council meeting, a tender specification has been circulated to six organisations with receipt of tenders closing on 25 May 2022.	
17.0	Date of Next Council Public Meeting	The next Public Council meeting is scheduled for 09:30 on Thursday, 15 September 2022. It is hoped that this meeting will be in person.	

Pharmaceutical Society NI – Council Paper

Ref: Annual Report and Accounts 2021-22

Date: 16 September 2022

Reaffirmation of decision taken by e-paper: APP-Sept22-01

Type of Paper: For approval (ratification)

Title – Annual Report and Accounts 2021-22

Purpose of paper

The purpose of this paper is to seek re-affirmation of Council's approval of the Annual Report and Accounts 2021-22 taken via e-paper on or by 15 September 2022.

Action required by Council

Council members are requested to re-affirm the following decisions:

1. Amendment proposed by DoH:
 - a. Goal 2(b) was in relation to the HSC Reform programme and made note of Covid-19 and the lack of an NI Executive. DoH proposed that the first half of the sentence be removed.

Council's decision was to retain the original wording relating to Goal 2(b).

2. Approval of the Annual Report & Accounts 2021-22:

Council approved the Annual Report & Accounts 2021-22, to be laid in the Northern Ireland Assembly on 04 October 2022.

For further information

Trevor Patterson
Chief Executive

Pharmaceutical Society NI – Council paper

Date: 15 September 2022

Title: Confirmations of Awareness

Type of Paper

- *For Approval*

Title: Council Confirmations of Awareness – Annual Report & Accounts 2021/22

Action Required by Council

Council is asked to give the above confirmations prior to the approval and signing of the Annual Report & Accounts 2021/22.

The Annual Report & Accounts 2021/22 are presented to Council for approval by the Chair of the Audit & Risk Committee.

Prior to approval and signing of the document, Council is required to give the following confirmation:

- Council confirms that it is not aware of any subsequent events that have occurred between year-end 31 May and the signing of the accounts.
- In respect of the organisation's Subsequent Events procedures up to the date of the signing of the audit reports, Council confirms its awareness of any subsequent events that have occurred up to the date of signing the accounts, including:
 - o The current status of items that were accounted for on the basis of preliminary or inconclusive data;
 - o Whether new commitments, borrowings or guarantees have been entered into;
 - o Whether sales or acquisition of assets have occurred or are planned;
 - o Whether the issue of new shares or debentures or an agreement to merge or liquidate has been made or is planned;
 - o Whether any assets have been appropriated by government or destroyed, for example, by fire or flood;
 - o Whether there have been any developments regarding risk areas and contingencies;
 - o Whether any unusual accounting adjustments have been made or are contemplated; and

- o Whether any events have occurred or are likely to occur which will bring into question the appropriateness of accounting policies used in the financial statements as would be the case, for example, if such events call into question the validity of the going concern assumption.

Action Required by Council

Council is asked to give the above confirmations prior to the approval and signing of the Annual Report & Accounts 2021/22.

For further information

For further information, please contact:

Joan Duffy
Director of Business Operations



Mrs Cathy Harrison
 Chief Pharmaceutical Officer
 DHSSPSNI
 Castle Buildings
 Stormont Estate
 Belfast
 BT4 3SQ

16 September 2022

Dear Cathy

On behalf of the Council of the Pharmaceutical Society of Northern Ireland, pursuant to Articles 4C and 4D of the Pharmacy (Northern Ireland) Order 1976, I wish to submit the accounts and annual report of the Pharmaceutical Society of Northern Ireland for the year 1st June 2021 to 31st May 2022 to the Department for laying before the Northern Ireland Assembly.

Should the Department need any further information, please contact Mr Mark Neale on 028 90326927 or via email: mark.neale@psni.org.uk.

A pdf of this report will be accessible on the organisation's website at <http://www.psni.org.uk/publications/annual-reports-2/>.

I trust all is in order to comply with the requirements as set out in the legislation.

Yours sincerely

Dr Jim Livingstone
President of the Pharmaceutical Society of Northern Ireland
Pharmaceutical Society of Northern Ireland
73 University Street
Belfast
BT7 1HL

Pharmaceutical Society of Northern Ireland

Report to Those Charged With Governance

31 May 2022



Pharmaceutical Society of Northern Ireland
Report To Those Charged With Governance
For the year ended 31 May 2022

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1. Introduction

This report summarises our audit of the financial statements of the Pharmaceutical Society of Northern Ireland (hereafter “the Society”) for the year ended 31 May 2022. We performed our audit remotely.

1.1 Overview and scope of audit

This report has been prepared for the Council of the Pharmaceutical Society of Northern Ireland.

Our procedures are conducted solely for the purpose of our audit of the financial statements. Our audit does not necessarily disclose every weakness within the Society’s systems.

We take this opportunity to remind that:

- This report has been prepared for the sole use of the Pharmaceutical Society of Northern Ireland;
- It must not be disclosed to any third party without our written consent;
- No responsibility is assumed by us to any other person who may choose to rely on it for his or her own purposes.

Qualitative aspects of accounting practices and financial reporting

During the course of our audit, we considered the qualitative aspect of the financial reporting process, including items that have a significant impact on the relevance, reliability, comparability, understandability and materiality of the information provided by the financial statements. We have considered:

- The appropriateness of the accounting policies to the particular circumstances of the Society;
- The timing of transactions and the period in which they are recorded;
- The appropriateness of accounting estimates and judgements, including the consistency of assumptions and degree of prudence reflected in the accounting records;
- The extent to which the financial statements are affected by any unusual transactions during the period and the extent to which such transactions are separately disclosed in the financial statements;
- The potential effect on the financial statements of any uncertainties including significant risks and disclosures, such as pending litigation that are required to be disclosed in the financial statements;
- Material uncertainties related to events and conditions that may cast significant doubt on the Society’s ability to continue as a going concern;
- Apparent misstatements in the Council’s report or material inconsistencies with the audited financial statements;
- Disagreements about matters that, individually or in aggregate, could be significant to the Society’s financial statements or the auditor’s report. These communications include consideration of whether the matters have or have not been resolved and the significance of the matters.
- Significant difficulties, if any, encountered during the audit.
- Significant matters, if any, arising from the audit that we discussed, or subject to correspondence with management; and written representations the auditor is requesting from management.
- Other matters, if any, arising from the audit that, in the auditor’s professional judgment, are significant to the oversight of the financial reporting process

Accounting system and internal controls

During the course of our audit of the financial statements for the year ended 31 May 2022, we examined the principal internal controls which the Council has established to enable them to ensure, as far as possible, the accuracy and reliability of the Society's accounting records and to safeguard the Society's assets.

We did not identify any weaknesses in the principal internal controls that we believe should be brought to the Council's attention. However:

- the purpose of the audit was for us to express an opinion on the financial statements;
- the audit included consideration of internal control relevant to the preparation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of internal control; and
- the matters reported are limited to those deficiencies that we identified during the audit and that we have concluded are of sufficient importance to merit being reported to those charged with governance.

2. Significant Audit Issues and Accounting Matters

2.1 Fraud

We confirm that we have considered ISA 240 Fraud in performing our audit.

We confirm that we are not aware of any instance of fraud and have no suspicions of any circumstances where fraud or suspected fraud could have a material effect on the financial statements.

We confirm that we are not aware of any instances of fraud and have no suspicions of any fraud involving management or employees who have a significant role in internal control.

We have sought management representations on this matter.

2.2 Management override of controls

This was included as a significant audit risk in accordance with ISA 240.

To address this risk we reviewed a sample of journal entries both throughout the year and over the year end to ensure that they were adequately supported, reviewed accounting policies and estimates for bias and made enquiries with management in relations to fraud risks.

We did not identify any significant issues.

2.3 Going Concern

Whilst not identified as a significant risk, we have considered and addressed the potential risks applicable to the Society in regard to Going Concern throughout our audit, in accordance with revised ISA 570. In line with our responsibilities set out within the ISA, we have obtained sufficient audit evidence regarding and have concluded on whether a material uncertainty related to going concern exists and on the appropriateness of management's use of the going concern basis of accounting in the preparation of the financial statements.

The Council has considered the results for the year, the amounts owed by the Society, its financial position at the end of the year and the trading results that are anticipated in 2023. Taking all factors into consideration the Council believes that it is appropriate for the financial statements to be prepared on a going concern basis and have considered a future period of at least one year from the date on which the financial statements are to be approved.

We did not identify any issues with respect to this assessment.

3. Audit Approach and Testing

This was our second year performing the audit we continued to undertake a comprehensive review of the systems that the Society has in place, in order to assess the risk of material misstatement in the financial statements. This was supported by substantive testing on both the Statement of Comprehensive Income and Balance Sheet values.

Our audit testing included the following areas:

- Income and debtors
- Expenditure and creditors
- Payroll
- Tangible fixed assets
- Investments
- Cash at bank and in hand
- Corporate governance procedures

3.1 Income and debtors

Objective

To gain assurance through our audit testing that all income received by The Pharmaceutical Society of Northern Ireland is received and recorded accurately, including testing that the year-end debtors listing is accurate.

Method:

- Perform an analytical review and obtain explanations for any large or unusual variances;
- Trace a sample of income amounts from source and trace through the accounting system, and repeat in the opposite direction;
- Review income around the year end, ensuring that income is recorded in the correct accounting period;
- Perform a reconciliation of income generated by retention fees, registration fees and licences.
- Obtain and review the aged debtors' listing, obtaining explanations for overdue balances and verify explanations received;
- Discuss recoverability of debtors with management and consider the need for provisions or write offs;
- Compare the listing with the previous period to identify any significant omissions;
- Review for credit balances and discuss with management where necessary;
- Review post year end receipts, invoices and credit notes for any unrecorded income and/or debtors;
- Vouch a sample of other debtors and prepayments to supporting documentation;
- Recalculate a sample of prepayments to ensure they have been correctly calculated.

Conclusions:

Income and debtors are complete and no material misstatements were identified.

3.2 Expenditure and creditors

Objective

To gain assurance through our audit testing that all expenditure incurred by The Pharmaceutical Society of Northern Ireland is paid and recorded accurately, and wholly and, including testing that the year-end creditors listing is accurate.

Method:

- Perform an analytical review and obtain explanations for any large or unusual variances;
- Vouch a sample of invoices received during the period ensuring they are addressed to the client, for goods/services normally used, arithmetically accurate and posted to the appropriate nominal code;
- Select a sample of postings from the nominal ledger, trace to invoice and to payment in bank;
- Perform cut off testing to ensure expenditure is allocated to the correct accounting period;
- Select a sample of trade creditor balances and reconcile to supplier statements;
- Perform an analytical review for other creditors and accruals;
- Vouch material balances and significant variances to supporting documentation;
- Review prior period list of trade creditors and accruals for potentially significant omissions in the current period;
- Obtain a list of other creditors and vouch a sample to supporting documentation;
- Detailed review of deferred income balances and recalculation of a sample of these;
- Review post year end payments and purchase ledger for evidence of payments relating to the current financial year;
- Identify debit balances and raise journal to gross up trade creditors where applicable.

Conclusion:

Expenditure and creditors are complete and no material misstatements were identified.

3.3 Payroll

Objective:

To gain assurance through our audit testing that persons employed by the Society exist and are remunerated accordingly, and that the payroll process is operating effectively.

Method:

- Reconcile wages control and PAYE control accounts;
- Check a sample of nominal ledger or payment summary records to employee records;
- Perform cut off testing on a sample of starters and leavers to ensure allocated to correct accounting period;
- Verify sample of employees to evidence of existence;
- Check that all payments due to pension schemes in the period have been paid;
- Ensure that provision has been made for all amounts due at the end of the period.

Conclusion:

Payroll is operating effectively and no material misstatements were identified.

3.4 Tangible fixed assets

Objective:

To gain assurance through our audit testing that fixed assets exist, are owned by the Society, and depreciation is consistent and calculated correctly.

Method:

- Obtain a schedule of additions and disposals;
- Vouch a sample of additions to supporting documentation and agree details. Confirm asset added to fixed asset register;
- Vouch a sample of disposals to supporting evidence, checking calculation of profit/loss and confirming the asset has been removed from the fixed asset register;
- Agree the total charge for depreciation for the period to the financial statements;
- Check provisions for depreciation and confirm the rates agree to the accounting policy, are arithmetically accurate, are consistent with prior periods, and are adequate;
- Review repairs and maintenance codes to identify any items that are capital which may have been expensed.

Conclusion:

Tangible fixed assets are complete, and no material misstatements were identified.

3.5 Investments

Objective:

To gain assurance through our audit testing that Investments held by the Society exist and are valued correctly.

Method:

- Obtain the 3rd party investment schedule and ensure that the client holds the stated investments;
- Reconcile the total value of investments held per the client's records to the value per the 3rd party's schedule;
- Vouch all additions and disposals of investments to 3rd party schedules.

Conclusion:

Investments are complete and no material misstatements were identified.

3.6 Cash at bank and in hand

Objective:

To gain assurance that all bank accounts are managed correctly, are held in the Society's name, included in the financial statements.

Method:

- Obtain confirmations from all banking institutions that the client holds accounts with and verify balances at the year-end;
- Obtain and verify reconciliations for all accounts, vouching outstanding amounts to post year end statements;
- Examine statements post year end for evidence of any dishonoured items and examine receipts and payments records around the year end to identify any large or unusual items.

Conclusion:

Cash and bank are complete and no material misstatements were identified.

3.7 Corporate governance procedures

Objective:

To gain assurance that corporate governance procedures are in place and operating effectively.

Method:

- Review Council and Audit & Risk Committee meeting minutes;
- Review and discuss any litigation with client;
- Review of the financial procedures manual.

Conclusion:

Corporate governance procedures are operating effectively.

