

Transcript of the Public session of the Council meeting held on Tuesday 7 October 2008 at The Wales Millennium Centre, Bute Place, Cardiff CF10 5AL

[NB: Decisions in square brackets and narrow type are taken from the unconfirmed minutes of Council and therefore are subject to amendment].

The Transcript of the public meeting of the Council is not the formal record of the meeting. The formal record comprises the papers presented to the meeting and the minutes as subsequently approved. The policy of the RPSGB is actively debated at the meeting. The views expressed in the transcript do not necessarily represent the Society's agreed policy.

PUBLIC BUSINESS

COUNCIL MEETING

Present

President	Mr S Churton
Vice-President	Mr M Astbury
Treasurer	Mr A Gush
Mr S Acres	Ms S Agha
Mr G Alexander	Mrs M Allan
Professor N Barber	Mrs C Brown
Mr David Carter	Dr B Curwain
Mrs D Drury	Dr C Duggan
Dr P Entwistle	Mr J Gentle
Mrs S Hikins	Mrs L Jacobs
Mr J Jolley	Mr A Kershaw
Mrs S Kilby	Ms A Moore
Ms M Saunders	Mr D Simpson
Mr D Thomson	

In attendance

Mrs B Taylor, Chairman of the English Pharmacy Board, Mrs S Melville, Chairman of the Scottish Pharmacy Board and Mr M Donovan, Chairman of the Welsh Pharmacy Board. Mr Jeremy Holmes, Chief Executive & Registrar

The President, Mr Steve Churton: Good afternoon colleagues. It gives me great pleasure to welcome you to the Council meeting in Cardiff. In its 167th year history, this is the first occasion that the Council has been held in Wales. I am particularly pleased therefore to bring Council to Cardiff today and I look forward to a productive meeting.

Helo bawb. Hoffwn gymryd y cyfle hwn i grosawu'r Cyngor i Gaerdydd. Mae hon yn foment hanesyddol, y tro cyntaf i'r Cyngor gyfarfod yng Nghymru ac edrychaf ymlaen at groesawu cyfweithwyr o Gymru ac at gyfarfod cynhyrchiol. **(Applause)**

1. Apologies for absence

Apologies have been received from Bob Michell, Jane Ramsey, Ray Jobling, Keith Wilson, Marcia Saunders for Wednesday, and Gerald Alexander and Brian Curwain, who are both also leaving at midday on Wednesday.

2. Declarations of interest

Just to remind Council members, they should declare any interests at the beginning of the relevant agenda item.

3. Welcome to guests

I welcome our guests today: Marilyn Davies from Morgannwg Branch, Mair Davies, Fiona Price and Peter Jones from the Welsh Pharmacy Board; Damien Dowling from Cardiff & the Vale Trust; Kate Kinsey from Manchester Branch and Martha Rogers from Guernsey Branch.

4. Minutes of the public business part of the Council meeting held on 24 July and 4 September 2008

Could I ask for any accuracy issues to start with?

Ms Alison Moore: I have an amendment to these minutes. They said I nominated David in the June minutes and I did not. It is not on the June minutes, but it refers to the June minutes in the July minutes, page 2. It says: "*David Thomson was nominated and seconded by Alison Moore.*" Much as I would have loved to have nominated David, I was actually nominating Catherine at the time, so I could not have.

Ms Averil Ridgway, Head of Secretariat: I will go back and make the right amendment.

[Council resolved that the minutes of the public business parts of the meetings held on 24 July and on 4 September 2008 be received and agreed as a correct record.]

5. Matters arising from the minutes of the public business section of the Council meetings held on 24 July and 4 September.

There is one matter arising.

Ms Averil Ridgway: If I could refer you to the minutes of 4 September on page 2, item 08/98, *Policy and Communication Forum*. This was discussed at the Officers and Executive Away-day and it was proposed that the lay member of Council working with Officers and the fourth member of Council elected to work with Officers should also be members of the Forum.

The President: Can I ask whether Council are content with the suggestion? **(Agreed)**

[Minutes of 4 September 2008: Policy and communications forum (minute 08/98 refers) - Following discussion at the Officers group and Executive away day, Council agreed that in addition to the Officers the other two members of the Council elected to work with the Officers would also be members of the Forum.]

Professional leadership matters

6. British Pharmaceutical Conference

Mr John Gentle: I think everybody is aware that the new professional body, in our opinion, may not have the resources, both financial and in terms of people and time, to devote to support BPC in the way it has been. Over the last 12 months, the Committee, staff, Council and particularly the finance department are looking at ways to rearrange and refocus BPC. Part of that was done this year and that would be made more dramatic and significant next year, with BPC science and practice programs.

The main thing we did this year was to move BPC to a Sunday. The idea was to attract more community pharmacist members and greater attendance in general, primarily to conference. The initially reports we have had so far in the surveys and analysis that has been done are basically good. The numbers, in terms of attendance, was good. We had a record single day attendance on Sunday than we have had in recent years. The feedback we are having on things like the success of the conference dinner, the ... **(Inaudible)** from the exhibitors and sponsors is overwhelmingly positive, which is very reassuring for those of us moving forward to next year.

Some of the things that happened at this year's BPC were certainly successful. There was positive feedback from the President's address, both on style and content, so well done Mr President for that.

Also on the hot topic sessions that were organised with people like Nigel Clarke and Ken Jarrold and Jeremy, on the Responsible Pharmacist and the new professional body. Again, the feedback we have had was very positive. It suggests that there are a lot of pharmacists out there who are interested in hearing about these things, if we make it easy for them to hear and we deliver things in the right way.

It is tempting sometimes to believe that most of the profession do not care about the new professional body, and that it is difficult to engage with them. But I think there is evidence to show that if we make it easy for people to get information, then very often they will respond and they are concerned. TransCom was at the BPC. A lot of students went to the BPC, which is good. It is a very positive thing to see younger members who are about to enter the profession going to BPC and taking part in the pre-reg conferences there and also the Forum.

In general, the media coverage for the BPC was extensive. It is getting better year on year. If you go back five or certainly 10 years, the national media almost ignored the conference. There were 27 main articles in the national press, papers like The Mail, The Independent, The Telegraph - national broadsheets and the tabloids.

Most of those referred to items that were in the discussion sessions at BPC, and were quality news items. The main feedback from the Conference will go back to members in a week or two by its extensive supplements in the Journal and a DVD with a summary of BPCTV highlights, going to all 40,000 plus members.

Some initial numbers. I will not bore you with all the stats, but some of them are interesting. We have had 200 plus people responding to the survey so far. Two-thirds have said they attended BPC for the practice programme, which is interesting again, based on the impression about the number of community pharmacists who go. But it is not just community pharmacists who go to those practice programmes, but also hospital pharmacists and academics.

Forty percent strongly agreed that Sunday opening was a good idea and just under 20 percent agreed it was a good idea. Almost two-thirds of people believed it was a good idea. From the buzz and vibe they felt that things had gone much better this year.

The quality of the practice programme was rated good by 64 percent as a response in the survey.

One slightly negative thing was that 48 percent of respondents said there were too many sessions of interest happening concurrently. It is always difficult to pitch this. If you put on one session, you put on another that would appeal to a different cohort of people. In the practice session, both sessions will appeal to pharmacists in practice. Therefore, it is very difficult to know which pharmacists want to go to which sessions unless you ask them in advance, which is a non-starter practically. It is something to bear in mind and that we are aware of on the Committee of organisers.

Two-thirds of respondents indicated "we are happy with the current mix, in terms of network and session time at BPC". It was interesting that over 90 percent of people who responded to the survey so far said they had learnt something new and of real value from the conference, which is extremely pleasing for those putting it on. It is important at this point to note the contribution made by the Science Chair, Andrew Lloyd, and the Practice Chair, Carmel Hughes, who both did an excellent job. There were a lot of the positive things coming back on the quality of the session. When people report back at 90 percent plus, levels that they have learnt something new and valuable, that is primarily down to the content and those two people.

The President: Thanks John. Can I put on the record Council's thanks to Andrew Lloyd and Carmel Hughes and of course to John for chairing the BPC Committee. I think it was a great success. Any questions for John?

Mr David Carter: I would like pick up on the Sunday, John, and congratulate you and the team for a superb day. As Chair of our LPC you know I took the LPC Committee down. It was an excellent day and there were certainly quite a number of them. It was an excellent day, very relevant to community pharmacists and everyone who went wants to go again next year.

Mr John Gentle: The only drawback to Sunday is the transport links around the country on a

Sunday. We were unfortunate with the weather which was horrendous. It is difficult to get around on Sunday morning very early, if you have to travel from Scotland or the South of England, South Wales and Manchester. You are talking of very early starts. We may look at an overnight stay on Saturday and making it easier for people ... **(Inaudible)**

Mr Douglas Simpson: I travelled on the Saturday and that was no better, because of the West Coast Line. So that is no solution, I am afraid.

Mr Andrew Gush, the Treasurer: I would like to have on the public record our big thanks to John. Under his stewardship we have gone from a conference which was a huge cost to the Society to one which is on course to break even or even show a profit. Well done, John Gentle. **(Applause)**

[Council noted the report.]

7. Branch Representatives Meeting 2008

The President: This item is to agree the Council responses to the motions. Background information was previously agreed by the Council and is not really for debate at this point in time. Council members were circulated with the Council response for comment on 10 September for comments. Those received have been incorporated into the paper today. I would be grateful for those who have submitted comments to ensure that they have been incorporated.