4. Major Internal Control Weaknesses detected during the audit

Our audit approach was primarily risk based and tailored to the Society and its business environment. We reviewed management controls and completed walkthrough tests for income; expenditure, payroll; journals; and fixed assets at the planning stage. We noted no major internal control weaknesses we wish to draw to your attention, however there is one minor finding which we have noted in Appendix 1

5. Uncorrected misstatements detected by us

At planning stage of the audit process, we determined an appropriate level of materiality for the financial statements as a whole to be £27,000. This was based on a level of 2% of incoming resources, which we consider to be an appropriate benchmark for the sector and in line with the level we would use for similar clients. The level below which misstatements are deemed to be trivial has been set at 1% of overall materiality, being £270.

We have discussed with you the misstatements or unreconciled amounts we identified in the financial statements, but which do not require adjustment due to their nature and amount. We attach a schedule which records these and the reasons for not making the adjustment. The schedule does not include matters we believe to be trivial as none were identified.

Pharmaceutical Society of Northern Ireland
Report To Those Charged With Governance
For the year ended 31 May 2022

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Appendix 1: Audit Findings & Recommendations

	Observation	Implication	Recommendation	Management Response
1	There are still cheques outstanding for greater than 6 months still included in the bank reconciliation.	There is a risk that bank balances may be under stated as the cheques are not likely to be cashed at this point, giving an untrue view of the bank balances	We recommend these continue to be reviewed and written off as necessary.	

Appendix 2: Unadjusted Differences

	Income Statement		Balance Sheet		Reason why misstatement was unadjusted
Difference between accruals workings and accruals in accounts		795	795		Difference deemed immaterial
Credit balances in trade debtor account			1,194	1,194	Difference deemed immaterial

Moore (N.I.) LLP
4th Floor Donegall House
7 Donegall Square North
Belfast
BT1 5GB

15 September 2022

Dear Sirs

Re: Pharmaceutical Society of Northern Ireland

This representation letter is provided in connection with your audit of the financial statements of Pharmaceutical Society of Northern Ireland for the period ended 31 May 2022 for the purpose of expressing an opinion as to whether the financial statements give a true and fair view in accordance with The Pharmacy (Northern Ireland) Order 1976.

By a resolution of the Council, passed today, I am directed to confirm to you, in respect of the financial statements of the Society for the period ended 31 May 2022, the following:

1. We acknowledge, as members, our responsibilities under the Pharmacy (Northern Ireland) Order 1976 for preparing financial statements which give a true and fair view and for making accurate representations to you. All the accounting records have been made available to you for the purpose of your audit and all the transactions undertaken by the Society have been properly reflected and recorded in the accounting records. All other records and related information, including minutes of all management meetings, have been made available to you.
2. We have provided you with:
 - access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;
 - additional information that you have requested from us for the purpose of the audit; and
 - unrestricted access to persons within the entity from whom you determined it necessary to obtain audit evidence.
3. All transactions have been recorded in the accounting records and are reflected in the financial statements.

4. We acknowledge as trustees our responsibilities for the design and implementation of internal control in order to prevent and detect fraud and to prevent and detect error.
5. In our opinion, the risks that the financial statements may be materially misstated as a result of fraud are low as there are few cash payments and all incoming amounts are vouched by two people and all outgoing resources are authorised by two people.
6. We have disclosed to you all information in relation to fraud or suspected fraud that we are aware of and that affects the entity and involves:
 - management;
 - employees who have significant roles in internal control; and
 - others where the fraud could have a material effect on the financial statements.
7. We are not aware of any allegations of fraud or suspected fraud with a potential effect on the financial statements which have been communicated to us by employees, former employees, regulators or other third parties.
8. We have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements.
9. In our opinion the significant assumptions used by us in making accounting estimates are reasonable.
10. We have disclosed to you the identity of the society's related parties and all related party relationships and transactions of which we are aware.
11. Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of UK Generally Accepted Accounting Practice.
12. In particular, no trustee, shadow trustee, their connected persons or other officers had any indebtedness, agreement concerning indebtedness or disclosable interest in a transaction with the society at any time during the year.
13. The following have been properly recorded and, when appropriate, adequately disclosed in the financial statements:
 - losses arising from sale and purchase commitments;
 - agreements and options to buy back assets previously sold;
 - assets pledged as collateral.

14. We have no plans or intentions that may materially alter the carrying value or classification of assets and liabilities reflected in the financial statements.
15. The society has satisfactory title to all assets and there are no liens or encumbrances on the society's assets, other than as disclosed in the financial statements.
16. We have recorded or disclosed, as appropriate, all liabilities, both actual and contingent, and all guarantees that we have given to third parties.
17. There have been no events subsequent to the date of the financial statements for which UK Generally Accepted Accounting Practice require adjustment or disclosure. Should any material events occur which may necessitate revision of the figures included in the financial statements or inclusion in the notes thereto, we will advise you accordingly.
18. The society has complied with all aspects of contractual agreements that could have a material effect on the financial statements in the event of non-compliance.
19. Except as disclosed in the financial statements, the results for the year were not materially affected by:
 - any change in accounting policies;
 - transactions of a type not usually undertaken by the society;
 - circumstances of an exceptional or non-recurrent nature; or
 - charges or credits relating to prior periods.
20. We have disclosed to you all known actual or possible litigation or claims whose effects should be considered when preparing the financial statements and that they have been accounted for and disclosed in accordance with UK Generally Accepted Accounting Practice.
21. We confirm that we agree with the total comprehensive income for the year of £(116,988).
22. We have reviewed going concern considerations and are satisfied that it is appropriate for the financial statements to have been drawn up on the going concern basis. In reaching this opinion we have taken into account all relevant matters of which we are aware and have considered a future period of at least one year from the date on which the financial statements are to be approved.
23. We confirm the financial statements are free of material misstatements, including omissions. There were no misstatements identified during the audit which were not corrected.
24. All income has been recorded, all restricted funds have been properly applied and all constructive obligations have been recognised.

25. All correspondence with regulators has been made available to you, including any serious incidents reports.

We confirm that the above representations are made on the basis of enquiries of management and staff with relevant knowledge and experience (and, where appropriate, of inspection of supporting documentation) sufficient to satisfy ourselves that we can properly make each of the above representations to you.

Yours faithfully



Dr Jim Livingstone
President

Signed on behalf of the Council of Pharmaceutical Society of Northern Ireland
On 15 September 2022

Dr. Briegeen Girvin
Senior Lecturer
School of Pharmacy
Queen's University Belfast

by email: b.girvin@qub.ac.uk

16 August 2022

Dear Briegeen,

Re: Reaccreditation of Queen's University Belfast independent prescribing course

Following the reaccreditation event on the 23 June 2022, the accreditation team agreed to recommend to the Registrar of the General Pharmaceutical Council (GPhC) and the Council of the Pharmaceutical Society of Northern Ireland (PSNI) that the pharmacist independent prescribing course provided by Queen's University Belfast should be reaccredited for a further period of three years. No conditions or recommendations were made. A copy of your report will now be shared with the Council of the PSNI.

The Registrar of the GPhC has reviewed the accreditation report and has accepted the team's recommendation to reaccredit the course for a further period of three years.

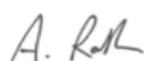
I am therefore pleased to confirm that the course is reaccredited to the January 2019 Standards for the education and training of independent prescribers until the end of **August 2025**.

I have enclosed a final copy of the accreditation report, which will be made available on our GPhC website shortly.

Congratulations to you and your colleagues on this achievement.

If you have any questions in relation to the above, please feel free to contact me.

Yours sincerely



Alex Ralston
Quality Assurance Officer (Education)
E alex.ralston@pharmacyregulation.org | T 020 3713 7813

Queen's University Belfast independent prescribing course reaccreditation event report, June 2022



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Event summary and conclusions	
Provider	Queen's University Belfast
Course	Independent prescribing course
Event type	Reaccreditation
Event date	23 June 2022
Approval period	August 2022 – August 2025
Relevant standards	GPhC education and training standards for pharmacist independent prescribers, January 2019
Outcome	Approval The accreditation team agreed to recommend to the Registrar of the General Pharmaceutical Council (GPhC) and the Council of the Pharmaceutical Society of Northern Ireland (PSNI) that the pharmacist independent prescribing course provided by Queen's University Belfast should be reaccredited for a further period of three years.
Conditions	There were no conditions.
Standing conditions	The standing conditions of accreditation can be found here .
Recommendations	No recommendations were made.
Registrar decision	Following the event, the Registrar of the GPhC accepted the accreditation team's recommendation and approved the reaccreditation of the course for a further period of three years. A copy of this report will be shared with the Council of the PSNI.
Maximum number of all students per cohort	30
Number of pharmacist students per cohort	30
Number of cohorts per academic year	One
Approved to use non-medical DPPs	No
Key contact (provider)	Dr Briegeen Girvin, Senior Lecturer

Provider representatives	Professor Lezley-Anne Hanna, Director of Education Dr Brian McCaw, Manager of the Distance Learning Centre Dr Briegeen Girvin, Programme Lead, Senior Lecturer (Education) Dr Sharon Haughey, Reader Aileen McKenna, Assistant Manager of the Distance Learning Centre Dr Mary-Carmel Kearney, Lecturer (Education) Clare Murray, Lecturer (Education)
Accreditation team	Fiona Barber, Independent Member, Leicester City Council (event Chair) Dr Andrew Sturrock, Associate Professor of Public Health and Primary Care, Northumbria University Charles Odiase, Consultant Pharmacist Primary Care and Diabetes (Lead Clinical Pharmacist) Dacorum GP Federation, Hertfordshire UK
GPhC representative	Alex Ralston, Quality Assurance Officer, General Pharmaceutical Council
Rapporteur	Ian Marshall, Emeritus Professor of Pharmacology, University of Strathclyde
Observers	Chris McKendrick, Senior Quality Assurance Officer, General Pharmaceutical Council Daniel Young Education, Training and Pharmacy Lead, PSNI

Introduction

Role of the GPhC

The General Pharmaceutical Council (GPhC) is the statutory regulator for pharmacists and pharmacy technicians and is the accrediting body for pharmacy education in Great Britain. The accreditation process is based on the GPhC's standards for the education and training of pharmacist independent prescribers, January 2019.

The Pharmacy Order 2010 details the GPhC's mandate to check the standards of pharmacy qualifications leading to annotation as a pharmacist independent prescriber. It requires the GPhC to 'approve' courses by appointing 'visitors' (accreditors) to report to the GPhC's Council on the 'nature, content and quality' of education as well as 'any other matters' the Council may require.

The powers and obligations of the GPhC in relation to the accreditation of pharmacy education are legislated in the Pharmacy Order 2010. For more information, visit:

<http://www.legislation.gov.uk/ukxi/2010/231/contents/made>

Background

Queen's University Belfast 'the provider' was accredited by the GPhC in 2019 to provide a course to train pharmacist independent prescribers, for a period of 3 years. In line with the standards for the education and training of pharmacist independent prescribers January 2019, an event was scheduled on 23 June 2022 to review the course's suitability for reaccreditation. The course was initially a modified version of the Pharmacist Independent Prescribing (PIP) Programme run by the Northern Ireland Centre for Pharmacy Learning and Development (NICPLD), which caters for Northern Ireland students. In 2016, the NICPLD course was tailored by Queen's to suit students from Great Britain (GB) and was first run in 2016/17 with two students from GB. Since then, cohorts have been around 20-22 students. During 2018 and 2019, the PIP programme was redesigned based on the new GPhC guidelines and the educational needs of the GB students. The GPhC accredited the new PIP in June 2019, without any conditions or recommendations. Two cohorts have completed the new programme and there are currently 22 students undertaking the programme (cohort 2021-22).

The submission stated that as a result of the COVID-19 pandemic, the 2019-20 cohort had assignment extensions for up to one year to allow them to complete the course at their own pace, while coping with COVID pressures. The learning in-practice hours were reduced from 90 to 80 for this cohort. Subsequent cohorts for 2020-21 and 2021-22 have worked to the original timetable with no extensions to deadlines, unless specifically requested. For the residential teaching and assessments the five-day face-to-face residential session in February 2021 was replaced by three days of virtual teaching and assessment on Microsoft® Teams and two days of face to face teaching in June 2021; Similarly in February 2022 the five-day face-to-face residential was also replaced with three days of virtual teaching and assessment on Microsoft Teams and two days of face to face teaching in June 2022. In 2020 the residential period had been completed before the outbreak of the pandemic.

Documentation

Prior to the event, the provider submitted documentation to the GPhC in line with the agreed timescales. The documentation was reviewed by the accreditation team and it was deemed to be satisfactory to provide a basis for discussion.

The event

The reaccreditation/monitoring event was held remotely by videoconference on 23 June 2022 and comprised several meetings between the GPhC accreditation team and representatives of Queen's University Belfast prescribing course. A small number of students who were currently undertaking the course, or who had completed it in the last three years, contributed to the event by completing a qualitative survey, responses to which were reviewed by the GPhC accreditation team.

Declarations of interest

Daniel Young declared that his undergraduate education had taken place at QUB.

Schedule

Meeting	Time
Private meeting of accreditation team and GPhC representatives, including break	09:30 - 11:00
Meeting with course provider representatives	11:00 - 13:00
Lunch	13:00 - 14:00
Learning outcomes testing session	14:00 - 14:30
Private meeting of the accreditation team and GPhC representatives	14:30 - 15:30
Deliver outcome to the provider	15:30 - 15:45

Key findings - Part 1 - Learning outcomes

The team reviewed all 32 learning outcomes relating to the independent prescribing course. To gain additional assurance the team also tested a sample of 6 learning outcomes during the event was satisfied that **all 32 learning outcomes continue to be met** to a level as required by the GPhC standards.