Mr Gerald Alexander: I must apologise to the President and the staff. I did not comment on Branch Motion F, Harrow and Hillingdon on page 17/27. I apologise for that. This is a sort of regulatory matter. I find some of the language in the response a little too watered down. It says at the top of the page: *"It is likely that the European Commission would consider this requirement to be burdensome."* Do we know for certain? I am not happy that we are guessing. The other thing is the next bit: *"Were the Society to introduce language testing for EEA nationals this would be contrary to the policies of other UK healthcare regulators and contrary to Treaty rights and free movement."* Again, it is a little too weak. Further down, we have said *"Council is supportive of the motion, but notes the letter clarifying the position of language testing of European nationals and the Chief Executive and Registrar of the Pharmaceutical Society of Ireland."* I do not remember seeing that, so I apologise. I would like to see it.

In the next statement it says: *"The Council hopes that the blanket restriction on language testing of European nationals in the Pharmacists and Pharmacy Technicians Order may be amended."* I think we need to say something a bit stronger than "hopes"; it is too aspirational. Quite frankly, we either have an opinion on this or we have not. I believe that we should be language testing. So regardless of whether it is contrary to the rules and regulations of Europe, best practice demands that we promote public and patient safety. The organisation does promote patient safety and hoping is not consistent with patient safety. I think we should actually say it loud and clear.

Mr Martin Astbury, the Vice-President: Can I support what Gerald said? The Officers and Jeremy have assured me that there is work going on behind the scenes to try and bring something to Council regarding this issue and the position Ireland certainly have. But I totally agree with you, it is not necessarily 'hopes'; we should be doing something to ensure that something is done about this inequity that is there at the moment.

Mr Gerald Alexander: I think it is a matter of policy and how we say it. The profession and the public need to know we are very supportive of patient safety. And writing narratives like this does not support our position, so I think we need to be firmer in our response.

The President: Do you want to suggest a form of words, Gerald?

Mr Gerald Alexander: At a later stage perhaps we can talk about that, but we need to be more than aspirational.

Mr Jeremy Holmes, Chief Executive & Registrar: Can I respond briefly to say yes, we can revise the wording and we are seeking to influence the drafting of the Section 60 Order in this particular respect. I have raised the issue with the Chief Executive of the Steering Group where the nine healthcare regulators sit around the table with CHRE, because this issue is not unique to us. The regulators need to have a common position on it, and it should be a very strong position in the interest of patient safety.

Ms Alison Moore: I have a query on Motion B on paying by cheque and resource implications. When we are asked for comments, I asked how much it would cost the Society to go back to processing cheques. At the moment it says "this is how much it would cost us" and I think I was told £100,000. If that is case, I am surprised, and we should perhaps put that in the resource implications, so people can see that the cost of setting up a working group to look at this issue is nothing at all related to the cost that it would be to the Society of going back to using cheques. Is that really the case? Am I right on the figure? It sounds huge.

Mr Andrew Gush: It is the cost of administration which pushes it up greatly. The smaller the number of cheques, the more expensive it gets to do. The number of cheques we receive at the moment is still small. Therefore the cost is disproportionately high. I cannot actually say what the exact cost is, but it does not surprise me that it is so high.

Ms Alison Moore: Could the comparison go into the resources implications? Otherwise it looks like we are spending money for no reason. I wanted to say something quickly on Motion E, on MURS. I did comment at the time, and I think that my comments have been taken into account. The only thing I still wonder about is the wording. The point of the motion was very much that pharmacists did not want to be driven by targets and costs when doing MURs. They wanted to be able to focus on it in a professional manner. I do not think the first set of phrasing indicates that the Council has taken account of the fact that it is targets which are concerning people when they were writing this motion. The first bit picks out two little phrases from it, but misses out the bit about they must do it in a more professional manner and not be driven by targets and costs. At the bottom, however, it does now say the motion raises concerns about the use of targets and says that we are going to publish information and support on that. Can that be highlighted further up the paragraph, because I think that is the key point of the motion? It looks as though we are trying to talk around it.

The President: Okay. With those amendments on board in Motion F, if we could find a new form of words to speak to Gerald's points on the Council response to the motion. Perhaps you could suggest some words for that. That would be helpful. On Motion D, if we could put resource implications into the issue you raise, Alison. Also in Motion E, if we could strengthen the point Alison has made? Apart from that, are we agreed? **(Agreed)**

[Council agreed the Council responses to the resolutions of the Branch Representatives' Meeting on 22 May 2008.]

8. Pharmacist Support

The President: We are to receive an oral report from the Chairman of Trustees.

Mr David Thomson: Bore da and grateful thanks to the West British Branch! **(Laughter)** I am extremely grateful for the opportunity to update Council on what has been a very hectic period for what was previously known as the Benevolent Fund and is now Pharmacist Support. I hope that change of name has not escaped your notice. It has been around for some time that principles of benevolence have been embedded in the pharmacy profession for some time. Sandra kindly gave you that background this morning.

Changes were required in 2006 as a result of changed legislation within the Charities Commission. That brought in a requirement for the Society to look at how they handled the Benevolent Fund differently. They brought in a new board of trustees. Previously all Council members had been trustees of the Benevolent Fund, and the day-to-day working of it had been devolved to a small subgroup. It consists now of two Council members (myself and Seema), two lay members and four Fellows of long-standing. They are charged with the

day-to-day running and are accountable for the operational performance of the Fund, and they treat the responsibility very seriously without exception.

Part of the efforts since 2006 have been to develop a business plan, and in part to take forward a marketing plan. The outcome of that, and one of the major tangible elements of that, was to recruit a new business manager. I am delighted to welcome David Qualter, who has been with us roughly 12 months. It must be coming up to his first anniversary and he has done a sterling amount of work in that short period. I think the pace of development will only add additional workload to your burden, David, so well done for that.

Part of the review procedures was to look at how the Fund stood in the eyes of members. We issued a questionnaire earlier this year through the PJ. I think in the first weekend it had about 600 responses in the first four days of it going out, so a tremendous response.

Off the back of that we also held three focus groups across Great Britain, one in Scotland, one in Cardiff and one in London. The findings from that identified the strengths and weaknesses of the previous arrangement. There was certainly good recognition of the strength of the organisation, in that Listening Friends and the Pharmacists Health Support Programme were identifiable by members as a good service to provide. The advice offered through the network and the signposting was also appreciated.

It also highlighted some weaknesses that we would be ill-advised to ignore. The messages came back with a clear and strong opinion of a need to change and heed those messages. There was strong concern and challenge to the perception of a close association with the parent body. A link with the RPS was seen as a handicap to the development of the Fund.

The term *benevolent* was confusing. It was fairly archaic language and meant something different to what people were expecting it to deliver. The most concerning issue was that because people did not recognise or appreciate the Fund at that stage, applicants often came to us as a last resort. Consequently, the situations they were in were very much more drastic and severe than if they had approached it earlier.

So from that exercise and a clear message to do something, and do something quite quickly, we recruited a consultancy called Three Day Week, who provided excellent input and support. That was manifested in the re-launch at BPC of the Fund as Pharmacist Support. I know many of you will have seen that and came to the stand at BPC. We had a lot of interest demonstrated at BPC from those attending Conference. We brought Pharmacy Support as a new brand. It does what it says on the tin; it means what it is supposed to. It came from the grassroots questionnaires and the focus groups themselves. It was the grassroots members who identified that and strongly suggested that was the best name for the organisation. It is trying also in the future, as we realise the ambitions in the Charter objects, so the principle of that has not changed as we move forward. Also to meet the requirements of the Charity Commission -- because we cannot ignore those. We would fail and expose trustee members to scrutiny if that arose. But most importantly, we meet the needs of our members as we progress the Fund forward. Certainly with the developing de-merger of the organisation, the pharmacist support element fits neatly into the membership organisation as a tangible, helpful and meaningful service direct to members.

The only other issue I might suggest is also we have launched the Fund in a way that promotes the services. We have had a considerable demand on the service since it was launched. That is to be expected and we very much welcome that. We have had a doubling of contacts since the re-launch in September.

The next phase you will hear of in due course will be a request to support the Fund financially. So if I plant those seeds with you now, in the future we will be issuing direct debit forms for you to complete and return in due course, but that will be next time. For the moment, either David and myself are happy to answer questions.

Mr Douglas Simpson: Presumably we will be seeing him with a clipboard standing outside as we walk past the shopping precinct on the way to the hotel! I want to emphasise what

David said. I was a bit disturbed to see that the Pharmaceutical Society, when you did your research, was seen as a detrimental link and as not a good thing for the Fund to be associated with the Society. I was very disappointed to hear that. In the future, it will be very good that the pharmacist support is going to be linked to the Society. It is going to be part of the services which we have always provided, ever since we were founded in 1841. We have always seen the need to act in a benevolent way to help people who have come upon hard times. It is a very important thing for the future and an important part of the basket of services we offer to members.

Chief Executive & Registrar: The research was disappointing in that respect, I agree with you, Doug. It is primarily a result of our regulatory role. Moving forward to the new professional body, I think there is an opportunity for a very productive relationship. Indeed, I went to a meeting of the Benevolent Fund trustees, which was very constructive. We discussed the nature of that relationship and agreed a statement which was circulated to Council members in the so-called Friday letter, which just encapsulates the kind of relationship we want to see: benevolence as a genuine benefit and service to the members of the professional body.

Ms Marcia Saunders: I chaired the Appointments Panel for the new trustees a couple of years ago. I would like to congratulate David, David, Seema and the others. Just listening and seeing the presentation outside, it really has moved on fantastically. It was difficult in chairing the Panel to convey to people what it was about and what the issues were. That has become much clearer now, so I really congratulate you.

Mrs Margaret Allan: Can I ask a question on how we are promoting this to the profession? I feel that there are a lot of people out there who are not aware of what you could offer.

Mr David Thomson: David might come in on this. We have a communications programme. BPC was obviously crucial to get the message out there, but beyond that a series of articles in the pharmaceutical press to keep the brand alive, and to keep it in the members' eyes as we progress elements forward. There is a dedicated website and promotional material that is on the branch speaking programme. There are a number of ongoing events to keep it active.

Mr David Qualter: From BPC we have a big communications plan now in place. Part of it is to look at organisations we can link with to reach the membership. The BPSA, for example, and their regional representatives. We can cascade information down to student groups and so on ... **(Inaudible)** and it would be possible to put it in the national press ... **(Inaudible)** ... not in the community we need to reach them. So we have a big plan.

Mrs Margaret Allan: Is communication going to be two-way back into the new body, so if there are issues that you are identifying with our workforce, if there is something we can do, you will be feeding that back?

Mr David Qualter: Yes, it is. We have a new website and we want to make it as interactive as possible; meeting with branches and so on and getting people's opinions. We have feedback on information and so on and we are looking at that constantly. We did the online survey in February and we want to look at doing that every year or so. We are focusing on what people really want.

[Council noted the report.]

9. The Society's Awards

The President: Thank you, David. This is paper C88.

Chief Executive & Registrar: This is first of all a summary of the awards that the Society currently makes. I would like to draw your attention to the appendix, which lists the current awards. The Academic Excellence Awards are the subject of a separate agenda item, item 32. You will see the other various awards on that Appendix. I just draw attention to two more of them. The penultimate one on the first page, the GlaxoSmithKline Achievement Award is not, strictly-speaking, a Society award, but it is awarded by GSK and the lecture associated

with the recipient is given at the BPC. Over the page, a third of the way down, the Safety in Medicines Award is not the award made to Bill Scott earlier this year; that was a separate award, just for clarity.

The proposal is that we should put hold on the creation of new awards pending the development of the new professional body with, I would like to suggest, one exception which has come up since the paper was drafted. That is that we consider at the Branch and Regional Secretaries Meeting on 17 October an award for a local champion. It is an idea that John has been very keen on, which I understand has come up before. In the BRSM meeting I think it is a great opportunity to signal our desire to support local champions and the importance of grassroots innovation and leadership. So I would like to make that exception, if the BRSM and indeed the branch sponsors, John and David, pursue the idea of a local champion. I would like to make that exception to the principle of creating no new awards, pending the development of the professional body.

All other awards, I think it would be unwise for us to pre-empt what the professional body will decide on its strategy for awards. This paper is going to TransCom, so it will form part of their thinking. But I would like Council's agreement not to create any new awards for the time being.

Mrs Sue Kilby: I totally agree with what you are saying, Jeremy. It is just really on the issue around Fellows. I was partly horrified, but also pleased, that recently there were a number of people made Fellows who actually I thought should have been made Fellows years ago. Two of them are sitting in this room. One is Beth Taylor and the other is Gerald. There is also Tony West. These people have been serving our profession for years. In fact, Beth received a public honour before she was made a Fellow of the Society. I would like to encourage pharmacists sitting around this table to think about the people they work with; to think about the people they work and have contact with and actually think, should they be nominating, or if you are not a Fellow -- which most of us are not round this table, is they could get a Fellow to nominate and then they could support. I am pleased to be able to say my four Chairs of Practice, when I was Head of Practice, and my former Chair that I worked with most closely, are now Fellows. All those people served me amazingly well and also the profession. They have put in a lot of time and effort and also risen to a high level within their own specialty. I do not think we honour enough of our members, and I think everybody around this table who is a pharmacist should not be here unless they are actually prepared to think about who they should be putting forward to be made a Fellow.

Mr John Jolley: One point of clarification. We are talking of continuing with these awards, as you have defined them in appendix 1. Up to what period of time? Presumably once the new professional body takes over in 2010, then they have the right to determine what awards they are going to adopt. So are we talking of continuing this list of defined awards on appendix 1 up to January 2010.

Chief Executive & Registrar: That is correct, John, with the exception of the separate agenda item on academic excellence awards. I am very hopeful that TransCom will make some specific recommendations, either in the prospectus or thereafter, on what the award strategy should be for the new professional body. But up until the point at which that body is launched, the proposal is that we should continue with these, but not create any more, with the exception I made about academic excellence.

Dr Catherine Duggan: I must declare an interest as Chairman of the CPA. I wonder whether there is an opportunity in capturing, following on what Sue was saying, other associations and groups which themselves have developed awards for different levels of practice, contributions to that specialist area. One of the big wants from the profession has been a professional body that recognises you as a professional. Whilst the Pharmaceutical Society has got a plethora of awards, I think other groups have got examples of where they have made those awards. I think the branch one is an excellent example of being flexible and being able to recognise good practice out there where it has not necessarily been recognised in the past. But there are groups that have many awards that might be able to contribute to member services.

The President: With the exception of Local Champion, are Council agreed that no new awards should be created until the professional body is established? **(Agreed)**

[Council agreed that, with the exception of the local champion award, no new awards be created until after the new professional body was established.]

10. Pharmacy Practice Framework

Could I remind Council that this is the final stage of a Council-led project which started in 2006. The project was overseen by a Council working group chaired by Graham Phillips that involved all special interest groups and committees at the Society and the PPI team, to secure valuable input from across the profession and from the public and patients. The framework will inform the setting of both regulatory and professional standards and provides a foundation for the development of advanced frameworks in key areas like industry, veterinary pharmacy and the definition of advanced general practice and specialist clinical practices. It is an important project for Council to consider at this particular time. Sue, could you introduce the paper for us?

Dr Sue Ambler, Education Policy Lead: It has been a long time in the hatching. I would like to thank Graham and other members of the working group who stood by us through thick and thin with this project, and all the special interest groups and committees who helped us with the first draft that went out for consultation. It is all the people who we met on the road, who responded to the written consultation, who phoned us up and emailed us. We really owe what is in front of you today to them, and to my colleagues, who rubbed me down with a damp edition of the PJ when it all got too much for me!

I guess the thing to say is that this has already been shared before it came to you. We had a couple of opportunities. One was the Education Policy Seminar last week. That is one of the things that this document will lead to next, which is the definition of the education standards. It is where the project started and where it goes to next within the Society through the Education Committee. I guess the thing to say is because we are saying in this document that this is essentially the scope of practice for day-one pharmacists. I took the opportunity over the summer of sharing it with the drafting group of educational standards, just to ensure that what was in the document could be delivered by Education, Pre-reg and the schools of pharmacy. The feedback from the drafting group was yes, most of it could. But as a result of those discussions, a couple of the activities are highlighted now, because they do not really think we can get there on day one without significant changes, which may come along. That is why those things are highlighted now, and I owe the group a lot of help. I do not intend taking long to go through the document, but I know Marcia wants to say a few words, as she was on the working group with me.

Ms Marcia Saunders: I want to commend this piece of work to you, and particularly to draw attention to the chart on page 23/59, which identified the other processes that influences practice. I think this is going to be a very useful schematic diagram, and also to the diagrammatic deconstruction on 29/32, which needs to be published in a very simple and punchy form. I think it will have the same kind of impact that *Good Medical Practice* has had in the medical professions. If it is published in an attractive way that people can have at their fingertips, it would be very helpful. I think this is very timely. The paper does point out that in times of change, it is really useful to have a fixed point and a set of four principles. It will, of course, change over time. I doubt the core principles will change much over time, but I think a lot of what follows from them will. I would see this as a living document. At the moment, it is also particularly timely, as it will influence both the regulator and the profession body in the standards setting process. I had a minor role in this. It was a great privilege to be part of it, and I learned a great deal. It will be of huge benefit as this organisation moves forward in its de-merged form.

Mr Douglas Simpson: I declare an interest, as I have been a great follower of the concept of pharmaceutical care. When I used to work for the Pharmaceutical Journal I had the great privilege to go Minnesota to interview Professor Linda Strand and the people working in Minnesota on the Pharmaceutical Care Project. Linda, as many of you know, spoke at the

British Pharmaceutical Conference in Manchester. I spoke to her afterwards. I am sure she would be absolutely delighted with what I can see on page 27/59, where we talk of the five roles and descriptions, where it talks about pharmacists ensuring they have ownership of the safe, rational and cost-effective use of medicines. I think that is at the heart of the pharmaceutical care concept, which she has been developing and pretty well leading the development of that particular project. I think she would be absolutely delighted to read those particular sets of words, and I am too.

Also, when we turn to page 4, we talk about working with the patient on a care plan to ensure the effective use of medicines. Again, this is a concept at the heart of the pharmaceutical care process which is being developed, not only in America but also in various projects in the UK, but Hemant Patel in Barking and Claire Mackay in Glasgow. I wanted to commend that part of the document. It is the heart of the document and it is reaching for the stars, but we should be reaching for the stars. So I want to commend the document to everybody.

Dr Catherine Duggan: Thank you for an excellent report. This feeds in superbly well with the work from the working group in TransCom which has the biggest acronym, the Improved, Advanced and Specialist Practice Working Group. This will form the bedrock, if you like, of day-one practice with aspirations. There are the framework and things the group has researched and put forward as a progression of opportunities. This is absolutely the bedrock of our professional development. I am not sure which fits exactly with the regulator and which with the professional body, but we do know that the two dovetail at points anyway. So this is a superb piece of work. I am mindful of the fact that other pieces of work have gone on, and are going on, to think about progression thereafter, which I think is very important for our profession to be aspirational towards.

Mrs Sue Kilby: I think this is an incredibly important piece of work, as it will inform the M MPharm. It will also be a basis for revalidation for the future. Therefore, we have to look at it very carefully. Graham was very much involved with the original practice framework and he did a lot of work, actually going out and working with the reference groups. When he saw this document -- because he was at the education strategy day -- I asked him for his comments on this document, and he said it did not represent anything that he had actually seen before; that there was a significant difference in what he had actually been working on and what was now produced. It does not mean that this document is actually a poor document; but it is actually different from what the group was actually working on. My concern is that the Practice Framework Group, when Graham came off Council in May, no pharmacist was appointed to replace him. The technician member was Lesley Morgan. No technician member was appointed to replace her. So two lay members were left with Council. There was no pharmacist and no technician. We have not had involvement with this in the current Education Committee at all. It has not been to Education Committee, so I do not want anybody around Council to think that Education Committee has been closely involved with producing this document; they have not. Again, it does not mean that it is a poor document. I just want to make it very clear that it has not been there. I think we do need to check what is actually in the finer details before we actually sign it off. So that needs to be managed in some way. That is what I want to say to Council.