The following learning outcomes were tested at the **5, 9, 14, 23, 27, 31**

Domain: Person centred care (outcomes 1-6)
Learning outcomes met/will be met? Yes ☒ No ☐
Domain: Professionalism (outcomes 7-15)
Learning outcomes met/will be met? Yes ☒ No ☐
Domain: Professional knowledge and skills (outcomes 16-26)
Learning outcomes met/will be met? Yes ☒ No ☐
Domain: Collaboration (outcomes 27-32)
Learning outcomes met/will be met? Yes ☒ No ☐

Key findings - Part 2 - Standards for pharmacist independent prescribing course providers

Standard 1: Selection and entry requirements

Standard met/will be met? Yes ☒ No ☐

The team was satisfied that all six criteria relating to the selection and entry requirements will continue to be met

The submission stated that only pharmacists who meet the GPhC entry requirements, and are fit to train as an independent prescriber, are admitted onto the course. The Postgraduate Admissions Policy of QUB is available to learners through the Student Gateway and the selection criteria for the course are detailed on the School's website. The team was told that prospective trainees must complete the Pharmacist Application Form using the guidance provided that explains the pre-requisites for the course based on the GPhC requirements. Admissions decisions are based on transparent criteria ensuring that prospective students understand how the admissions process works. Applications are processed in a timely manner. The type of experience a pharmacist should have, in addition to the other entry requirements, is outlined in the Pharmacist Application Form and on the QUB website.

Prospective applicants are encouraged to contact the programme lead with queries about the entry requirements prior to applying; a long lead-in period allows any queries/problems to be resolved. The team learned that the programme team does not interview applicants but will request further information if necessary. The entry requirements are designed around the GPhC prerequisites for admission on to a PIP programme. Applicants enter their registration number on the application form which is checked against their status on the GPhC/PSNI register. They must state their area of clinical/therapeutic practice and provide evidence of at least 2 years' appropriate patient-orientated practice in a UK hospital/community/primary care setting following their pre-registration year, plus provide a curriculum vitae.

The programme delivery team is responsible for checking that all the pre-requisites have been met. The team learned that this includes evaluating the suitability and relevance of applicants' clinical/therapeutic experience in a systematic and structured way using a spreadsheet. All applications are reviewed within 4 weeks of the application deadline. The team was told that the programme lead takes responsibility for ensuring that the entry criteria are met but will consult with others on the teaching team. In the case of problems with a pharmacist's application, the applicant will be contacted for further information. If the programme team decides that the applicant has insufficient relevant experience, the application will be rejected and the applicant informed of the reasons. The team was told that it had only been necessary to reject two applications to date, with one having reapplied after gaining more experience and completing the programme successfully. A record of the application evaluation meeting is maintained.

Applicants must also submit a completed form from their designated prescribing practitioner (DPP) who has agreed to supervise their learning in practice. These forms are also assessed and approved by the programme delivery team. The team noted that only medical practitioners will continue to be eligible to undertake this role. In addition, a completed sponsoring organisation form should be

submitted demonstrating approval for the trainee to complete their in-practice training on the organisation's premises.

Standard 2: Equality, diversity and inclusion

Standard met/will be met? Yes ☒ No ☐

The team was satisfied that all five criteria relating to the equality, diversity and inclusion will continue to be met

The University has policies which comply fully with all Northern Ireland and GB legislation relating to equality and discrimination including that all applicants and trainees are treated fairly. To this end, the University has a dedicated Diversity and Inclusion Team within the Human Resources Department. Its role is to help create a culture that is inclusive at all levels, in every system and process. QUB has systems and policies in place for capturing equality and diversity data. The team was told that within the School there is an MPharm EDI working group that examines EDI data. Most of the IP cohort is white followed by Asian students. Seventy percent of the IP students are female, in accord with the profession as a whole. Most are aged between 25 and 34 years, and with two disabled students. A possible potential concern of the teaching team was said to be related to age with older students being unfamiliar with clinical skills, OSCE assessment and physically examining patients.

The University EDI policy applies to all staff and students and applicants for courses and relates to all decisions in respect of the admission of students and the provision of all services to students including teaching and supervision, assessment, progression and award, and support services.

A range of training courses relevant to EDI is provided by the Staff Learning and Development Unit and by Disability Services. The team was told that all staff members have been trained and that the training and support has helped the programme delivery team and the School of Pharmacy Disability Officers to embed and promote EDI principles through the programme design and delivery. The programme has been designed so that the environments, both virtual and physical, and learning experiences provide all trainees with the opportunity to reach their full potential. Thus, the team was told that the residential period is sited at the end of January to avoid a clash with Ramadan, all meat served for meals is Halal in origin. Patient beds can be lowered to allow better access in the case of students' restricted movement, and facilities are available for hearing impairment and for the expression of milk.

So far there have been no patterns/trends identified in terms of the protected characteristics of gender, age or disability in relation to module failure or failure to progress although it was stressed that student numbers are low. It has not been possible to identify such trends with respect to ethnicity. The programme lead identifies any trainees that have registered with disability services and require reasonable adjustments to meet the learning outcomes. All reasonable adjustments for trainees are passed on to the relevant staff prior to the delivery of the residential week and to DPPs. However, in line with GPhC requirements learning outcomes cannot be changed. At the induction session webinar, the programme lead ensures that all trainees understand their legal responsibilities, including confidentiality regarding patient information, and Equality and Human Rights legislation.

In terms of prescribing to patients of different ethnicities, the team was told that students are taught to be aware of cultural differences. As the local population in Northern Ireland is not as diverse

ethnically as in Great Britain, international postgraduate students from the University are invited to be used as simulated patients in addition to people from Northern Ireland.

Standard 3: Management, resources and capacity

Standard met/will be met? Yes ☒ No ☐

The team was satisfied that all six criteria relating to the management, resources and capacity will continue to be met

A management plan for the programme includes a tripartite agreement setting out the roles and responsibilities of the University, the student and the DPP, and who to contact if there are concerns about safety in the learning in practice environment. By signing the tripartite agreement, both student and DPP agree to report any such safety concerns to the programme lead. Oversight of the School's educational portfolio is the responsibility of the Head of School. Management of the accredited courses is then devolved to the Director of Education (Pharmacy). The Director of Education works closely with the Manager of the Distance Learning Centre, programme leads and the Distance learning Subgroup of the Education Committee (Quality and Standards), in order to assure appropriate delivery of the Centre's postgraduate taught courses. External teachers have contracts in place which also outline their role and responsibilities. The programme is delivered in one cohort per year. It is accredited for a maximum intake of 30 students, with usually 20-22 students per year.

The programme lead is a qualified independent prescriber with experience of general practice and spends 0.5 FTE delivering the programme. The programme lead is supported by five other pharmacist staff within the School of Pharmacy, two of whom are qualified independent prescribers. Course provision is also supported by six external pharmacists, all of whom are independent prescribers, a nurse and medical doctor, who work on a sessional basis to provide the programme and support.

There is a live risk register which is considered by the School Management Board. A red, amber and green traffic light system is used to flag issues with the Head of School and the School Manager will assign risk scores. The team was told that the student:staff ratio had been considered in March 2022 and that, driven mainly by key changes in the MPharm provision, the School had been given permission to appoint an additional lecturer in education. It was stressed that the budget cut referred to in the submission did not relate to pay or staffing for teaching and had not compromised the education provision. The team was told that the IP programme has a limit of 30 students and that, should this be exceeded, extra resources would be required.

Learning materials are reviewed annually and provided by the University's virtual learning environment, Canvas, which is supported at University level. Trainees complete the modules on the programme using e-learning, webinars, in-practice learning and a one-week residential period in Belfast. Students have access to the same clinical skills resource materials as the medical and nursing students at QUB, through access to the Clinical Skills Education Centre website. The residential week is held within the recently-opened simulation centre at QUB – InterSim with sufficient space and clinical resources to accommodate the cohort. Students have access to simulated wards, acute care and general practice environments, which all contain equipment normally used in clinical practice.

The programme lead meets with external tutors individually to discuss their duties and roles, including expectations around assessment and student feedback. Staff members are supported to develop the knowledge and skills required to teach on the programme by attending courses on clinical and diagnostic skills. DPPs are contacted by email formally three times during the course, after modules 1,

3 and 5, and requested to contact the programme lead if they have any concerns about the pharmacist or any queries about the course. The team was told that there is an introductory webinar for DPPs that covers their responsibilities. Students are asked to encourage their DPP to view the webinar. Reflections on conversations between students and DPPs are included in the e-portfolio with any necessary extra activities. Although the teaching team does not see the portfolio until it is submitted, students are encouraged to ensure early resolution of any problems.

The team noted that there are currently 1.8FTE staff members for 30 students. The team was told that the University has not used pharmacists historically in the teaching of clinical skills, but the programme lead is qualified in clinical skills, and other IP pharmacists are brought in to help teach the clinical skills in collaboration with nurses and other staff experienced in teaching medical students at the University. It was stressed that in the experience of the programme team, pharmacists required strong teaching in diagnostic skills. Students interviewed rated the clinical skills teaching as one of the highlights of the programme. Trainees and DPPs are encouraged to contact the programme lead at any stage if they have questions.

Standard 4: Monitoring, review and evaluation

Standard met/will be met? Yes ☒ No ☐

The team was satisfied that all six criteria relating to the monitoring, review and evaluation will continue to be met

The programme was approved and validated by the University Courses and Regulations Group (Queen's University Belfast) on the 16th April 2019. The programme was then initially accredited by the GPhC in June 2019 and there have been no major changes to the programme since then.

All modules are updated annually to include any changes to pharmacy laws or general legislation. The standard of teaching and assessment is monitored through module and course evaluations, peer review of teaching, Student Voice and the University Examination Board structures. Action points for the course are prepared on an annual basis. Trainees complete a Module Evaluation Questionnaire (MEQ) at the end of each of the six modules. The results of the MEQs are reviewed by the programme lead annually and by the distance Learning programme sub-group of the School's Education Committee. Additionally, following completion of the programme, the cohort is contacted for feedback, including how it prepared them for the prescribing role, how they were supported by QUB and their DPP, and how useful they found each module.

The external examiner for the 202-21 cohort was completely satisfied with all of the subject standards and programme quality measures and made no recommendations. External tutors and DPPs also provide feedback about the programme. The team was told that DPPs have suggested that students could benefit from the development of more cognitive assessment skills and more on depression screening. DPPs working in niche areas have provided important feedback, and DPPs have also suggested a greater emphasis on remote prescribing. Patient feedback in the published literature has indicated that patients still prefer initial diagnosis to be performed by medical doctors before non-medical prescribing. So far there have been no issues raised about the programme at Student Voice Committee meetings. IP students are invited to the committee but so far have not attended. This is likely to be because any issues or queries that IP students have, are raised during the webinars which occur regularly throughout the programme.

The team was told that there is an intention to institute a specific stakeholder group for the IP programme with a first meeting planned for late summer. English patients' groups will be approached for advice. Suggested outcomes from meetings will be fed back to the IP team meetings.

Advances in practice are reflected in the programme development through the use of practising prescribers on the programme team, who are involved in updating programme materials, writing assignments and OSCE station scenarios. As part of CPD requirements the programme lead and team ensure that they keep up-to-date on advancements in pharmacy practice or changes to national standards/frameworks through completion of courses and attending clinical pharmacy conferences. The programme team is also encouraged to subscribe to the NICE Medicines Awareness Service or equivalent and become members of pharmacy organisations such as RPS. The team was told that members of the teaching staff receive email updates from, for example, NICE and GPhC. There was particular emphasis on guidelines and practice for remote prescribing, described as a constantly developing and evolving practice, with students having to be aware of when such prescribing is appropriate. As a result, in future there will be an OSCE station devoted to remote prescribing.

Standard 5: Course design and delivery

Standard met/will be met? Yes ☒ No ☐

The team was satisfied that all ten criteria relating to the course design and delivery will continue to be met

The programme consists of six 10-credit modules and a zero-credit portfolio. It is a distance-learning programme that involves more than 26 days of structured learning activities, including a residential element held at the University. It is a 60-CATs programme, comprising 600 hours of structured learning activities.

The Teaching and Learning Strategy acknowledges that trainees have a diverse range of prescribing areas, experience and knowledge. Each module builds on the knowledge and skills sets of pharmacists and integrates it with further knowledge and skills required for the prescribing role. The team learned of feedback on the residential element subsequent to the enforced move to a virtual approach during the COVID-19 pandemic. This indicated that there had been mixed views on virtual versus face-to-face provision, with some students finding the virtual approach easier and more comfortable. Nevertheless, the team was told that it is the intention to revert to a full face-to-face approach for the 2022-23 cohort.

The programme team includes six pharmacists, three of whom are qualified prescribers. Five of the external tutors are practising pharmacist prescribers working in a practice setting on a regular basis. The programme has been developed in collaboration with members of the School's Stakeholders group that meets annually and has a number of pharmacist prescribers and patients. Patient feedback is included in the programme, where possible. Patient feedback shapes indirectly programme content and assessments when members of the teaching team bring recent examples from their practice back into the programme, including misunderstandings around explanations, adherence issues, or the impact of medication-related errors. Twelve DPPs responded to a short DPP survey for the 2019-20 and 2020-21, agreeing that the programme was appropriate and prepared the pharmacist to undertake their prescribing role.

During the Introduction webinar, students are reminded that as a pharmacist part of their professionalism means they should not practise beyond their competence. When carrying out

physical examinations in-practice, these will occur under the Direct Observation of Procedure (DOPs) by their DPP or other appropriately qualified healthcare professional in order to ensure patient safety. During the residential week, students practise physical examination skills on simulated patients under the direct supervision of a tutor.

Information for the DPP includes a link to the GPhC's Guidance on tutoring pharmacists and pharmacy technicians. The DPP is made aware that the trainee must spend at least 50% of the 90 hours in-practice training under their direct supervision. They are provided with examples of the type of other staff who are appropriately qualified and experienced to undertake this supervision. Should a patient safety issue become apparent either in an assignment, OSCE or the in-practice training, the NPSA risk analysis table will be used to determine the potential level of harm. Potential harm at or above a 'moderate' level may require removal from the programme. In these instances, advice will be taken from clinical experts and the decision will need to be approved and ratified through the appropriate University procedures.

The progression policy for the programme limits the number of attempts in terms of assessment. GPhC Standards are highlighted to trainees and they are informed that any concerns regarding fitness to practise will be investigated and may result in a report to the relevant healthcare regulator. The team was informed that there is a parallel academic offences process operating alongside the fitness to practise process. A dedicated School member of staff has responsibility for monitoring student conduct. All trainees, DPPs and all staff in contact with trainees during the programme are made aware that all concerns regarding trainees can be raised. The team was told that should the programme lead be unavailable, another staff member will always deputise to deal promptly with any concerns.

Standard 6: Learning in practice

Standard met/will be met? Yes ☒ No ☐

The team was satisfied that all five criteria relating to the learning in practice will continue to be met

The 90 hours of learning in practice must take place in patient-facing environments. A record of where the trainee will have their in-practice training is kept by the programme lead as part of the application process. The approval of the supporting organisation where the training will occur is also required. Trainees provide evidence of their time with patients as part of their e-portfolio. Most pieces of evidence should take the form of Patient Consultation Reflective Records, demonstrating their prescribing competencies via direct patient-facing activities. Students should provide evidence of exposure to a range of patients in a clinical setting. The DPP is contacted at three time points on any questions or concerns about the trainee's progress and learning in practice. Students can contact the programme lead or their Advisor of Studies at any point during the programme and/or raise issues about learning in practice at Student Voice committee meetings.

At the end of the programme, DPPs must sign and declare that the pharmacist has undergone the required 90 hours in-practice training, passed the DOPs and in their opinion is suitable for annotation as an independent prescriber. DPPs are supported to do this via attending the Introduction webinar, during which they are given the opportunity to ask any questions. They are encouraged to contact the programme lead should they require any clarification or support. Detailed information on how trainees should lead consultations and make prescribing decisions and monitor patients, all under the

supervision of their DPP, is provided within the Portfolio webinar. This is evidenced through submission and marking of the portfolio.

The DPPs must be medically qualified and provide information on the DPP agreement form to meet the programme requirements. This includes a signed declaration that they have prescribing competence applicable to the relevant clinical/therapeutic area, that they have supported or supervised other healthcare professionals and that they have the ability to perform and assess patient-facing clinical and diagnostic skills.

Standard 7: Assessment

Standard met/will be met? Yes ☒ No ☐

The team was satisfied all eleven criteria relating to the assessment will continue to be met

All teaching and learning activities and assessments have been designed and aligned with the learning outcomes. The OSCEs require trainees to recognise and resolve appropriately a number of issues that would affect patient safety on an eight-station circuit. Situational judgement tests (SJTs) are used to assess ability to choose the most appropriate action in workplace situations. The assignments are designed to test skills such as critical appraisal, evidence-based and shared decision-making, and reflection. The RPS Competency Framework for all Prescribers is used for the portfolio evidence. Trainees are given formative learning opportunities in a safe environment and are given feedback on their performance to enable development and improvement. All summative assessments are limited to two attempts.

Assessment points in each of the six modules and the portfolio of learning in practice provide monitoring points for the trainees and programme team. The module coordinators and programme lead have oversight of all assessments and trainees failing to progress can be identified. Attending the residential week is mandatory and attendance at webinars is monitored. Webinars are recorded for the benefit of students who cannot attend.

The programme lead has overall responsibility and oversight of all assessments to ensure quality and consistency. Assessments are developed by the module team and peer-reviewed by the module coordinator or programme lead. All written summative assessments are returned with detailed feedback from the assessors within three weeks of the submission deadline. Ten percent of assignments are double-marked by the programme lead when a new tutor is employed, to ensure consistency. Where there are two tutors marking the same assessment, they double mark 10% of the assessments to ensure consistency of marking. All fails are also double-marked.

All OSCE assessments are developed and scrutinised by the programme team in advance of the residential element, with tutors meeting to review each station, to agree an Angoff score and any essential criteria within the marking scheme. All OSCE assessors have undergone training on OSCEs and any queries that arise during examinations are brought to a scrutiny meeting.

Direct Observation of Procedures (DOPs) of clinical and procedural skills are quality assured by the programme lead who checks that all returned documentation is appropriate, according to the clinical/therapeutic area in which the student has specialised. The programme lead also checks that the DPP has signed the DOPs confirming that each skill was carried out on three patients appropriately and safely. Patient safety is paramount at all times and trainees must demonstrate

through assessments their ability to practise safely. The tripartite agreement with the DPP includes four time points for review and feedback to students on their progress.

Pharmacists must pass every assessment independently, including their practice portfolio and in-practice clinical skills DOPs. Compensation or condonement is not permitted. Pharmacists who successfully complete the programme are awarded a Practice Certificate in Independent Prescribing.

Standard 8: Support and the learning experience

Standard met/will be met? Yes ☒ No ☐

The team was satisfied that all four criteria relating the support and the learning experience will continue to be met

Students surveyed indicated a high level of satisfaction with the support provided by the programme lead, DPPs and the teaching team. Induction sessions are conducted via webinars to introduce the programme lead and encourage active participation of all trainees. Trainee engagement is regularly monitored through webinar attendance, online learning activity and assessments. Supervision requirements are detailed in the DPP information and any issues can be raised directly with the programme lead by the trainee through the tripartite learning agreement or through monthly virtual meetings. The team was told that the close relationship between staff and students allows the early identification and resolution of any problems or concerns. Documentation of problems on a spreadsheet provides an audit trail accessible to teaching team members.

The student workload for the course is comparable to other equivalent certificate courses offered by the University. The Manager of the Distance Learning Centre acts as an Advisor of Studies for all trainees on the programme, and trainees are fully supported by the programme lead who can be contacted at any point. Canvas, the virtual learning environment, allows trainees access to a variety of learning resources.

Trainees have access to the Clinical Skills Education Centre (CSEC) portal, which has numerous resources for clinical examination skills. During the residential week trainees have access to clinical teaching facilities to develop clinical and consultation skills. Trainees must formally meet with their DPP on at least four occasions during the in-practice training, during which there should be discussion of strategies and identification of mechanisms for achieving the learning outcomes for the in-practice training. In the portfolio all competencies must be rated and evidence provided to support that final rating. Records of meetings and discussions are maintained in the portfolio. The trainee must report any lack of engagement by the DPP to the programme lead as soon as possible. If any student concerns relate to patient safety issues in practice the trainee has a professional responsibility to raise concerns and will be advised to do so using the procedures in the Trust or GP Practice.

Standard 9: Designated prescribing practitioners

Standard met/will be met? Yes ☒ No ☐

The team was satisfied that all five criteria relating to the designated prescribing practitioners will continue to be met

It is the responsibility of the applicant to identify a suitable DPP. The submission stated that DPPs must be senior medical practitioners; preferably a general practitioner in primary care or consultant physician in secondary care with whom the student currently works closely in daily practice or intends

to work closely with. All DPPs will have at least 3 years' recent prescribing experience and be an active prescriber consulting with patients and making prescribing decisions based on clinical assessment with sufficient frequency to maintain competence. Students may also work with other healthcare professionals within the practice environment. DPPs must complete an application form in which they state their name, work address and GMC number. This, and any restrictions against their prescribing, is checked on the GMC register by the programme lead. The team was told that the programme lead will request further information from the applicant if there is any ambiguity around the suitability of their DPP or proposed setting for their in-practice training.

The information for DPPs refers potential DPPs to the RPS DPP competency framework. DPPs declare that they have the competencies required to taking on the DPP role. The team was told that in the rare case of a DPP being insufficiently fit to take on the role, the student would be required to identify an alternative DPP.

At the start of the programme all students and DPPs are invited to an introduction webinar. All DPPs are also sent a link to a recording of this webinar. DPPs are contacted by email formally three times during the course and are encouraged to get in touch with the programme lead if they have any concerns about the pharmacist or any queries about the course. There is a general list of suggested skills to be undertaken in practice per clinical area, but in specialist areas the programme lead will meet with the DPP and student to decide on the most relevant clinical skills to be undertaken in practice.

There is no formal training for DPPs organised by the University, but a link is provided should further training be required. The team was told that there have not been any situations where the programme team has had to intervene and provide additional support to DPPs. The team was told that general practitioner DPPs are regarded as all-rounders and are not required to submit a curriculum vitae. However, more information is requested if the programme lead has any queries about the suitability of DPP for the student's chosen clinical/therapeutic area.

If a student reports an issue with a DPP, including non-engagement or not being provided with opportunities to lead consultations with patients, this will be dealt with promptly and a meeting arranged between the programme lead, Advisor of Studies, DPP and trainee to attempt to resolve the issue, including the possibility of the student finding an alternative DPP. An anonymous student feedback questionnaire includes questions about DPPs. Students are encouraged to provide open and honest feedback. Individual feedback cannot be provided to each DPP. However, the feedback is collated and a generic version sent to all DPPs to highlight examples of constructive criticism and feedback from students.



Pharmaceutical Society NI – Council paper

Date: September 2022

Title: Council Meetings Schedule 2023

Type of Paper

- *For Approval*

Action required by Council

Council is asked to review and approve the proposed dates for Council Meetings in 2023.

Purpose of paper

The purpose of this paper is to finalise dates for the 2023 Council Meetings.

Council Meetings – Proposed Dates

01	Tuesday	24 January 2023
02	Tuesday	21 March 2023
03	Tuesday	09 May 2023
04	Tuesday	27 June 2023
05	Thursday	14 September 2023
06	Tuesday	07 November 2023

Action required by Council

Council is asked to review and approve the proposed dates for Council Meetings in 2023.

Resource Implications

None

Further information

For further information, please contact:

Trevor Patterson
Chief Executive



Pharmaceutical Society of Northern Ireland

Annual Internal Audit Assurance Report 2021/22

8 September 2022



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Trevor Patterson
Chief Executive
Pharmaceutical Society of Northern Ireland
73 University Street
Belfast
BT7 1HL

8 September 2022

Dear Sir

Re: Annual internal audit assurance report 2021/22

Introduction

1. In accordance with the terms of our appointment, and the Public Sector Internal Audit Standards ("PSIAS"), we hereby report our formal annual opinion on the adequacy, reliability and effectiveness of the Pharmaceutical Society of Northern Ireland's ("PSNI") system of risk management, control and governance for the year ended 31 May 2022.

Background

2. The PSNI is the regulatory body for pharmacists and pharmacies in Northern Ireland. The underlying statutory basis for the PSNI is set out in the Pharmacy (Northern Ireland) Order 1976 and the Pharmacy Amendment (NI) Order 2012.

3. The PSNI's key risks and challenges include: failure to effectively perform a key function as a Regulator; failure to have adequate systems and resources in place to function effectively and ensure compliance; failure to influence and respond to external policy development; failure to have adequate and effective governance structures in place; and failure to adequately engage and communicate with key stakeholders.

Scope

4. The PSNI prepares annual financial statements to 31 March each year. The scope of the work undertaken during the year and summarised in this annual report, relates to the twelve month period from 1 June 2021 to 31 May 2022.

5. The 2021/22 Internal Audit Plan was established within the context of the PSNI's Internal Audit Strategy which covered the period from 2020 to 2023. The 2021/22 Internal Audit Plan was formally approved by the Audit Committee on 29 November 2021.

Respective responsibilities of the Chief Executive and the Internal Auditors

6. In accordance with our Internal Audit Charter it is the responsibility of the PSNI's Chief Executive to ensure that the PSNI operates and maintains an effective system of risk management, control and governance sufficient to safeguard the assets of the PSNI and to prevent and to detect fraud or error. It is our responsibility to form an independent opinion, based on our internal audit work, on the systems of risk management, control and governance and to report our opinion to you annually.

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Restricted – management only

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Basis of assurance

7. We planned and performed our internal audit work to obtain reasonable, rather than absolute, assurance that the systems were operating as described. However, you should not rely on our work to identify all instances of fraud or error. The responsibility for these matters rests with management and the Chief Executive.

Independence and objectivity

8. We have not become aware of any circumstances during the year e.g. personal conflicts of interest, scope limitations or restrictions on access to records which would impair our independence and objectivity.

Findings

9. Detailed control objectives were identified in advance of each audit. Background details for each audit, the specific control objectives identified for each system and the key findings identified in the course of our fieldwork, are outlined in each of the internal audit reports. We have summarised below the outcome of each review:

System	Date of final report	Assurance rating	Number of recommendations by priority		
			1	2	3
Registration of pharmacists	20 May 2022	Satisfactory	-	-	2
General Data Protection Regulations	20 May 2022	Satisfactory	-	1	4
Review of KPIs covering all regulatory functions	8 September 2022	Satisfactory	-	-	3
Total recommendations			-	1	9

10. We have attached definitions of the assurance ratings and priority levels at **Appendix A**.

Internal audit coverage - actual and planned

11. All internal audit work, as detailed in the 2021/22 Internal Audit Plan approved by the Audit and Risk Committee on 29 November 2021, has been completed.

Significant issues

12. The PSIAS requires that we bring to your attention those significant control issues which may be relevant to the preparation of your Governance Statement for the year ended 31 May 2022. We do not consider that there are any significant issues which need to be brought to your attention as a result of our reviews.

Other sources of assurance

13. In addition to our own work there are a range of other sources of assurance available to the PSNI. These sources include the PSNI's risk management system, incorporating the PSNI's Risk Register which is reviewed regularly by both management and the Audit and Risk Committee. In addition, the PSNI's External Auditors identify within their "Report to Those Charged with Governance" those control weaknesses identified during the course of the annual external audit.

Our opinion

14. In our opinion, during the twelve month period ended 31 May 2022, the PSNI's systems in relation to risk management, control and governance provided **satisfactory** assurance in relation to the effective and efficient achievement of the PSNI's objectives.