Ms Marcia Saunders: I guess I am the only continuity sitting around the table, and I actually disagree that this bears no relationship to the earlier work. I think it *is* the earlier work, it was just tightened up, and I think it is excellent. I do feel I am the only continuity here and that is what I would like to say.

Chief Executive & Registrar: Can I add a point to that? My understanding is that Graham is very happy with the document. He has no difficulty with the content. The process has been a long time in gestation, so there is going to be some change of personnel. I think we have arrived at a very good place, and this is a very important document which will be an underpinning for so many other things, including the work of the Education Committee work going forward, and indeed a lot of working groups on TransCom. Not just advanced and specialist practice, but CPD as well. There is a practical application of this through mechanisms like CPD and the education programme. So I think it needs to feed through into those work streams, but my understanding is that Graham Phillips is very supportive of this.

Mrs Sue Kilby: Well, it is not what he said to me.

Professor Nick Barber: Some minor things on working. Coming from the point that we want this to be seen widely, internationally, I think the two things which struck me on the patient-centred care was (a), (b) and (c) do come over very much as the person as object. You could read that as: *What are their needs? Oh well, they are overweight. They've got a gammy leg and therefore they need to lose some weight and do this, that and the other.* When you go down levels, you do get to engaging with the desired health outcomes of the patient. I think there could be some rewording of that section around engaging with patients once and their aspirations and helping them meet them, and making it sound much more positive. We might want to think about that.

The second point is to some extent a pet one of mine. One is that concordance still means nothing to most of the world. And what happens, if we are going to be talking about ourselves as prescribers, and engaging with other prescribers, most prescribers – certainly in other countries and in this country – do not use that terminology. We want to engage with patients and to work together towards agreement. The other thing is that the definition in the glossary is not the definition on the website. That is one of the problems with concordance; its definition has changed markedly over time. Doug and I have clashed over pharmaceutical care in the past, but we both agree with the ends and where it is wanting to be. I am still not keen on the term, but if you are going to use it, then define it, put in the definition, because it is a pharmacy-only term, which does not communicate to other people what we are about; the same ends as prescribers and, we are going to be prescribers, so let us use that.

Dr Brian Curwain: I welcome the work. It is a huge piece of work that has been done. It defines what we are as pharmacists wherever we are working in the profession. Those of us on the Science Committee will be very pleased to note that science is clearly there as the background of what we do, as well as our clinical work.

Mr Steven Acres: I respond to the point of having a technician on the group. I was not around when the group was formed. My guess is that Lesley was on the group because of her wider academic interests, and not necessarily as a pharmacy technician, because this is a framework for pharmacists and not technicians.

Ms Seema Agha: Should this not have gone through to Education Committee at some point as a final sign-off?

Dr Sue Ambler: No. This is a Council working group that was set up. So it has always been owned by Council and Council appointed the working group. Graham was the Chairman as a member of Council. It has been taken forward by the Education Committee Standards Group, which was the work I was referring to, but because it cuts across fitness to practise, practice, Code of Ethics and all those things, it was a Council working group. But Education Committee was consulted in the first draft, along with the Practice Committee and all the special interest groups. So it was basically taking it and giving it a much wider construct than Education in the first place, but it is going back there with the standards.

Ms Seema Agha: There is some divergence as to whether or not Graham Phillips has agreed the version. So I think we need to resolve that.

Dr Sue Ambler: Maybe I can shed some light on that, because the working group never met again after Graham chaired the last one. Basically, it was tidying up, sending it out over the summer and working with the Education Standards Group that has been happening over the summer. So the group never met and it did not change substantially from the draft that was seen in April. It got tightened up and of course we put the highlights in, after we spoke to the Education Drafting Group. But beyond that, it did not change at all after that, and there was never any intention that it would meet after that.

Mrs Cathryn Brown: On the glossary it talks about practising pharmacist, and then the definition goes on and talks about pharmacists or pharmacy technicians. What are we

defining in the glossary? Are we defining 'Practising'? In which case it should be pharmacist/pharmacy technician in the glossary. Or are we trying to define pharmacist? It is not very clear.

Dr Sue Ambler: I think that is a hang over, because when we started on the document we were trying to get one overarching document for both pharmacists and technicians. As it has gone through, it has become clearer that one has to be done for technicians to inform their education standards. I guess that is a hangover, so I will go back and check that.

Dr Catherine Duggan: I should have raised this in my earlier point. I have the same concern about advanced practice, because I think there is a difference in there between advanced and specialist, and the work I **(Inaudible)**

Dr Sue Ambler: We will make sure we get that right.

The President: Thank you for a useful discussion. If I can summarise, what I am hearing is that irrespective of how we have got here, we have a very good paper on our hands, with near universal applause for the paper and the outputs. Could I suggest, with the comments made by Nick and others in terms of amendments, that we go forward and Council agree (i), (ii) and (iii)?

Mr John Jolley: I agree with what you have just said, in that it is an excellent paper. My concern is that we are proposing to put this forward without total agreement and commitment, certainly by the key standing committee in education. I would have preferred this paper to have gone to Education for consideration before it had come here. What concerns me greatly is that we move ahead on this without Education's agreeing to the principles of this paper. We may then subsequently in years to come find that there are some issues and we have not necessarily got full and total commitment. So I think we have to consider that step of getting ratification from the Education Committee before giving total and absolute acceptance to this excellent paper.

Mrs Sue Kilby: All I was going to say was that if it is to be agreed, could we at least spell Graham's name correctly, because it is in here as Phillips with only one L in it. Because if there are errors like this, I would not want to agree it as it stands. It needs to be looked at by somebody. I am not criticising the paper in its totality. We need it, it is important and it is a good piece of work but it needs to be looked at by some group, someone, to actually check that it is actually acceptable.

Mr Gerald Alexander: As a Council member who has not been connected with this, other than knowing that it was in existence and was going through the process, I would like to hear more comment from members of Education Committee, because that sits within the remit of the Education Committee. I think Professor Barber has spoken, and he has found one or two little points in there. Would Professor Wilson be on the same Committee? He is not here today. And Margaret, you were on the Committee. I would like to hear more praise. I am sure it is an excellent paper. I believe that to be the case, but I would like to hear the Committee backing this paper so the Council can feel absolutely assured that what is before us allows us to see that it is right for the future.

Dr Brian Curwain: I am seeking a little clarification, because this is the pharmacy practice framework. I am not sure why Education Committee are becoming quite so exercised about it, and the fact that that Graham was Chair of Education, which is a separate body. The Practice Committee was subsumed into the National Boards. So I think we should leave the paper as it is, correct the typos and not make a big song and dance about it.

The President: Just for a point of clarity, when is the next Education Committee?

Mrs Sue Kilby: The 24th.

The President: Cutting to the chase, can we go to a quick vote? Those members who would prefer it to go to Education in October before it is signed off, please show. **(Vote taken:**

Carried) So can the paper go to Education on 24th? We will bring it back to Council in December.

Can I thank Sue and the Council Working Group for the paper. I think it is an excellent piece of work, notwithstanding it should go to the Education Committee. I thank them for their work, which has been a long process. Thank you very much.

[Council agreed to refer the Pharmacy Practice Framework to the Education Committee for consideration prior to Council discussion in December 2008.]

11. Research strategy 2007-2011: Update on progress

The President: Item 11 is for noting. I do not propose to take questions on this.

[Council noted (i) progress made in commissioning the first phase of projects taking forward the second 2007-2011 Research Strategy which focuses on three priority areas: patients, medicines and professionalism in pharmacy; patient safety and pharmacy practice; social capital, health inequalities and pharmacy, and (ii) progress made on completing (publishing and disseminating) projects from the initial 2002-2006 Research Strategy which focussed on three priorities: workforce, education and ethics.]

Regulatory Matters

12. Rules: Fees 2009

If I could follow through on the back of this to item 16, both for the Treasurer to introduce.

Mr Andrew Gush: It is a great privilege to present Council in Wales. As Treasurer, I have been asked to comment over the last few weeks of the cost implication of holding a meeting in Wales. There is one unique cost implication of doing that. Those who drove will see that you paid to come to into Wales, and you do not pay to go into England.

Moving on, I would like to take you to agenda item 12, paper 08/10/C92, Rules: Fees 2009. I thank Wendy [Harris, Deputy Registrar & Director of Regulation] and the team for producing this procedural paper. I always enjoy my collaborations with Wendy and colleagues in the finance team.

The purpose of the paper is to make rules under the Pharmacists and Pharmacy Technicians Order 2007 relating to the collection of fees for 2009, and to be updated with regard to the Privy Council approval of changes to the byelaws. This is the next part of the process of Council's discussion on fees on 4/9.08. A copy of the proposed rules is found in Appendix 1. The required gazetting has been completed and subsequently the revised byelaws have been sent to the Privy Council for approval.

The risk implication to the Society. The Society will not be able to send out requests for retention fees for 2009 at the end of October 2008 unless the rules are made. The action required of Council is to make the rules as attached to appendix 1 and secondly to note that following requirement for gazetting, the revised byelaws have been sent to the Privy Council for approval.

Mr Douglas Simpson: At (i) it talks about the fee being funded by an increase of retention fee for practising pharmacists of 4.5 percent. Of course, that is not correct. It is an increase of about ...**(inaudible)** It is a factually incorrect statement to put it as baldly as that.

Mr Andrew Gush: You are absolutely correct. It should say the practising pharmacist fee increased by 4.5 percent, ...**(inaudible)**.

The President: Can we move to (i)? Is that agreed? **(Agreed)** (ii)? **(Agreed)**

[Council (i) made the Rules as attached to the paper, and (ii) noted (ii) that following the required gazetting, the revised Byelaws had been sent to the Privy Council for approval.]

16. Board of Examiners Fees

Mr Andrew Gush: I draw your attention to paper 08/10/96, Board of Examiners fees. I thank Wendy and her team for producing the paper. The purpose of the paper is to consider the level of fees payable to the Board of Examiners. The action required at (i) is to agree amendments to the fees for examiners for the remainder of 2008, as set out in the table. The proposed rise for the Chair is £330. That is both in England, Wales and for the Scottish Chair, and for all members' fees to rise to £223.

The second action required that is the fees for the Board of Examiners, Chair and members should in future increase annually and remain in line with those paid to the Chairman of Health, Investigating, Registration Appeals Committee and Accreditation Panel team leaders, and for members, the fees paid to the panel members for Health, Investigating, Registration Appeals Committee and Accreditation team members.

The paper clearly states that appointments to the Board are made on the basis of expertise. It describes its remit, accountability and appraisal process. The Board provides specialist expertise that ensures that the registration exam is quality-assured and fit for purpose. The operation of the Board is the most cost-effective way of providing this specialised advice. Currently, the Chairs and Board Members receive a flat committee rate of £160 per meeting. Due to the work carried out and the high level of accountability, it is proposed that the fee paid be aligned to the Society's Statutory Committees. The proposed increases to Chairmen reflects the responsibility and preparation required prior to the meetings. This is also in line with the Statutory Committees. This paper has been triggered by complaints from members of the Board, some of whom are also members of Accreditation Panels, and who are therefore unhappy at the inequity of fees paid to different cohorts for similar work and workload.

Members of RMC have received this paper before it was circulated to Council for comment. They support both actions and recognise the risks and resource implications. RMC will be discussing payments and costs associated with non-Statutory Committees at its November meeting. I would ask, President, you to draw you back to the action points.

The President: Does anybody wish to comment?

Mr John Jolley: On a point of information, could I ask is the recommended fee quoted a fee per meeting, per day or part-day?

Mr Andrew Gush: A day fee.

Mr John Jolley: For an eight-hour day?

Mr Andrew Gush: No, not for an eight-hour day. It is a fee paid for that day, regardless of the number of hours it takes to perform the task. It is the fee paid for the task on that day. If that task extends to a second day, there would be a subsequent payment. If you look at the paper, there has been a rationalisation of the way it is worked. A lot of work is done virtually now and the budget is reduced. It is anticipated that the number of days they will work in the year will be no more than five days. The resource implications for the rest of the year are £1,734. It would be like when you, John, have one of your industrial pharmacy meetings, regardless of whether it lasts for three or six hours, you have the same attendance allowance.

Mr John Jolley: Can we have that clarification put into the paper, so everybody is quite clear as to what the fee is for?

The President: Absolutely.

Mrs Sue Kilby: I am in support of the fees. It is a very reasonable rate of reimbursement of the level of people you will be involved with probably as members and chairs. Are we setting a principle now that if you are a Chair of a committee you actually receive an increased allowance for being Chair of committees?

Mr Andrew Gush: What I said at the end of my presentation, Sue – and I will say it again – is RMC will be discussing payments and costs associated with non-statutory committees at the meeting in November, which I think is inclusive of what you said. Obviously I try to keep my number of words to a minimum so we can get business done in the time allocated to it, but in future maybe I will be a bit more expansive.

Mrs Lorna Jacobs: On page 3/3, where it says “the efficiency of the board processes,” and talks of increased use of teleconferencing, increase of documents to be posted and face-to-face communications; if examiners are paid for a day’s work, is that a day’s meeting? If they are actually working by teleconference or by email, does that mean that some of the work is moving from a day’s work, which is paid, to this ‘between meeting’ work, and is that therefore unpaid effectively?

Mr Andrew Gush: Going back to John’s comments on section 2/2, it says: “Currently board of examiners are paid a flat rate committee day fee of £160.” Going on to Lorna’s comments, Wendy, would I be correct in saying that when no physical meeting takes place, and it is a virtual discussion, we make no payments?

Mrs Wendy Harris, Deputy Registrar & Director of Regulation: That is correct.

Mr Andrew Gush: We have made a decrease in budget by this smarter way of working. I thank members of the team for doing that piece of work.

The President: Can we move to the first recommendation. (i)? **(Agreed)** (ii)? **(Agreed)**

[Council agreed (i) the following fees for Examiners for the remainder of 2008: Chairman – Overall Chair - £330 per day; Chairman – Scottish Chair - £330 per day; Board members - £223 per day. Council further agreed (ii) that the fees for the Board of Examiners Chairmen and members should in future increase annually and remain in line with those paid to the Chairmen of Health, Investigating, Registration Appeals Committees (non-legally qualified) and Accreditation Panel Team Leaders, and for members, with the fees paid to panel members for Health, Investigating, Registration Appeals Committees and Accreditation Team members.]

13. Regulation of pharmacy technicians certification for those transferring from the voluntary register to the statutory register

Dr Sue Ambler: This is a straightforward, administrative change that we are requesting to tide us over from the statutory registration of technicians to the General Pharmaceutical Council.

The President: Has anybody any questions on the paper?

Mr Steven Acres: Firstly, to declare an interest as Vice-President of the Association of Pharmacy Technicians UK, and secondly as a practising pharmacy technician. I support this pragmatic and cost-effective approach.

The President: Can we agree (i)? **(Agreed)** (ii)? **(Agreed)**

[Council agreed (i) that pharmacy technicians whose names were transferred from the voluntary register to the statutory register would be issued with a letter of certification in that register; and (ii) that pharmacy technicians whose applications for registration were granted after the statutory register came into force continue to be issued with a certificate of registration identical in format to the certificate issued to pharmacy technicians registered in the voluntary register, until such time as the Society’s regulatory powers transfer to the General Pharmaceutical Council.]

14. Transitional registration criteria for pharmacy technicians: clarification of qualification requirements relating to the Boots 1 year dispenser training programme

The President: If I can declare an interest in this item and pass the Chair to the Vice-President.

Mr Martin Astbury: This is paper C94.

Dr Sue Ambler: This is again straightforward; to set a date and make it clear to people who are applying under the transitional arrangements for registration on the voluntary register, and in going forward in the first two years of the statutory register that the qualification offered by Boots, which was a one-year course and a top-up course, has a cap date of 7 March 2005. It just makes it clear to people the slight confusion between this course and another course that has operated.

Mr Martin Astbury: Can I put the recommendation to Council? **(Agreed)**

The President: Thank you, Martin.

[Council B that the transitional registration criteria for pharmacy technicians be amended by the addition of an end date of 07/03/2005 for achievement of the Boots 1 year dispenser training programme.]

15. Referral to Law and Ethics Committee: Pandemic flu – possible amendments to legislation

Mr David Carter: Council, if you could turn to paper 95. This is the pandemic flu hospital amendments to legislation, and possibly a contentious issue. In February 2008 the Council agreed that subject to public consultation with members and others, the professional standards and guidance for sale and supply of medicines should be amended so that in the event of a pandemic flu outbreak, date-expired and patient-returned medicines could be supplied. The consultation ran for a six-week period and at the Law and Ethics meeting in July, the response was considered to the consultation.

The paper before you is for you to consider, but there is one minor correction to the paper. If you could turn to page 2/2, both paragraphs in Italics at 6, it should say; phase 6, level 2, which is quite confusing. There are 6 distinct phases defined by the World Health Organisation to help global planning. The first two phases are for an internal pandemic period, where we have a new virus in animals and no human cases. So phase 1 is low risk of human cases; phase 2 is higher risk of human cases. Phase 3, is no or very limited human-to-human transmission; phase 4 is evidence of increased human-to-human transmission; phase 5 is evidence of significant human-to-human transmission. Then we move into the pandemic period, phase 6, which is efficient and sustained human-to-human transmission.

We are currently at phase 3, as a virus new to humans causing infections, but does not spread easily from one to another. Experts are concerned because the H5N1 virus could be circulated from birds in Africa, Asia and Europe and has demonstrated the ability to cross the species barrier to cause disease and death in humans. The WHO alert level remains at phase 3, and a particular risk of pandemic emergence arises through adaptation of the virus so it is circulated in human viruses. Although there have been no major changes in the behaviours of the H5N1 virus in humans or animals since they emerged a decade ago, it is possible that they could suddenly, and this could lead to more efficient transmission among humans.

So if we reach phase 6, according to the WHO, we then move into UK alert levels. UK alert level 1 is where we have no cases in the UK. UK alert level 2 is a virus isolated in the UK. UK level 3, outbreaks in the UK. And UK alert level 4 is where we have widespread activity across the UK.

The paper refers to phase 6, level 2. So we are in efficient sustained human-to-human transmission phase and we have viruses isolated in the UK.

So Council are asked to agree the amended wording outlined in the attached paper to enable the use of patient-returned medicine in the event of pandemic flu. The Department of Health are in the process of drafting guidance to support pharmacists in the use of date-expired medicine and patient-returned medicines in the event of a pandemic flu outbreak. A Pan Pharmacy Group has been convened to consider this guidance. The Society representative is Heidi Wright, Head of Practice. I will take comments and then we can move to the

recommendations.

Dr Phillida Entwistle: I have an interest in this about the effect it might have on the outcome of the review that Drug Donation Working Group is undertaking on behalf of Law and Ethics. As you know, that is looking at whether or not the current policy of the Society on donated medication should be changed. That group were told fairly strongly by representatives of WHO that it was totally unacceptable for patient-returned medicines or date-expired medicines to be used as donated drugs, and if they were unsuitable for use in the home country then they are certainly not suitable for use in third world countries. It seems to me this potential amendment to legislation could raise the issue about what is totally unacceptable. If the home government here can change the definition of what is totally unacceptable, why can't the Society change its views on donated drugs?