Performance and quality of the internal audit service

15. We confirm that we have conducted our internal audit work in accordance with the PSIAS. In accordance with the PSIAS Standard 1300 on Quality Assurance and Improvement Programmes, each internal audit file is reviewed by a Manager and each internal audit report is reviewed by the Head of Internal Audit. This process is supported by ASM's internal quality control procedures which include a system of peer file reviews. Our internal audit team held ISO 9001 (Quality Management Systems) and ISO 27001 (Information Security Management Systems) certification, accredited by UKAS, throughout the year.

16. Our nominated Head of Internal Audit, Christine Hagan, is a Fellow Member of Chartered Accountants Ireland ("FCA") and an Associate member of the Institute of Internal Auditors, UK and Ireland ("CMIIA"). Our internal audit team are either qualified/part qualified Chartered Accountants and/or Internal Auditors. There were no issues arising during the year in relation to either the adequacy of the audit resources or the status of the audit function.

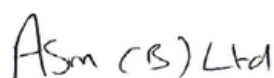
17. To comply with our obligations of Proficiency and Due Professional Care, all staff members have undertaken an ongoing programme of training to ensure they are equipped with the knowledge and skills to perform their responsibilities.

Other matters

18. We would take this opportunity to thank you and your staff for their assistance and co-operation in completing our work.

19. If you have any queries in relation to this correspondence, please do not hesitate to contact Christine Hagan or Philip Whitehead.

Yours faithfully



ASM (B) Ltd

Email: christine.hagan@asmbelfast.com
philip.whitehead@asmbelfast.com

Assurance and priority rating definitions

A

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Assurance rating

Assurance rating	Definition
Satisfactory	Overall there is a satisfactory system of governance, risk management and control. While there may be some residual risk identified, this should not significantly impact on the achievement of system objectives.
Limited	There are significant weaknesses within the governance, risk management and control framework which, if not addressed, could lead to the system objectives not being achieved.
Unacceptable	The system of governance, risk management and control has failed or there is a real and substantial risk that the system will fail to meet its objectives.

Priority rating

Priority rating	Definition
1	Failure to implement the recommendation is likely to result in a major failure of a key organisational objective, significant damage to the reputation of the organisation or the misuse of public funds.
2	Failure to implement the recommendation could result in the failure of an important organisational objective or could have some impact on a key organisational objective.
3	Failure to implement the recommendation could lead to an increased risk exposure.

Type of Paper: For Information

Title: Legal advice on review of interim orders after High Court extension

Action required by Council – Council is asked to review this paper and provide any feedback it considers appropriate.

Background

As part of the review of the Fitness to Practise Manual completed in May 2022, carried out in conjunction with Field Fisher, an issue arose in relation to our interpretation of paragraph 8 of Schedule 3 to the Pharmacy (Northern Ireland) Order 1976, and related practices.

The Statutory Committee has the power, where it is satisfied that it is necessary for the protection of the public or is otherwise in the public interest, or in the interests of the registered person, to make an interim conditions or interim suspension order, for a period not exceeding 18 months. Interim order hearings do not consider whether a registrant's fitness to practise is impaired, but rather makes a risk assessment, based on the necessity to protect the public, the public interest and the interests of the registrant. No Statutory Committee members who sit on an interim order panel, can sit on a full fitness to practise hearing, relating to the same registrant.

Should a case not be resolved by the Statutory Committee, via a Fitness to Practise hearing, before the 18-month period is up, the Society may apply to the High Court for the interim order to be extended, or if it has previously been extended, further extended. Upon such an application the High Court may extend, or further extend, the order for up to 12 months.

This scenario will only usually occur in the most serious or complex cases, which are usually subject to a lengthy investigation by a third party. We on average apply for one High Court extension a year.

The Issue

Paragraph 8 of Schedule 3 had been interpreted to mean that once the High Court had granted an extension to an interim order, the High Court had full jurisdiction over the interim order and the Statutory Committee did not need to carry out any further reviews.

Upon engaging with Field Fisher on an aspect of the Fitness to Practise Manual, it became apparent that this interpretation may need to be reviewed.

On 14 June 2022, formal independent legal advice on the issue was formally requested from Field Fisher.

Initial advice was received from Field Fisher on 28 June 2022. We provided feedback, having several queries, which were returned to Field Fisher on 04 July 2022. Field Fisher provided updated and final legal advice on 15 July 2022.

The finalised independent legal advice can be summarised as follows:

Whilst the High Court, in the broadest sense, does review the jurisdiction of the order and will not extend it if it does not consider it meets the test for an interim order, its primary role is limited to extending the period of an interim order. Once an interim order is extended by the High Court the ongoing obligation to review the orders, and test the necessity for continuing with the order, reverts to the Statutory Committee.

The legal advice also raised a number of additional points in relation to the timing of reviews after a High Court extension and reviews after an interim order is replaced by a Statutory Committee.

This legal advice was then shared with the Chair of the Statutory Committee for review and to provide confirmation that it was accepted and in so doing that he agreed with the suggested interpretation.

The Chair provided confirmation that the legal advice was accepted on 14 August 2022. The Chair of the Statutory Committee is currently developing a Practice Direction to deal with a number of the issues raised in relation to the timings of reviews.

All reviews are now taking place in accordance with the accepted legal advice and the practice direction will be published on our website upon completion, with relevant parties being directed to it.

Whilst it is recognised that the previous interpretation of the legislation was an oversight, Council should consider the following points:

1. It is acknowledged that aspects of the provisions laid out in paragraph 8 of Schedule 3 of the Order are unhelpfully drafted.
2. The issue was identified by us and has been rectified by us
3. The public has always been protected, as interim orders extended by the High Court have been maintained for the relevant duration.
4. No registrant has raised an issue or challenged the previous interpretation of the legislation or practices, suggesting no actual prejudice has occurred.
5. Provisions in the Regulations for requesting an early review of an interim order have always been available to registrants and could have been exercised by them whether or not the High Court had granted an extension.

Action required by Council

1. Council is asked to review this paper and provide any feedback/comments it considers appropriate.

Resource implications

Approximately £1000 for drafting the Practice Direction which will clarify the position for all parties

For further information

Trevor Patterson, CEO

Pharmaceutical Society NI – Section 60 Orders update- Council paper

Date 15th September 2022

Type of Paper - For Information

Title – Section 60 Orders update

Action required – Council are asked to review the content of this paper

Background- This paper is to provide an update to council on the progress of the Section 60 orders on Pharmacy rebalancing legislation.

Progress to date- Since my last update, we had a meeting with GPhC, Department of Health and Social Care and the Department of Health. We discussed a timeline for commencement of the orders and agreed that the GPhC and PSNI would work together to bring the orders in at the same time in both GB and Northern Ireland and would work closely on developing our guidance. We were advised that the orders are permissive meaning that commencement of the order would change the characteristics of the roles of RP and SP, so therefore it becomes clear that the RP is responsible for the pharmacy when it is open, but the SP is responsible for all pharmacies of a particular business 24/7. However, any rules, regulations or standards developed alongside that are essentially permissive. We also had a lengthy conversation around the role of the Chief Pharmacist and what this role will look like.

The orders themselves have passed through parliament and plan to be laid before the next Privy council on the 1st of October, we have been advised that the commencement of both orders will be 1st December 2022. I will continue to engage with Trusts, Private Hospitals and the independent sectors of Pharmacy, so they are well informed and prepared for when these orders are commenced. The society will continue to liaise with GPhC in relation to the consultation work that will follow the commencement of both Orders.

Attached Papers

Appendix 1- Draft RP-SP Commencement order

Appendix 2- Draft Hospital Dispensing Errors Commencement order

For further information -

Ryan Duffy

Interim Project Manager

STATUTORY INSTRUMENTS

2022 No. XXX (C. XX)

HEALTH CARE AND ASSOCIATED PROFESSIONS

The Pharmacy (Responsible Pharmacists, Superintendent Pharmacists etc.) Order 2022 (Commencement) Order of Council 2022

Made - - - - - October 2022

At the Council Chamber, Whitehall, the [x] day of [October] 2022

By the Lords of Her Majesty's most Honourable Privy Council

Their Lordships, with the agreement of the Department of Health in Northern Ireland^(a), make the following Order of Council in exercise of the powers conferred by article 1(3) of The Pharmacy (Responsible Pharmacists, Superintendent Pharmacists etc.) Order 2022^(b).

Citation

1. This Order may be cited as the Pharmacy (Responsible Pharmacists, Superintendent Pharmacists etc.) Order 2022 (Commencement) Order of Council 2022.

Appointed day

2. [1st] [December] 2022 is the appointed day for the coming into force of Parts 2 and 3 of, and the Schedules to, the Pharmacy (Responsible Pharmacists, Superintendent Pharmacists etc.) Order 2022.

Name

Clerk of the Privy Council

EXPLANATORY NOTE

(This note is not part of the Order)

This Order of Council provides for the commencement of The Pharmacy (Responsible Pharmacists, Superintendent Pharmacists etc.) Order 2022 in so far as it is not yet in force.

The commenced provisions clarify and strengthen the organisational governance arrangements of registered pharmacies, specifically to define and clarify the core purpose of responsible

a (?) See article 4(4) of S.I. 2022/849
b (?) S.I. 2022/849

pharmacists and superintendent pharmacists, with professional regulation defining how that purpose is to be fulfilled.

It does this by amending the Medicines Act 1968 so as to provide a general statutory duty for superintendent pharmacists. The amendments to that Act also provide clarification to the general statutory duty of a responsible pharmacist, whilst taking the power to make provision about the statutory responsibilities of a responsible pharmacist from Ministers and giving them to the regulators (the General Pharmaceutical Council, as regards Great Britain and the Pharmaceutical Society of Northern Ireland as regards Northern Ireland).

The commenced provisions also amend both the Pharmacy Order 2010 and the Pharmacy (Northern Ireland) Order 1976 so as to provide powers to the regulators to define the professional responsibilities of both superintendent pharmacists and responsible pharmacists within the professional standards of conduct and performance that they set. The minor and consequential amendments in the Schedules are also commenced.

S T A T U T O R Y I N S T R U M E N T S

2022 No. XXX (C. XX)

MEDICINES

HEALTH CARE AND ASSOCIATED PROFESSIONS

The Pharmacy (Preparation and Dispensing Errors – Hospital
and Other Pharmacy Services) Order 2022 (Commencement)
Order of Council 2022

Made - - - - - October 2022

At the Council Chamber, Whitehall, the [x] day of [October] 2022

By the Lords of Her Majesty’s most Honourable Privy Council

Their Lordships, with the agreement of the Department of Health in Northern Ireland^(a), make the following Order of Council in exercise of the powers conferred by article 1(3) of the Pharmacy (Preparation and Dispensing errors – Hospital and Other Pharmacy Services) Order 2022^(b).

Citation

1. This Order may be cited as the Pharmacy (Preparation and Dispensing Errors – Hospital and Other Pharmacy Services) Order 2022 (Commencement) Order of Council 2022.

Appointed day

2. [1st] [December] 2022 is the appointed day for the coming into force of Parts 2 and 3 of the Pharmacy (Preparation and Dispensing Errors – Hospital and Other Pharmacy Services) Order 2022.

Name

Clerk of the Privy Council

EXPLANATORY NOTE

(This note is not part of the Order)

This Order of Council provides for the commencement of The Pharmacy (Preparation and Dispensing Errors – Hospital and Other Pharmacy Services) Order 2022 in so far as it is not yet in force.

a (?) See article 4(4) of S.I. 2022/851
b (?) S.I. 2022/851

The commenced provisions extend the defences inserted into the Medicines Act 1968 by The Pharmacy (Preparation and Dispensing Errors – Registered Pharmacies) Order 2018. These defences relate to offences of contravening the following provisions of that Act: section 63, which relates to adulteration of medicines; and section 64, which relates to the sale or supply in pursuance of a prescription of medicines not of the nature or quality demanded. The new modifications to the defences relate to preparation and dispensing errors by registered pharmacists and registered pharmacy technicians, or persons supervised by them, at hospitals and other relevant pharmacy services where there is a chief pharmacist. Pharmacy technicians are not statutorily registered in Northern Ireland, and so, as regards Northern Ireland, the commenced article only makes provision relating to preparation errors and dispensing errors by registered pharmacists and persons supervised by them.

The commenced provisions introduce as a condition of the defences for hospitals or other relevant pharmacy services that they need to have a chief pharmacist. The chief pharmacist is the pharmacist who is responsible for securing that the pharmacy service in question is carried on safely and effectively.

The commenced provisions also amend provisions in both the Pharmacy Order 2010 and the Pharmacy (Northern Ireland) Order 1976 so as to enable the regulators (the General Pharmaceutical Council as regards Great Britain, and the Pharmaceutical Society of Northern Ireland as regards Northern Ireland) to describe the responsibilities of chief pharmacists and to set standards of performance and conduct in relation to them.

An open letter to:

**Government Health Secretaries of England, Northern Ireland, Scotland and Wales;
Chief Executives of the National Health Service in England, Northern Ireland, Scotland and Wales;
NHS Chief Pharmaceutical Officers for England, Northern Ireland, Scotland and Wales;
Chief Executive of General Pharmaceutical Council and Pharmaceutical Society of Northern Ireland.**

19 July 2022

Re: Patient safety concerns around pharmacy closures

As an organisation representing employed and locum pharmacists and with more than 35,000 members across the UK, we have grave concerns about patient safety and the impact of the reduction of the community pharmacy service to the public brought about by unnecessary full or part-day closures throughout the UK by some of the large multiple operators. What they are telling affected patients and also the government is that they are doing so because they have been unable to find pharmacists citing an alleged national pharmacist shortage. However, the reality experienced by our members is often very different.

We have evidence to show that these closures are being announced up to four weeks in advance. In other examples, the services of locum pharmacists have been contracted in advance, only for a large company to attempt to reduce the pre-agreed rate; Where this is not accepted, the shift has been cancelled resulting in the pharmacy being closed with a supposed national shortage of pharmacists being blamed when communicating this to the public. Such statements are clearly untrue, these closures appear to be caused by commercial considerations, and bring the reputation of the profession into question through this unethical practice.