Mr John Jolley: I have the final report of the Drug Donation Working Group, which is very strong in recommending that there be no reuse of medicines under any circumstances, even within the Third World. We had a number of cases that the Red Cross were quoting where medicines had been attempted to be re-used with some disastrous consequences, and that any movement in line with the recommendation of this motion would certainly raise some major issues, given that this report is shortly to be published.

The President: Has this report been back to Law and Ethics? Should we be reporting on this case if it has not been back to the Law and Ethics.

Mr John Jolley: The Drug Donation Working Group. I have the final report here for approval, and I believe it is in fact tabled to go to the next Law and Ethics meeting.

Mrs Lorna Jacobs: Can I clarify the situations in which it is proposed these things come into force? My understanding when this came to Council before – and there was some quite considerable discussion – was that what we are talking about, for a layperson, is when life gets a bit hairy, where there are substantial numbers of people laid off with flu and the number of pharmacists available will be difficult, etc. As I understood it from what you said, you said UK 6 level 2. That did not match with what I had understood from previous situations. From your descriptions of levels 1 to 4, I think level 4 was more what I anticipated and understood; where life is getting really difficult, whereas level 2 sounds like there is flu about. I think that is a very different situation.

Mr David Carter: Can I ask David if he has a comment to make?

Mr David Pruce, Director of Policy & Communications: I think what one has to remember with this is that the situation being envisaged by WHO and by the UK Government is that medicines supply will be significantly disrupted at level 2. That is the basis on which this is being proposed. It is a permissive action; it is not a mandatory action. So it permits the reuse of medicines rather than mandates them. At level 3 and 4, you could have significant communication breakdown. You could have no medicines being supplied from wholesalers, etc. This is a permissive action at a stage just before the whole system falls over. That is why the thinking has been put in at level 2, rather than waiting until the whole system has gone.

Ms Alison Moore: I remember this question being mooted at the Department of Health as a possibility, and I still have the same concerns now that I had then. It feels very much like the thin end of the wedge, and concerns that people have like: if it is acceptable to use donated drugs in this circumstance, why is it not in this one, which is equally dire? And what about that one, where the situation is really bad? It seems wrong just to discuss it in the context of pandemic flu. There must be other emergencies that could come up where you could envisage a similar situation. Perhaps we should be a little broader about this than just looking at pandemic flu. That is to say: in what dire circumstances is it possible to use donated drugs? I know the Department of Health want us to go down this route, but it does not mean we necessarily have to do it.

The other question is that WHO are very anti the use of donated drugs. What is their view of the use of donated drugs in a pandemic situation? If they were involved in the discussions,

they must have offered some opinion, and I would be interested to know what it is.

Mr John Jolley: Can I answer that and the earlier question? In the dialogue with WHO, it very much questioned that serious issues of quality are raised with regards to all returned medicines. In a pandemic incident, the one thing you do want is security and assurance that the medicines that you may be using are in fact of the appropriate quality and are not going to do more harm than good. It is in that climate that basically the two situations are very much analogous; that if we are to reuse medicines, we have to be assured that they are of the absolute quality and standard, as if those medicines had been freshly prepared. Otherwise we are making further problems for ourselves. On that basis, I think we have to step back and revisit this whole area.

Mr Steven Acres: David has answered my question, but I think there is a very clear link between the severity of the situation and medicines availability and what you do under those circumstances.

Mr Andrew Gush: Alan, in our discussions this morning you talked about when making policies - there was a specific scenario that we should be mindful of broadening the output. Can you comment on that?

Mr Alan Kershaw: I use this as an example, but in the light of the discussion I am not sure it is a good one. I would like us wherever possible where formulating policy is to include in it, or record alongside it, the underlying principles, so that they can be applied to other situations. But in the fairly apocalyptic situation we may be faced with, or we think we are going to be faced with, I am not sure, in the light of the discussion this afternoon, where it should need to go further on the principles of this. I think the immediate issue is to deal with this one.

Mr Gerald Alexander: I understand the concern that Phillida has raised and completely understand the potential for the use of medicines that have been patient-returned or come from some other source. Listening to what David Pruce has said, this is a permissive regulation, allowing the professional judgement of the pharmacist, who is on the spot, who potentially would be working within exceptional circumstances; within dire emergency circumstances; within emergency regulations. A potentially dangerous situation would exist already. We are looking at the disaster scenario, hence you could use parallels, in policy terms, with terrorists using dirty bombs and all sorts of other situations. I am sure that the Government have looked at the broader circumstances, but I think what we are being asked here, and what Law and Ethics has looked at -- because I was a member of Law and Ethics -- is: What would we do in such circumstances? As professionals, we would try to act in the best interests of our patients. What this is saying to me, as a professional who is working in a community pharmacist -- let's say, the only pharmacist working in the community pharmacy that had very little access to medicine -- is: what would I do in such circumstances? Are patients to go without completely? We are not talking about antivirals, but other drugs for other uses. In such circumstances, you are in an emergency situation. You have to deal with the situation as you find it. You do not really want to be penalised by your professional body or your professional regulatory body six months after the event, when you have put the world to rights. What you want to be able to do is to work in emergency circumstances and do the very best for your patients.

This is a permissive view that the regulator would take. I fully understand what Phillida said and what WHO say, but disaster is disaster and emergency is emergency, and I think you have to think about saving lives.

Mr Martin Astbury: There are a lot of people down here who want to speak. I hope, given what has been said now, we are happy to move on. We have to decouple it from donations to other countries. The Government are looking at this as a one-off specific issue. We need to bring papers back once they have been produced and gone through Law and Ethics and so on, on the drug donations. There are other issues and other reasons. The Government is specifically looking at this and wants to know our position and thoughts on it. I totally agree with what Gerald says. At the moment, if this was to happen then I would dispense these medicines, and it probably would not matter what you said here today. I would dispense

these medicines for the good of my patients and that is what it is all about. It is a permissive thing so that someone does not get their legs slapped further down the line. It is one specific issue, and I would ask you to wait for drug donation to come as a separate item.

The President: Would anybody want to argue against that point that Martin just made?

Mrs Lorna Jacobs: Yes. I think what we have to recognise is that what we see as a potentially disastrous catastrophic situation if this were to happen is everyday life in some Third World countries. Some Third World countries are living in those situations, where the supply of medicines is completely disrupted and where, if they do not get returned medicines, they are going to get no medicines. This is a comparable principle that goes across emergency disaster type situations, whether you are talking of a disaster here, which is not what we usually live with, or a disaster somewhere else, which people live with day in, day out. I think we separate them at the risk of making two decisions being driven by the Government one way and the WHO the other, so that we make decisions that are not consistent with each other.

Mr Martin Astbury: I totally agree on ground that those issues are massive. However, in the environment which we have here, where you have a healthcare professional who would make a judgement, the problems that we have here are the transportation of medicines and the problems that can arise with their transportation. Who is giving them out and distributing them? There are all those issues that need to be looked at by another group elsewhere. We are looking at one tiny specific thing the Government are looking at, where we know who is doing what in a controlled environment. I agree with you and what is happening in those countries. It is a very important issue, but it has to come through those other committees.

Mr David Thomson: Just to try and remove the emotion from the discussion, as emotive as the supply of drugs to the Third World is, WHO guidance is right that it is not appropriate to send medication to Third World disaster zones. That is because often people like Oxfam and Save the Children incur huge costs in handling the destruction of inappropriately supplied items. People are well intentioned, but the system is not there yet to manage it. But the decision to support the supply of reusable items would inform that subsequently. It may be cart before the horse but a pandemic is an exceptional set of circumstances. It might never happen, but you are authorising someone legally to supply a product that they know they have within their pharmacy, rather than commit a crime that they might or might not be punished for. It is giving the leeway within the system to allow that to happen, and again, it might never happen.

Dr Brian Curwain: I am going to support what Martin said very briefly. The reason is that there are two safeguards which are available to people in this country, which are not available in the Third World disaster situation. The two situations are not, in my view, comparable. The two safeguards that we have here are, first of all, a skilled pharmacy workforce, albeit decimated by flu, but we have people who can make a judgement about whether it is safe or not. That does not happen in the Third World by and large. Secondly, we will have guidance written intelligently to guide that workforce. So I do think the two situations are very different. I hear what Lorna says, but I am happy to support that.

Mrs Sylvia Hikins: I would be sympathetic, empathetic to what Lorna said, but I would hate us to get the two things mixed up, as I think they are completely different. I recount in 1994, I was part of a group of women that went to supply aid to former Yugoslavia. I stood in a warehouse in Zagreb dumped full of drugs that were way out-of-date. That is the kind of issue around providing drugs for the Third World. It is entirely different. In this situation, we are talking of UK-based equivalent of the plague where all supplies are disrupted, where patients are desperate to get medicines, and what is left will still be a trained workforce who with their permission, can actually devolving it down to them at local pharmacy level to use their judgement to provide what is available. If there are a lot of deaths there are going to be lots of bottles of medicines on shelves and probably people bringing them back to a central point and so on. An enabling device to allow that situation to be managed. Whatever we decide today, if - and I hope it never does occur - people like Martin would see the situation, take the risk and prescribe. And we have got to think pragmatically and realistically about

that. Please do not get the two things mixed up.

Professor Nick Barber: I agree we should not get things mixed up. To put the purity of the products much higher than all the other risks, does not seem sensible to me. When I was a chief pharmacist we had a production unit which produced sterile and aseptic things. Sometimes we had to be able to say, "This is needed on the wards, but it has not been through QC yet," and we had to make a professional judgement. You balance the risks of a product that may not have been quite right against a patient not receiving anything at all. That is what our training is about; being able to make those judgements. Although it is only level 2, the description of level 2 is that it moves really efficiently between people and it is here. So it is the start of the take-off curve, and we need to be able to react quickly.