These closures and the impact upon patients have been enabled because neither the government, nor the NHS contractual arrangements, nor the patient safety and regulatory regimes appear to be taking responsibility for acting upon these practices. Those in government who provide the overall funding arrangements, and those in the local NHS organisations charged with the job of ensuring, through contractual arrangements, that the public receive a service appear to have accepted the fallacy that the closures are genuinely because of the inability to find a pharmacist. Those charged with the task of regulating to ensure patient safety appear to have taken the view that this is a contractual matter and not one that demonstrates a failure in the required standards of professional conduct.

This lack of control by the overall system allows some large pharmacy businesses to choose, with impunity, to restrict patients' access to NHS funded services and cause harm to patients rather than engage pharmacists appropriately. This does not just deny communities access to a pharmacy and increase the demands on other parts of the health system, but also places individual patients at risk if they cannot access medicines, services, and advice. These companies face no financial penalty in their arrangement with the NHS for these decisions, nor have their superintendents (to our knowledge) faced any professional regulatory consequences for breaches of required professional standards.

Worse still, we believe that some multiple operators are now seeking to misdirect the healthcare systems into believing that this 'national shortages' façade can be used as a legitimate pretext to make a change to the pharmacy regulations. We assume that these are the regulations which currently require there to be a pharmacist in the pharmacy for it to be able to operate safely.

The PDA has been constantly and consistently highlighting this issue; however, those with the collective ability to take the necessary steps to bring this unacceptable situation under control appear unwilling or unable to act. The PDA therefore now finds itself in the unusual position of having to publicly lobby you en masse to demand action to protect patients by ensuring that essential community pharmacy services are provided safely and consistently.

Pharmacy closures have become widespread and are now being orchestrated. They severely impact patients and local communities in restricting their access to medication and other services, and displace activity unnecessarily to other parts of the NHS which are already under significant pressure, such as GP practices, urgent care, or A & E. Our members who practice in these environments also report many other direct consequences to their patients.

We believe that you need to take urgent and effective action on this issue without further delay. Under the circumstances, we would require a response to this letter as a matter of extreme urgency.

Yours sincerely

A handwritten signature in blue ink, appearing to read 'Mark Koziol'.

Mark Koziol, M.R.Pharm.S
Chairman

By email only

Mr Mark Koziol
Chairman
Pharmacists' Defence Association
The Old Fire Station
69 Albion Street
Birmingham
B1 3EA

15 September 2022

Dear Mark

Thank you for raising your concerns about pharmacy closures with us and a number of other organisations. As you know, we cover only the NI jurisdiction where there appears to be a lower level of closures of the type you describe than in GB. It is nonetheless an important issue.

The purpose of this communication is to formally set out how the role we perform interfaces with the issues raised by you.

We have included a fuller statement which we are happy to discuss with you and we have liaised with GPhC who, we understand, will also respond. In due course, we will publish our response.

Yours sincerely



Trevor Patterson
Chief Executive & Interim Registrar



Pharmacy Closures Statement

Pharmacists and pharmacy technicians and the pharmacies in which many of them serve and care for patients and the public are highly valued within communities. Access to pharmacy services is an issue of utmost importance to patients, carers and their families.

Pharmacy closures can therefore be distressing for all involved, and potentially may raise concerns for patient safety, particularly if people cannot access the medicines and other pharmacy services many rely on.

The causes behind the level of closures that we are seeing are both complex and multifactorial, including financial, commercial, labour market and contractual factors. The Pharmaceutical Society of Northern Ireland is committed to playing its part in working with stakeholders across the system, to understand and address this important issue.

There are broadly two types of community pharmacy, both are private enterprises, one type is contracted to the Health and Social Care system to provide services to the HSC and the other serves private patients only.

Design and delivery of HSC services

As the independent pharmacy regulator, we do not have a role in planning or authorising where pharmacies should be located, when they open or what they offer. We do not regulate the market itself or have the jurisdiction to decide how many pharmacies are needed, should be available in any given area or when they are open.

Community pharmacies are private businesses, albeit some are contracted to deliver HSC services, in the vast majority of premises.

- In Northern Ireland, the Department of Health carries out a pharmaceutical needs assessment, which looks at the current need for pharmaceutical services versus the current levels of community pharmacy service provision across Northern Ireland.

Procedures for reporting closures

We do not have a direct role in relation to authorising, logging or investigating pharmacy closures, nor in monitoring opening hours.

There are established procedures for reporting pharmacy closures to the Strategic Planning and Performance group within the Department of Health NI.

Our standards

Our focus in regulating pharmacies is on patient safety and whether a pharmacy is operating safely and effectively. The Council of the Pharmaceutical Society NI approved new premises standards in 2018, which have not yet been implemented. We consider, however, that the following Standards, which await a commencement order, as laid out in the 2018 Premises Standards, are relevant in this context. Pharmacy owners and pharmacy professionals should take these standards into consideration when considering pharmacy closures

The following **standards for registered pharmacies** are particularly relevant in this context:

- The risks associated with pharmacy services must be identified and managed through appropriate risk assessment (Standard 1.1)
- Provide pharmacy services that are accessible to patients and the public (Standard 3.1)
- Ensure the management and delivery of safe and effective pharmacy services (Standard 3.2)
- Staff must feel empowered to raise concerns in a way that is consistent with a culture of openness, honesty and learning (Standard 5.4)
- Staff must ensure that incentives or targets do not compromise their professional judgement, or the health, safety or wellbeing of patients and the public. (Standard 5.5)

Where a pharmacy has a planned temporary closure we would expect the pharmacy to make sure that they have made arrangements so that patients can get the medicines and pharmaceutical care they need. It is essential that the pharmacy also communicates these plans to appropriate stakeholders (including local GP practices, other local pharmacies who may be affected, addiction services etc.) and to the relevant NHS organisations.

Individuals (including responsible and superintendent pharmacists) also need to meet **our standards for pharmacy professionals** in this context. This includes communicating effectively (Standard 4.1), upholding the duty of candour and raising concerns appropriately (Standard 1.2) and managing risk (Standard 2.2).

We expect that pharmacy professionals and pharmacy owners are open and honest, and apply the duty of candour when communicating the reasons for any pharmacy closures to patients and the public and to other stakeholders, including service commissioners.

Any concerns about pharmacy closures (for whatever reason) should be reported to the Strategic Planning and Performance Group within the Department of Health. This organisation oversees the provision of pharmacy services in line with contractual commitments.

We will also look into any concerns that pharmacy owners and pharmacy professionals are not meeting our professional standards when closing a pharmacy. Any concerns raised with us are of course considered on a case-by-case basis, in accordance with our statutory process and our published policies.

Locum rates and other arrangements

We are aware that locum rates and arrangements have recently been referenced in the context of pharmacy closures. We do not have a regulatory role in relation to the rates agreed between locum pharmacists and pharmacy owners.

Rates for locum bookings must be individually agreed between the locum and the pharmacy owner or through a locum agency. This is an important element of a free-market arrangement. It would be inappropriate for the PSNI as the pharmacy regulator to play a part in setting or influencing locum rates.

It is unlawful for anyone (including pharmacy owners, agencies or locum pharmacists) to seek to manipulate market rates and inhibit free market conditions, for example by working with others to 'fix' rates. Any concerns that anyone is seeking to manipulate or fix locum rates in either direction should be referred directly to the Competition and Markets Authority (CMA), as the lead competition enforcer in the UK. As well as being unlawful, any such activity could undermine public confidence in pharmacy or even potentially affect patient safety.

Both pharmacy owners and pharmacy professionals must make sure they are meeting our professional standards at all times, including when arranging locum bookings.

We have in the past received queries from both pharmacy owners and locum pharmacists about whether they should raise a fitness to practise concern about a pharmacy professional (either the locum or an employee working on behalf of the pharmacy owner) who in their view has behaved unprofessionally in connection with a locum booking.

Employers should consider the difference between conduct by a pharmacist which relates to contractual arrangements, which require action by an employer, compared with conduct by a pharmacist, which raises concerns about a pharmacist's fitness to practise. Failure to honour a locum booking is unlikely to raise concerns about a pharmacist's fitness to practise.

Working in collaboration

We are committed to supporting and taking part in ongoing discussions about workforce matters with key stakeholders in NI

We are aware that the Department of Health has recently published a Pharmacy Workforce Review report and are committed to playing our part in its recommendations.

14 September 2022

Pharmaceutical Society NI – Council paper

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Date: September 2022

Title: Safer Care of All - Solutions from professional regulation and beyond

Type of Paper: For Information

Action Required by Council:

Council is asked to review the content of the attached paper.

Purpose of paper

To provide the Council with summary information on paper released 6/9/2022 by Public Standards Authority (PSA); Safer Care of All - Solutions from professional regulation and beyond.

Background

PSA report examines the current state of professional health and care regulation in the UK. It considers the fragmented landscape of health, social care, and four countries; each with complex patient and public safety mechanisms spanning numerous different bodies. The report sets out the main findings and recommendations to support safer care for all by addressing inequalities and the challenges facing health and social care.

Summary

The report considers four main themes that can contribute to safer care for all:

1. Tackling inequalities: Unequal and unfair outcomes for protected groups in aspects of professional regulation.
2. Regulating for new risks: Changes to how care is funded and delivered can impact risk.
3. Facing up to the workforce crisis: Patients and service users at risk in the UK due to workforce shortages. Consideration of contribution of professional regulation to workforce planning.
4. Accountability, fear and public safety: Just cultures and individual accountability are both essential to better, safer care, and must coexist.

The report recommends that each UK country has a Health and Social Care Safety Commissioner, or equivalent function, with broad responsibility for identifying, monitoring, reporting, and advising on ways of addressing patient and service user risks.

The Commissioners should sit above all other health and care organisations, spanning public as well as private provision. They would be independent of Governments, and transparent in both their approach and outputs. They would look across the whole system through the eyes of the patient and service user.

Full report and summaries are available in the links below:

[Safer Care for All - Full report](#)

[Safer Care for All - The Essentials](#)
[Safer Care for All - Executive Summary](#)
[Safer Care for All - Recommendations](#)

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Discussion

The PSNI already provide robust regulation for the profession and are involved in activities to further address issues identified in this report (e.g. Post-registration assurance of practice advisory group, registration of Pharmacy Technicians and Fitness to Practise concerns).

Resource Implications

Resources required to engage with the Commissioner and review/implement recommendations.

Action Required by Council:

Council is asked to review the content of the attached paper.

For further information

Scott Gill
Council Member

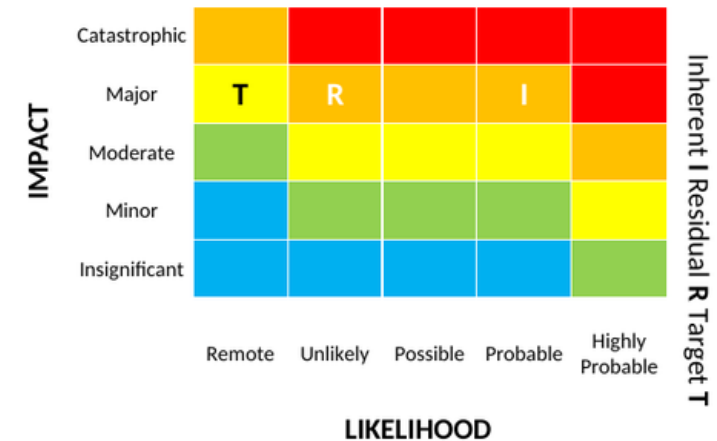
PSNI.R0001 Failure to effectively perform a key function as a Regulator

Owner: CE and Registrar

Risk Detail

Risk Rating

Explanation of Inherent Rating	Explanation of Residual Rating	Explanation of Target Rating
	Work in progress in a number of areas, working on recommendations from internal and external audits. Note inherent in Regulatory activity, due to the moving target basis of regulation.	The target likelihood is recognised as aspirational due to the complexity of the activity.



Risk Strategy: Action Required/Treat

Controls

Ref	Control Title	Control Rating	Control Owner
C0001	Suite of process documents - policies in place	Partially Effective	Registrar
C0002	Key staff in place, appraised and adequately trained	Effective	HBO
C0003	Awareness and implementation of relevant legislative requirements	Effective	Registrar



C0004	To have adequate standards for the Profession	Partially Effective	Registrar
C0005	Internal and external audit of key functions	Effective	CE
C0006	Suite of KPIs covering all regulatory functions in place and reported against	Partially Effective	Registrar
C0037	Regulatory Compliance Project	Effective	CEO/HPA
C0171	Controls in the absence of the New Premises Standards - continued use of the Advisory Standards for Premises	Partially Effective	CE & Registrar
C0172	Controls in the absence of the New Premises Standards - working with the Department to develop a new inspection regime	NYE	CE & Registrar
C0177	Quality Assurance of Fitness to Practice Committee procedures and processes	Partially Effective	CEO/HPA
C0189	Covid 19 Response	Effective	SMT

Actions

Ref	Action Title	Action Co-ordinator	Target Date	Action to be Taken
A0247	Lessons Learned Report following incident	CE & HPA	01-Oct-20	
A0247	Lessons Learned Report following incident	CE & HPA	01-Oct-20	
A0239	Covid 19 Response - regulator activity	SMT	29-Nov-20	IT resources were procured enabling staff to work from home, office initially closed.
A0067	Regulatory Compliance -	HPA & CE	31-Dec-20	
A0001	To continue to lobby Government to	CE	01-Mar-21	



	bring forward modernising legislation			
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PSNI.R0002 Failure to have adequate systems and resources in place to function effectively and ensure compliance (Finance, HR and IT)

Owner: CE and HBO

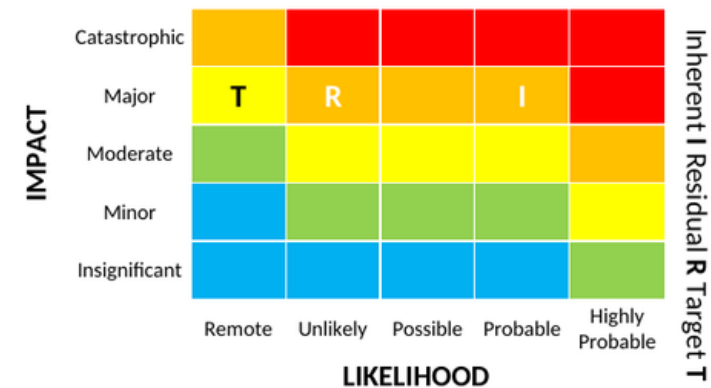
Risk Detail

Noting that income is derived primarily from two sources. Registrants and Premises fees

Risk Rating

Explanation of Inherent Rating	Explanation of Residual Rating	Explanation of Target Rating

Risk Strategy: Action Required/Treat



Controls

Ref	Control Title	Control Rating	Control Owner
C0001	Annual income stream from registration	Effective	HBO
C0002	Adequate financial reserves	Effective	HBO
C0003	Experienced and trained staff in	Effective	HBO



	key posts		
C0004	IT resource - robust and effective systems in place	Partially Effective	HBO
C0005	A robust and effective Business Continuity Plan is in place	Effective	HBO
C0006	Effective systems in place to ensure compliance with reporting requirements	Effective	HPA/HBO
C0158	GDPR	Partially Effective	HPA
C0190	Covid 19 Response - Resources - remote working, staff absence and increased workload	Effective	HBO

Actions

Ref	Action Title	Action Co-ordinator	Target Date	Action to be Taken
A0248	Shortterm arrangements agreed with Department of Health	CE	31-Dec-20	
A0248	Shortterm arrangements agreed with Department of Health	CE	31-Dec-20	
A0240	Business activity to cope with Covid-19 pandemic	SMT		

PSNI.R0003 Failure to influence and respond to external policy development

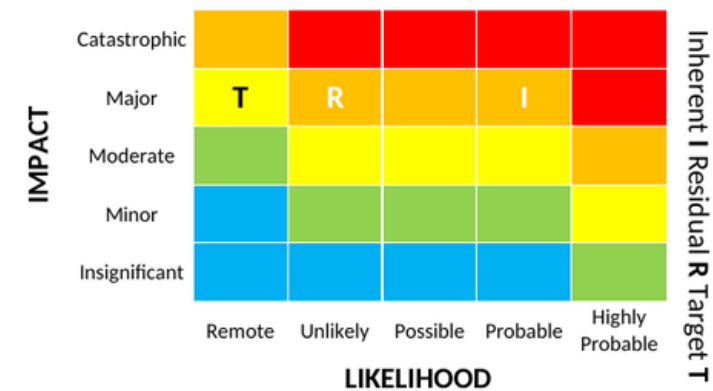
Owner: CE and HPA

Risk Detail

Risk Rating

Explanation of Inherent Rating	Explanation of Residual Rating	Explanation of Target Rating

Risk Strategy: Action Required/Treat



Controls

Ref	Control Title	Control Rating	Control Owner
C0001	To ensure ongoing awareness of external policy development	Effective	HPA
C0002	To ensure effective relationships	Effective	HPA
C0038	Response to Brexit	NYE	CEO
C0170	Work with the Department to bring forward requisite	NYE	CE & Registrar



	Commencement Order		
C0202	External Influence	Partially Effective	CE President

Actions

Ref	Action Title	Action Co-ordinator	Target Date	Action to be Taken
A0003	Response to Options Project-Department of Health's consultation of regulatory Reform	CE	02-Dec-19	Council to inform debate and make representation/response
A0054	Monitor and respond to UK Government policy and any subsequent legislative changes at Westminster.	CE and HPA		
A0068	Monitoring the effect of Brexit on pharmacy regulation in NI	HPA		



PSNI.R0004 Council fails to have adequate and effective governance structures in place

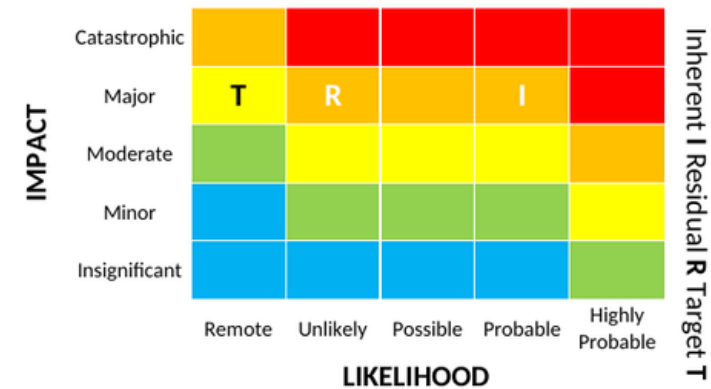
Owner: CE

Risk Detail

Risk Rating

Explanation of Inherent Rating	Explanation of Residual Rating	Explanation of Target Rating

Risk Strategy: Action Required/Treat



Controls

Ref	Control Title	Control Rating	Control Owner
C0002	Robust governance performance management in place	Partially Effective	CE
C0003	Ongoing compliance with the requirements of the Corporate Governance Handbook	Effective	CE
C0004	Committee structure - annual	Effective	Vice President



	review, performance review.		
C0005	Council oversight of internal, external and PSA audits and monitoring of actions arising	Effective	President
C0006	Governance framework (Strategic Plan, Risk Management and Financial reporting tools)	Effective	President

Actions

Ref	Action Title	Action Co-ordinator	Target Date	Action to be Taken
A0250	Council Recruitment	President	31-Mar-21	Continued pressure is to be applied to the Department and the Public Appointments Unit to enable a swift resolution of the issue. In the absence of progress through this challenge, the Council may seek approval to run the appointment system using independant recruitment consultants, making proposals of suitable candidates to the Minister.



PSNI.R0006 Failure to adequately engage and communicate with key stakeholders

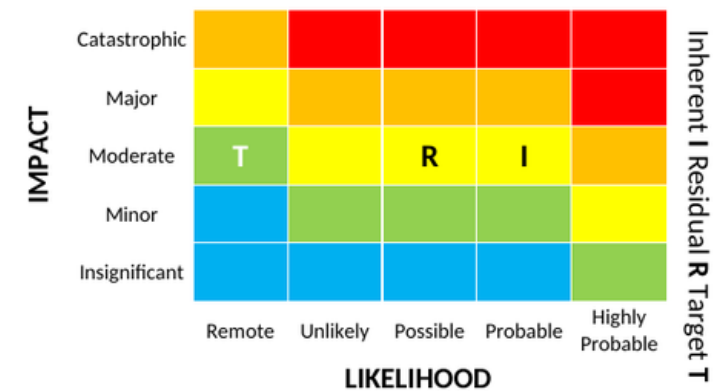
Owner: HPA

Risk Detail

Risk Rating

Explanation of Inherent Rating	Explanation of Residual Rating	Explanation of Target Rating

Risk Strategy: Action Required/Treat



Controls

Ref	Control Title	Control Rating	Control Owner
C0001	Adequate and effective communication strategy	Effective	HPA
C0002	Systems to measure effectiveness of communication and engagement activity	Effective	HPA



Actions

Ref	Action Title	Action Co-ordinator	Target Date	Action to be Taken



CORPORATE STRATEGY PROGRESS REPORT - SEPTEMBER 2022					
Objective 1: To deliver high quality pharmacy regulation that is proportionate and cost-effective					
No	Goals	Current Status	Tending towards	Update - September 2022	SMT
a	We will meet all performance standards in annual PSA appraisals in at least 4 of the next 5 years.			2019 annual review resulted in meeting 22 of 24 standards - work is complete to address the customer service issues identified for improvement in FtP. 2020 year shows failure to meet three standards which is disputed but not appealable. In 2021 PSA have confirmed all previously unmet standards are now met but identified a further standard not met, which is again not agreed.	TP
b	We will secure policy agreement with DoH to make legislative and non-legislative changes required to modernise pharmacy regulation and, following policy agreement, develop an implementation plan for delivery, including delivery of actions specified by May 2023. (Revised 10/1/22).			Whilst we have agreement from the CPO to work together to produce a 5 year plan, it is not formalised. The current impasse at the NI Assembly will prevent any further progress for now. We have however secured agreement to advance the reforms necessary to advance IET reform and await agreement on method to be used. We are working with DoH on updating the Indemnity Regulations and introducing the English Language Regulations	TP
c	We will secure policy agreement with DoH for the statutory regulation and registration of technicians and, following approval, consult upon entry routes to the register.			The recently published Pharmacy Workforce Review Board report, of which we were a part, sets out the intention to register technicians. The minister has written to us in June 2022 asking that we aim to commence registration in June 2022. Work is underway on entry routes and legislative reform needed	TP

d	We will employ a financial strategy (to be reviewed annually to increase efficiency and cost-effectiveness and report against targets therein bi-annually.			Financial Strategy approved by Council in November 2018. Implemented April 2019. Actions reviewed by the Finance & Performance committee Feb 2022, next review August 2022. <i>With agreement of the Chair of Finance & Performance the August review has been postponed until Oct 22.</i>	JD
e	We will collaborate with other relevant Regulators and PSA to effect change designed to maximise use of shared principles and practices.			A number of joint statements have been issued, for example, on candour and directing payments in relation to medicines. CEORB was established to provide momentum and a number of projects are underway and a large number of sub-groups meet regularly - there is significant evidence of shared work arising from Covid 19.	TP
f	We will deliver reforms developed as a consequence of Rebalancing Medicines Legislation and Pharmacy Regulation, including the issue of criminal prosecution for dispensing errors and delivery of standards and guidance around RPs and SPs.			Premises - working group established for the introduction of outcome based Premises Standards in NI which we co-chair. Resource issues in DoH now resolved and implementation of Premises Standards is progressing, next steps being IT system development by the DoH. RP, SP, hospital defence and Deputy Registrar are all consulted upon and have now been laid in Westminster with a coming into operation date of December 2022	TP

CORPORATE STRATEGY PROGRESS REPORT - SEPTEMBER 2022					
Objective 2: To set pharmacy standards that are evidence-based, output-focused, achievable and necessary for patient and public safety					
No	Goals	Current Status	Tending towards	Update - September 2022	SMT
a	We will review and, where appropriate, enhance the current set of pharmacy standards. We will complete a full review of the Code by May 2023 followed in next corporate strategy by phased review of Standards related to the Code.			Review has been completed and a programme of Standards revision is underway. All other revisions are on schedule though staff shortages may impact all of 2a - 2c. TP has liaised with DH on compliance indicators which now need to be built into a DoH IT platform, for premises standards and CPD Framework approved and now implemented. Work will shortly commence on the Code review.	MN
b	We will test the ongoing efficacy of pharmacy standards in context of the newly emerging HSC reform programme as part of Goal 2(a).			The HSC reform programme and the impact on Pharmacy service provision remains unclear. However, we continue to liaise with the Strategic Performance and Planning Group of the Department of Health in regards to the new developments. We are currently working with the Dept & stakeholders on the emerging pathways for education and this will lead to further work within goal 2(a).	MN
c	We will test and report on the feasibility of developing and applying new standards over and above Minimum Standards designed to encourage improved service quality to ensure that they remain fit for current and future practice. Subject to review at the next Corporate Strategy review.			This remains difficult until the developments in 2b are more clear.	MN

CORPORATE STRATEGY PROGRESS REPORT - SEPTEMBER 2022					
Objective 3: To conduct Fitness to Practise processes that are robust, timely and fair					
No	Goals	Current Status	Tending towards	Update - September 2022	SMT
a	We will improve timeliness, efficiency and cost of Fitness to Practise processes and report on progress made.			We are operating a hybrid model for hearings, we continue to offer both remote and in person hearings as we move out of the challenge that the pandemic offered. We continue to be challenged on efficiency in FTP cases due to time delays with external agencies due to restructure of BSO to SPPG and internal resource pressures with the DOH and associated MRG.	LH/MN
b	We will ensure regular reports on learning from Fitness to Practise cases are effectively disseminated to pharmacists and other interested parties.			Reminders being placed on Facebook and key learnings shared via the regulatory Newsletter.	MN
c	We will develop Fitness to Practise processes for Pharmacy Technicians.			This is to synchronise with the registration of technicians and we have commissioned work to begin in this area beginning with legislative reform in relation to the Registration of Pharmacy Technicians. Work here cannot be completed until the enabling legislation is drafted, whilst that will not be in the life of this strategy we are back on target	LH

CORPORATE STRATEGY PROGRESS REPORT - SEPTEMBER 2022					
Objective 4: To ensure that pharmacy education and professional development is fit for purpose					
No	Goals	Current Status	Tending towards	Update - September 2022	SMT
a	We will review the Pre-Registration Framework and implement necessary improvements including developing a plan for, and commencing transition to a Foundation Training Year.			Stakeholder event on IETP held in Nov 2020. A new IETP Advisory Group has been set up to advise GPhC and PSNI Councils on IETP Standards and their implementation. The aim of these standards is to transform the education and training of pharmacists. As part of this work, NICPLD now operationally run the Foundation programme as of 2021 intake. The first year of FTY has been completed and work is underway on the remaining actions - including further development on QA.	LH
b	We will review and improve undergraduate and accreditation standards with our partners. We will work with our partners on delivery of the implementation plan for undergraduate and accreditation standards.			Accreditation visits completed for 2019 and UU report on Sept 21 WE cahir Education Reform Implementation Group NI and work is ongoing with NICPLD and local universities with a view to all those entering the register in 25/26 are IP.	LH
c	We will explore the feasibility of developing a joint education strategy with both NI Universities and GPhC. We will lead on the development of the new IET Standards and their implementation.			This work is now being taken forward through the Education Reform Implementation Group. The Reforms agreed to IET, including entering the register from 2016 onwards, amount to the strategy. Common Registration Assessment arrangement with the GPhC began in November 2021.	LH

d	We will review CPD processes and develop a strategy for the establishment of a continuing Fitness to Practise regime. We will undertake to engage with stakeholders in relation to the development of a Continuing Fitness to Practise Strategy.			CPD Framework consulted upon and revised framework approved by the Council March 2020. The new CPD framework has now taken effect as of 1st June 2021 and the first year of operation has since completed on June 2022. We will begin the engagement work on CFTP now that there is familiarity with new CPD.	LH
e	Post Registration Education and Training. Develop a PSNI policy position and implementation strategy for Post Registration Education and Training arrangements for pharmacists and pharmacy technicians, when registered, operating within Northern Ireland. (Added 10/1/22).			The UK wide Post- registration assurance of practice advisory group has been established with representation from both Council and the Registrar, the associated task and finish group will be established in September/October 2022.	LH