Ms Marcia Saunders: I agree with that. It just seems to me that whatever decision we take, we need to have a rational audit trail that is a bit clearer than would appear in the set of minutes. I do not suggest referring it back to the Committee. There would be some beauty in asking Law and Ethics to look at both, but we need to have some kind of note that goes beyond a minute that actually captures some of the points that have been made about why this is different and perhaps what is similar as well.

Dr Catherine Duggan: I want to reiterate that issue about quality. That should be a fundamental guiding principle of a professional pharmacist, to ensure quality where at all possible. I think possibly we are losing sight of the fact that we are not talking about even an epidemic of flu, but a pandemic. And a pandemic, even at level 2, which has not reached level 4 yet, means that everybody is at risk. We have not faced this since the 1920s, and most people did not live. That is something that it would potentially be a solution for.

Mr David Thomson: There was a pandemic in the Sixties.

Mr Alan Kershaw: This is such a classic example of a professional ethics problem. It is balancing two wrongs against two rights. There is no right or wrong answer to any of this. It is also a matter, as Nick rightly says, of balancing risk; the risk of giving versus the risk of not giving. We cannot be so risk averse - if we do not change this rule today, I hope my pharmacist breaks it when the time comes. So let us please approve that. I would like to suggest, because there is so much unpacking to do here, that Law and Ethics take the opportunity, when the Drugs Donation Working Party reports in January, to look at just talking of one drug; but drugs. I do not know the difference between most of them, and it would be helpful for someone to unpack that for us. Because some drugs will degrade very quickly, I gather, and might kill me just because they are out-of-date, and some will not. We have to unpack that as well. By all means let us look at that, but let us not let a problem over a general issue, which is very important and I really want to see sorted out about donation abroad, stop us dealing with an emergency situation occurring. Frankly, in principle I was thinking towards: In the event of this extreme sort of emergency all rules are suspended and all bets are off.

Dr Phillida Entwistle: Thank you for letting me come back. I did not set this hare running, but the discussion about the issue of donated drugs, because that has been covered very fully in the working group. My objective in raising it was to put on notice the fact that because it seems to me, that if we accept this paper, (which I am sure we shall eventually) it is setting double standards potentially. I think it is right we go back to the working group and raise the issue of double standards and ask what they intend to do about it. John has the draft report in front of him. I hope we can have another meeting of that group and I will certainly raise it with the professional members there about what has been said today.

Chief Executive & Registrar: If I may make one point about action that we could take from this discussion, which I found very helpful and interesting. I am very happy to go away and ask the team to draft a short paper that defines the circumstances very clearly, so that we know we are not dealing with a blurred definition. We are attaching it to level 2 criteria, and making the point that we need to use the assets that pharmacy has to meet that challenge, an emergency challenge. Those assets include a qualified workforce, appropriate guidance and crucially the professional judgement of us and our colleagues in which drugs are most

appropriate to supply, and what the balance of risk is in providing that supply. We can provide a short note that is the rationale for this position we are taking.

Just at a wider level, could I make the point that I think this is a good example of us as a Council and organisation showing professional leadership. It follows hot on the heels of the practice framework discussion, which I think is another good example. They are two really clear instances of where the organisation is showing leadership. So thank you.

Mrs Sue Kilby: We need to be aware, as far as drug distribution is concerned, that a lot of drugs are manufactured abroad. We may be in the middle, the end or the start of a pandemic attack. If it hits Europe and drugs are being produced in Europe, there could be a drugs shortage before we are on red alert in the UK. That needs to be built in. We need to think internationally and globally, because of the drug distribution chain. Secondly it is the code of ethics; that is what it comes down to at the end of day.

The President: I commend the idea Jeremy has just articulated for the paper which he has described that we produce, notwithstanding the law and ethics of the wider question on reuse of drugs. On the specific case that is mentioned in the paper, can we have Council's agreement around (i)? **(Agreed)** (ii)? **(Agreed)** We will have a short coffee break

[Council agreed to amend the standards for the sale and supply of medicines (i) to allow the re-use of patient returned medicines in the event of a pandemic flu, and (ii) to allow the use of date expired medicines in the event of a pandemic flu.]

(After a short break)

20. Policy Development process

Mr David Pruce: Council had a very helpful session this morning in Committee mode, looking at this paper and looking at the process of policy development and implementation. I will just highlight one or two of the things that came out of it, where you would have been seeking amendments to the paper. In particular, you wanted the involvement of the Public Liaison Group to be the norm in policy development and also for the group to have a role in horizon scanning, which I think there was fairly broad agreement with. I would like to reiterate that there was a list of potential policy issues that was circulated. It might be useful to get those on the screen, if that is possible, to get Council's agreement that these are some of the issues that you would like to see discussed. We discussed earlier whether some of these could be grouped together into major areas. However, the policy issues for the record relate to prescription charges, top-up payments, drug donations, responsible pharmacist, supervision, workforce, workload and staffing levels, POM to P shifts, potential pharmacist-only category of medicines, medicines safety, homeopathy, pharmacy practice, framework, collaboration with other professionals, alcohol misuse services in pharmacy, sexual health and contraception and end of life strategy.

We also recognise that there will be issues falling out of Darzi, like poly-clinics, leadership and development and there may well be some issues that come from the CHRE review and some issues from the TransCom review, such as CPD/revalidation support and education in the professional body. This gives Council a broad programme of policy development. There was wide agreement that the Council strategy days and Committee sessions would make good opportunities to discuss policy issues. If there are no matters for discussion, I would like to move to recommendations, but Council may have points to make.

Dr Catherine Duggan: I wanted to reiterate the idea that we would work more closely with existing associations; (a) because they often have the expertise to help with things like offering advice on specific areas, and (b) moving towards a new professional body, this increases engagement with ownership.

Mrs Sue Kilby: The other issue as far as policy is concerned is looking at it from the European and perhaps global basis as well, and seeing where we feed in there. I would assume that we would obviously be working closely with Gerald Alexander on the European agenda, because we need to be feeding back our views and comments on that.

Mr Douglas Simpson: I wanted to put on the list the issue of rural dispensing. This is an issue which severely prejudices the implication of the Pharmacy White Paper in many areas, particularly in England. It debilitates pharmacy in many areas. I was in a Hampshire town last week. I went to talk to the pharmacist. I knew it was an area where the doctors were dispensing. The place was a big wide high street, with 4x4s and Jaguars drawing up on either side parking. They did not have gift shops; they had art galleries. They had a trout stream running down the middle of the road – very nice restaurants serving cordon bleu food and tea rooms – that kind of environment. But the pharmacy is struggling. Say it does, as an example, X number of prescriptions; the dispensing doctors do 3X. There was no question of it being a deprived area. Each house in the area probably has 2 or 3 cars. It has turned the whole situation upside down. There is no question of people in this area having difficulty in accessing pharmaceutical services, because there is the pharmacy. It is a very serious issue.

The White Paper raises the possibility of the criterion for rural dispensing being changed to the distance between the pharmacy and the doctor's surgery. Obviously the doctors have seen this and they are absolutely up in arms about it. They have been lobbying about it. They have engaged very expensive public relations companies and are lobbying about it. We have seen questions in Parliament. We have barely got off the ground on this issue. The PSNC has not helped by, in a sense, shooting our fox, by saying they want to keep the status quo in rural areas. I think they are profoundly mistaken. We have yet to form a position on this matter. It is a very important issue. I think it is also an important position in Wales as well as England - not so much in Scotland, because they have a different situation there and not so much in Northern Ireland. Our remit does not run to Northern Ireland. Interestingly, in Northern Ireland independent pharmacy thrives more, because dispensing doctors are not really prominent in that particular country. But they are prominent in England. They debilitate pharmacy in large areas of the country. We have really got to get to grips with the issue and it should be on the top of our list of things to be dealt with, because it needs to be dealt with urgently. It is a key issue in the Pharmacy White Paper.

The President: Thank you, Doug. We will ensure it is on the list of topics to discuss.

Ms Alison Moore: Thank you for the paper. I am certainly in agreement with using strategy days to do something to develop these policies. I do not recall you saying anything about devolution, and how I agree perhaps we should not be reviewing devolution protocol right now, but we need to make sure that it is linked up with TransCom, because I think it is vital for the new professional body that we look again at Devolution.

Mrs Sylvia Hikins: I recollect from this morning the need to tweak the flow chart on page 9/9, so that it reflects more accurately the present policy on devolution. Particularly, that policy development is a process that needs to be raised in the flow chart. We discussed that this morning and it was agreed it would be changed.

Mr Martin Astbury: The point on TransCom and devolution. To give some reassurance, there are three members of TransCom appointed from the Boards. Two of those have been chairing working groups. One of them sitting over there is the Chairman of the Governance Working Group. Certainly most of the working groups, and certainly the working group that I chaired, had someone from each of the Boards invited along. That was the policy generally within all the working groups. There was someone from all the Boards, but you are still right to flag that up.

Mrs Lorna Jacobs: Can I raise a point which I raised this morning, that to get effective involvement from the public, we will need to strengthen our public involvement strategy and invest more time. It is difficult for the public liaison group to contribute. We are having only three meetings a year. It would be very helpful for us to have one or two strategy days for public involvement to bring together a bigger group to generate discussion with information beforehand and a facilitator, so they can contribute more effectively.

Ms Marcia Saunders: I support that. That is an extremely good idea.

Mr Martin Astbury: I do support public involvement, but we have to make sure it is when appropriate. Because sometimes there will be certain issues that come to Council for Council to comment upon, where someone is looking at what specifically pharmacy, pharmacists and pharmacy are after; Not necessarily looking for us to give the public's perception, because they can get that from lots of other places. Nick Barber mentioned the case whereby we should be looking at the experts out there, the other experts in pharmacy, to feed into us. That is probably a lot of times the highest priority, to get those links. But I still agree there will be a lot of cases where we must have that feed in, as a balance.