CORPORATE STRATEGY PROGRESS REPORT - SEPTEMBER 2022					
Objective 5: To be an accountable organisation with effective governance and operations					
No	Goals	Current Status	Tending towards	Update - September 2022	SMT
a	We will establish effective deputising arrangements for the Registrar.			As reported under Goal 1(f), this is now laid and coming into operation in December 2022, thereafter the minister will be asked to make an appointment. In the interim, we have twice used a protocol to appoint an interim at relatively short notice. Also as reported, deputy registrar provision expected 07/22.	TP
b	We will secure policy agreement with DoH on resolving the current Pharmacy Professional Leadership linkage with the Regulatory function. <i>We will agree a plan to deal with the link between the Leadership and Regulatory functions.</i>			This relates to 1 (b) and, whilst policy agreement with CPO is in place, we await ministerial approval in the current political context.	TP
c	We will annually review audit schedules, risk management processes and performance measurement organisationally and implement necessary changes for improvement.			1 year of the recently approved 3 year Internal Audit Plan remain. We re-appointed internal auditors in 2021, tender delayed due to Covid 19. Three internal audits conducted in each of 2020/2021 and 2021/2022 all with satisfactory controls and no priority 1 recommendations. New External Auditor in place for 2020/2021 and audit plans underway for 22/23.	TP
d	We will develop a new IT Strategy <i>and deliver against relevant goals, reporting to Performance and Finance Committee at least twice per year.</i>			IT strategy implemented 2019, Full review completed 2021, approved by Council Nov 2021. Actions reviewed by the Finance & Performance Committee Feb 2022, next review August 2022. <i>With agreement of the Chair of Finance & Performance the August review has been postponed until Oct 22.</i>	JD

CORPORATE STRATEGY PROGRESS REPORT - SEPTEMBER 2022					
Objective 5: To be an accountable organisation with effective governance and operations					
No	Goals	Current Status	Tending towards	Update - September 2022	SMT
e	We will review and improve organisational governance.			Governance review concluded and new committee structures in place. Further work to be done on performance management including appraisal.	TP
f	We will formulate and implement a new HR Strategy to improve organisational resilience, efficiency and effectiveness and deliver against relevant goals, reporting to Performance and Finance committee at least twice per year.			HR Strategy implemented February 2019. Actions reviewed by the Finance & Performance committee Feb 2022, next review August 2022. <i>With agreement of the Chair of Finance & Performance the August review has been postponed until Oct 22.</i>	JD
g	We will work with Government and other relevant agencies to ensure robust arrangements are in place to manage the effects upon pharmacy regulation in NI resulting from the UK's exit from the EU - including the provision of suitable transition arrangements. Key issues around recognition of qualifications and recent MHRA approach to PSNI re development of guidance on medicines use in N.I.(NIMAR).			Have met with GPhC and PSI for preliminary discussions on future recognition - have signed a data sharing agreement with PSI. Government policy continues to evolve in this area. BEIS are leading on mutual recognition and we are in contact with them	TP

CORPORATE STRATEGY PROGRESS REPORT - SEPTEMBER 2022					
Objective 6: To communicate effectively, be accessible and responsive					
No	Goals	Current Status	Tending towards	Update - September 2022	SMT
a	We will improve and report on communications effectiveness.			Communication report to be delivered to Finance and Performance Committee.	MN
b	We will develop a new strategy designed to enhance the public, pharmacy, media and political profile of the organisation. We will implement our Communications Strategy and report on its effectiveness including the response to and effectiveness of our Reach Out programme.			The Comms Strategy has been updated and delivered to Council in Nov 2021 This will be updated in line with the addendum.	MN
c	We will develop a "Reach Out" Programme to better engage with the public and pharmacists on regulation (What, Why, When and How).			In the current circumstances, further Outreach events by Council have been postponed. Outreach activities will resume once public meetings are permitted.	MN
d	We will review our current public consultation protocols.			This work has been delayed due to staffing issues and other pressures, . However work remains ongoing with an increased use of online focus groups and stakeholder involvement which is proving both popular and effective. These lessons will be incorporated into the review which can still be achieved by the end of 2022.	MN
e	We will review and improve external and internal complaints processes.			This review has now been completed proposals will go to Finance and Performance Comm for approval.	MN

CORPORATE STRATEGY PROGRESS REPORT - SEPTEMBER 2022					
Objective 1: To deliver high quality pharmacy regulation that is proportionate and cost-effective					
No	Goals	Current Status	Tending towards	Update - September 2022	SMT
a	We will meet all performance standards in annual PSA appraisals in at least 4 of the next 5 years.			2019 annual review resulted in meeting 22 of 24 standards - work is complete to address the customer service issues identified for improvement in FtP. 2020 year shows failure to meet three standards which is disputed but not appealable. In 2021 PSA have confirmed all previously unmet standards are now met but identified a further standard not met, which is again not agreed.	TP
b	We will secure policy agreement with DoH to make legislative and non-legislative changes required to modernise pharmacy regulation and, following policy agreement, develop an implementation plan for delivery, including delivery of actions specified by May 2023. (Revised 10/1/22).			Whilst we have agreement from the CPO to work together to produce a 5 year plan, it is not formalised. The current impasse at the NI Assembly will prevent any further progress for now. We have however secured agreement to advance the reforms necessary to advance IET reform and await agreement on method to be used. We are working with DoH on updating the Indemnity Regulations and introducing the English Language Regulations	TP

CORPORATE STRATEGY PROGRESS REPORT - SEPTEMBER 2022					
Objective 2: To set pharmacy standards that are evidence-based, output-focused, achievable and necessary for patient and public safety					
No	Goals	Current Status	Tending towards	Update - September 2022	SMT
b	We will test the ongoing efficacy of pharmacy standards in context of the newly emerging HSC reform programme as part of Goal 2(a).			The HSC reform programme and the impact on Pharmacy service provision remains unclear. However, we continue to liaise with the Strategic Performance and Planning Group of the Department of Health in regards to the new developments. We are currently working with the Dept & stakeholders on the emerging pathways for education and this will lead to further work within goal 2(a).	MN
c	We will test and report on the feasibility of developing and applying new standards over and above Minimum Standards designed to encourage improved service quality to ensure that they remain fit for current and future practice. Subject to review at the next Corporate Strategy review.			This remains difficult until the developments in 2b are more clear.	MN

CORPORATE STRATEGY PROGRESS REPORT - SEPTEMBER 2022					
Objective 5: To be an accountable organisation with effective governance and operations					
No	Goals	Current Status	Tending towards	Update - September 2022	SMT
b	We will secure policy agreement with DoH on resolving the current Pharmacy Professional Leadership linkage with the Regulatory function. We will agree a plan to deal with the link between the Leadership and Regulatory functions.			This relates to 1 (b) and, whilst policy agreement with CPO is in place, we await ministerial approval in the current political context.	TP

BY EMAIL:

Trevor Patterson
Chief Executive
Pharmaceutical Society of Northern Ireland

28 July 2022

Dear Trevor,

Adherence to business principles and reserves policy

Each business year, typically in quarter four, the PSA receives an internal audit of its adherence to its business principles and reserves policy.

In order to provide transparency and assure the healthcare regulators that the fees that have been collected have not been used to fund activities outside our statutory duties for regulatory and standards-setting work, we developed business principles to confirm how fees collected will be used. More specifically, all fees from the regulatory bodies are applied solely to the PSA's statutory functions of regulatory oversight and improvement as set out in legislation.

For several years now, including in 2021/22, this annual audit has reported full compliance with the business principles. The audit typically takes 7 days, representing a cost of approximately £5,000 to the Authority.

Due to the history of full compliance and the opportunity costs lost due to not being able to use internal audit services in other areas of our business, we propose to change the arrangements for this audit so that it is done every two years rather than every year. The next audit would therefore be in quarter four of 2023/24 (and would cover both 2022/23 and 2023/24).

I would be grateful if you could confirm you are content with this proposal. It would be helpful to receive this confirmation by 19 August to assist with the planning of internal audits for the remainder of 2022/23.

Thank you for your help.

Best wishes,



Alan Clamp
Chief Executive



Mr Trevor Patterson
Chief Executive
Pharmaceutical Society NI
73 University Street
Belfast
BT7 1HL

BY EMAIL ONLY

Mr Alan Clamp
Chief Executive
Professional Standards Authority
157 -197 Buckingham Palace Road
London
SW1W 9SP

04 August 2022

Dear Alan

Re: Adherence to business principles and reserves policy

I refer to your email correspondence of 28 July 2022 and note the proposal therein.

On behalf of the Pharmaceutical Society NI, I confirm that we have no objection to the proposal.

Yours sincerely

Trevor Patterson
Chief Executive

Policy Name	Hybrid & Resident (Society House based) Roles and Working Arrangements
Policy No	50
Policy Version No	01
Policy Owner	Senior Management Team
Date SMT Approved	August 2022
Date Established/Revised	August 2022
Date for Next Review	January 2023

1. **Scope**

These guidelines apply to all employees of the Pharmaceutical Society NI ("the organisation").

2. **Purpose**

The purpose of this document is to set out the guidelines for Hybrid and Resident (Society House based) roles and their respective working arrangements. Nothing in this document affects the default position, as set out in contracts of employment, that all employees are based in Society House and may be required to work from this location at any time or for all working hours.

3. **Introduction**

The Senior Management Team (SMT) recognises that there are material benefits to employees working together in the same physical location, based on the following principles, balanced with opportunities to work from other locations, subject to business needs:

a) **Belonging:**

An attachment to colleagues and the shared workspace can engender a sense of pride in individual/team achievements and successes; and encourages effective teamwork.

b) **Collaboration:**

Collaboration helps build on ideas, improves team working, time management and productive engagement between colleagues.

c) **Apprenticeship & Learning**

The ability to identify further learning and coaching in specific roles ensures that colleagues can benefit from training and development as set out in the HR Strategy.

d) **Competitiveness & Performance**

Working together, in the same physical location, breaks down silos, drives collaboration and improves individual and collective performance.

4. **Policy**

SMT is responsible for determining the most effective and productive working arrangements for the organisation.

Having examined the remit and functionality of each role within the organisation together with overall business needs and demands, SMT has decided to apply new job designations to each role.

4.1 Hybrid Roles

Where the Senior Management Team has determined that a particular role does not require a colleague, whether full-time or part-time, to work solely and exclusively from Society House, the role is designated as **Hybrid**.

Such colleagues have the opportunity, if they wish, to work remotely for part of their working week, by arrangement with the relevant Senior Management Team member to whom their function is ultimately responsible - see Point 5. The working arrangement for hybrid roles is as follows:

Full-time (5 days/week): a minimum of 3 days working from Society House and the remainder working remotely.

Part-time (4 or fewer days/week): pro-rata but a minimum of 2 days per week working from Society House and the remainder working remotely.

Flexible start and finish times, as per the Flexible Working Policy, remain unchanged.

Colleagues working in hybrid roles are required to be flexible in terms of their working arrangements which may change at short notice due to business needs and other factors.

The following issues may impact upon the continuation of a colleague's hybrid working arrangement:

- Health & Safety
- Performance
- Conduct
- Engagement
- Staff availability

Should any such issue(s) arise, a colleague's ability to continue to work within a hybrid working arrangement will be considered by the Senior Management Team and the hybrid working arrangement may be modified or withdrawn.

Hybrid arrangements will be designed in accordance with the business needs.

4.2 Resident Roles

Where the Senior Management Team has determined that a particular role is no longer permitted to be undertaken off-site/remotely, based on the remit and functionality of the role together with business needs and demands, the role is designated as **Resident**.

Normally colleagues working in such roles, whether full-time or part-time, are required to work solely and exclusively from Society House. As such, no pro rata arrangement applies. Recognising occasional needs for some flexibility, exceptional arrangements may be agreed for occasional home working.

5. Clarification of Working Arrangements

Colleagues who require clarification of their role designation and working arrangements should speak with the relevant Senior Management Team member as follows:

<u>Role/Function</u>	<u>Senior Management Team</u>
Executive Assistant/CPD	CEO/Registrar
Fitness to Practise	Registrar & Director of Regulation
Regulatory Projects	“ “ “
Registration (Registrants & Premises)	“ “ “
Education	“ “ “
Policy, Standards	Director of Public Affairs
Communication	“ “ “
Adjudication	“ “ “
Finance	Director of Business Operations
Reception	“ “ “
IT	“ “ “
General Administration	“ “ “

6. Transition Period & Review

There will be a 6-month transition period during which the Senior Management Team will monitor the effectiveness of and, where appropriate, revise the detail of some working arrangements. Thereafter, a review will be undertaken by SMT every 6 – 12 months.

The default position, should a disagreement occur with an individual employee on designation of role or the operational arrangements for Hybrid working, will be to revert to the contractual arrangement of all their work being conducted from Society House with no option for exceptional arrangements.