Mrs Lorna Jacobs: We are only having one or two strategy meetings for our public involvement group. There are plenty of areas where input from the public is vital, without treading on toes on professional issues.

Mr Gerald Alexander: Just to make that little comment I made – not the other about leadership and history, as I am sure Jeremy has taken that into account; that the Policy and Communications Forum keeps devolution protocol under review. We need to develop a mechanism within that particular group to bring back to Council when necessary. That is all I want to say on this.

Mr John Jolley: David referred earlier to the necessity for having broad policy statements on a whole range of issues in order to be able to identify and respond to urgent press requirements. While it is very helpful to see the current policy issues identified, I just wonder: is there a process in place to review many of the existing policies which have been evolved over a number of years? There have been recent cases where we have had to dust off very old policies which are not maybe as applicable now as when they were first brought up. There should be some form of date expiry put on some of these policies, so at least people look at them to see how appropriate they are. Is there such a review process in place?

Mr David Pruce: Just to reassure Council, we keep all policies under review. Often the point at which they are reviewed is when an issue comes up that relates to them. But we attempt to keep as many under review as possible. We have a database of policies. It is remarkably large already.

The President: I think I have heard most, if not all, of the comments made this morning and they have been put on the record. May I move to the recommendations of Council? (i)? **(Agreed)** (ii)? **(Agreed)**

[Council reaffirmed (i) its support for the process of policy development, implementation and monitoring set out in the paper, and agreed (ii) that the Policy and Communications Forum would keep the Devolution Protocol under review and bring recommendations to Council if required, but would not undertake a formal review of the devolution protocol.]

The President: The next items under public business are 17 (the PRLOG report), 18 (CPD Pilot interim report, paper 97) and 19 (Stat Com statistics), paper 98. These are all for noting. There are also other papers for noting.

17. PRLOG Report (For noting)

[Council noted the update, which had been circulated at 08.10/C/91.]

18. CPD Pilot Interim Report (For noting)

[Council noted (i) the report, which had been circulated at 08.10/C/9, and that (ii) the pilot was running late and due to technological difficulties with reviewing CPD records kept on paper; (iii) electronic CPD records had been reviewed successfully; (iv) independent research confirmed that members had responded favourably to feedback on their CPD records, while making suggestions for future improvement; (v) a report of the completed pilot with recommendations for introducing regular CPD record review would be brought to a future meeting of Council.]

19. Statutory Committee statistics (For noting)

[Council noted the report, which had been circulated at 08.10/C/98.]

23. Location of Council meetings in 2009

This is paper 100. Work is being done to identify suitable locations for future Council meetings and a paper will be brought to you when decisions are made.

[Council noted the report, which had been circulated at 08.10/C/100.]

24. Council Update (For noting)

[Council noted the update and progress report, which had been circulated at 08.10/C/10.]

Mr Gerald Alexander: Have you covered item 11? I know it was for a noting.

21. Minutes circulated since the June 2008 meeting of the Council

The President: We receive minutes of the Scottish Pharmacy Board, 11 June; English Pharmacy board, 2 July and the Welsh Pharmacy Board, 2 July. Scottish Pharmacy Board 8 July, Law and Ethics Committee, 15 July and Education Committee on 16 July.

[Council received the minutes of the following committees: Scottish Pharmacy Board - 11 June 2008; English Pharmacy Board - 2 July 2008; Welsh Pharmacy Board - 2 July 2008; Scottish Pharmacy Board - 8 July 2008; Law & Ethics Committee - 15 July 2008; Education Committee - 16 July 2008.]

22. Any other business

I have one item concerning Gerald. I would like to announce that Gerald Alexander has been appointed to the Executive of Europharm as Treasurer. We should congratulate him on that.

(Applause)

That is all for public business, with the exception of the presentation of Honorary Membership when Dr Rostron arrives at five o'clock.

(Council then dealt with the Confidential Agenda until 1715)

Presentation of Honorary Membership to Dr Chris Rostron

The President: Thank you, Council, for coming back. May I introduce Dr Chris Rostron to you. The Society was given the power to elect Honorary Members by virtue of its Royal Charter. We can elect as Honorary Members people who have rendered distinguished services to the Society or pharmacy. Only two or three members a year are selected. So, Chris, you are joining very select band of people.

You graduated in pharmacy in 1971 at Manchester University, then went to complete a PhD in Aston in 1975. You have worked for Liverpool School of Pharmacy for more than 34 years. During that time, your research interests focused broadly on medicinal chemistry. You have taught many aspects of pharmaceutical sciences, including medicinal chemistry, pharmaceutical control, pharmacology and industrial pharmacy. Your broad knowledge has enabled you to be at the forefront of the continued integration and development of the MPharm programme.

Among your responsibilities, you chair the Undergraduate Board of Study and the Accreditation Committee. Additionally, you are Framework Co-ordinator and Academic Manager overseeing the quality of the schools programme, including the MPharm programme. Your broader responsibilities include membership of the Faculty Policy Committee and Working Parties of Academic Proprietary and Programme Specifications. Your acquired knowledge of pharmacy education in particular has made you a valuable member of the Society's Academic Pharmacy Group, and these skills have been recognised by your academic peers who elected you on to the APG Committee on a number of occasions. You have sat on the Committee for 10 years, becoming Vice-Chairman 2001 and Chairman in 2002, a position you continue to hold.

This is an unprecedented level of service, and your enthusiasm, impact and commitment have been huge. Your expertise has been utilised by your appointment as external examiner in medicinal chemistry at pharmacy programmes at De Montfort, Kingston and Aston Universities. In addition to undergraduate education you have undertaken research and

enterprise in your former position as reader in medicinal chemistry and you supervised postgraduates students, both at Liverpool John Moore's University and as joint supervisor of students at Robert Gordon University.

Your publication lists comprise 29 full research papers and over 40 further abstracts; about 20 of which were presented at British Pharmaceutical Conference. You have current research collaborations with staff in pharmacy departments at Robert Gordon and Brighton Universities. In Merseyside you have undertaken NHS collaborations with the former Mersey Health Authority and Pain Relief Foundation in Liverpool, and industrial collaboration with several companies each emanating from your research in medicinal chemistry.

Your eminence has also led to you serving as a reviewer in the Journal of Pharmacy and Pharmacology, the European Journal of Medicinal Chemistry and the publishing House J. Wiley & Sons and Oxford University Press.

Chris, over your career you have impacted the careers of several thousand Liverpool-based pharmacy students through personal teaching. You have undertaken research and consultancy and contributed to the quality assurance of pharmacy programmes nationally. It is therefore my great pleasure to ask you to accept your certificate of honorary membership in recognition of these achievements and in recognition of your distinguished service to the Royal Pharmaceutical Society of Great Britain over the last decade through your unstinting commitment to the Academic Pharmacy Group. Thank you very much. **(Applause)**

Dr Chris Rostron: Mr. President, members of Council, thank you for those very kind words and thank you for this honour you have bestowed upon me. As you said, I have been in Liverpool 34 years and I have entered what I term my anecdotage. **(Laughter)** I want to fill in one or two details that are not there in the words of the President.

I have a degree in pharmacy but I thought it would be as well to say why I never registered. When I joined the course at Manchester, during the vacation in the first year, I went to work for Boots as a vacation student, and that was in my hometown Blackburn, Lancashire. I worked six weeks and it involved a tour of all the photographic counters of Boots in north east Lancashire. At the end of the summer vacation, I decided that retail pharmacy, as it was then, was not for me. So undaunted in the second year vacation I worked in Blackburn Royal Infirmary. I hesitate as say I worked in the pharmacy department, because I spent the entire time ensconced in a dungeon that was aseptic manufacturing. That was another branch of pharmacy I did not fancy too much either. I went back in the third year starting to get a little apprehensive. In between the third and fourth years, I went and worked for British Rail. I decided that was not for me either. **(Laughter)** However, when I went back in the Fourth year I was really quite anxious, what is to be my career with this pharmacy degree? What happened in the fourth year was an honours project which was responsible for me moving into academia. I knew then I wanted to do research and lecturing and that is what I did. I went straight on, did a PhD and the opportunity never arose to become admitted to the pharmacists register.

However, during those 34 years I have not been adrift from pharmacists, as I have been married to a pharmacist for a few years. So I was always kept up-to-date with the sharp end. She was an independent proprietor and that is where I gained all my background information of pharmacy and pharmacy practice.

I joined the APG Committee in '91 or thereabouts, because perhaps a bit later as I wanted to give something back. I felt I had enjoyed my 30 years in pharmacy education, so I joined the Committee and served under three excellent Chairmen, Paul Nichols, Jayne Lawrence and Anthony Smith. During that time I realised that being in charge of academics was, as I put it – and a phrase which Anthony Smith has stolen a few times (with my permission) – like herding cats. I became Chairman in 2002 or thereabouts, and that moved it to another level. I now realise it is not just herding cats; it is herding cats in a thunderstorm! There is a Chinese saying: "May you live in interesting times". As chairman of APG, I certainly am living in interesting times. There are so many things that have been going on during the period of my chairmanship. In fact, I was thinking on the train coming down.

I am now probably more familiar with Government legislation than with medicinal chemistry, because the White Paper, section 60, GPhC and so on.

So what am I to do with the remaining two years of my membership of the Committee? Well, I see it as my role to ensure that education is at the core of the new professional body. I will continue to strive in the next two years to make sure, as far as possible, that that happens, because I am a believer in education, education, education. You cannot have a professional body without education at its core. So thank you very much for this honour, I am very, very grateful for it. It is something that I never expected and I shall do my best to uphold it in the coming years. **(Applause)**

The President closed the public business of the Council.