

Royal Pharmaceutical Society of Great Britain

Transcript of the Public session of the Council meeting held on Wednesday 2 December 2009 at 1 Lambeth High Street, London, SE1 7JN

[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

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| President | Mr S Churton |
| Vice-President | Mr M Astbury |
| Treasurer | Mr J Gentle |
| Mr S Acres | Ms S Agha |
| Mr G Alexander | Mrs M Allan |
| Professor N Barber | Mr D Carter |
| Mrs D Drury | Dr C Duggan |
| Dr P Entwistle | Mr G Hall |
| Ms S Hikins | Mrs L Jacobs |
| Mr J Jolley | Mr A Kershaw |
| Miss Y Liddell | Dr T Learoyd |
| Mrs S Kilby | Professor B Michell |
| Mrs A Moore | Ms M Saunders |
| Mr D Thomson | Mrs V Turner |

In attendance

Dr B Curwain, 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 J Holmes, Chief Executive & Registrar

Welcome to guests

The President welcomed Mr Timothy Barlow, Wessex Region and Miss Gemma Donovan, BPSA President, to the meeting.

9. CHRE consultation on future GPhC standards – regulatory draft response

Mr Steve Churton, The President: We are going to kick off with item 9, the draft response for the regulatory part of the standards. Alan is going to lead us through this conversation. Then we will follow through with the professional response.

Mr Alan Kershaw: My part in this has been with the working group, looking at the regulatory perspective on the response to these standards documents, which I trust you have seen, which have not been reproduced in the papers as there is too much. The first thing to say is that I am very grateful that we are taking this together with the professional response. To split the two would have been unfortunate, given that they are very different perspectives in approach to this. That is fine, and I do not see a problem with that, personally. We will present at the end a single document in response to the consultation, but it will have two distinct parts in it. There is a very proper reason why those distinct parts should take different perspectives; will actually look different and sound different. It is this: Constitutionally we are the regulator at the moment, but from next year at some point there will be a new regulator.

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The new regulator will be responsible for these standards and they will be the ongoing entity to take this forward. From the regulatory point of view, we need to say what we are going to say, then hand it over.

On the professional side it is rather different, because the response has been brought together, as you see today, by the Boards, who are, in a way, the future of the professional side, and they will be the on-going entity themselves, albeit with slightly different personnel after the elections. So constitutionally they have a different place in this. They will be responsible on the professional side of things on into the future, whereas this Council, as regulator will not. So we are slightly different. On the regulatory side we can say what we want to say, then hand it over. On the other side there is a rather bigger stake in what goes forward. The fact that the two sides of the response look different should not worry us too much. I do not think we should spend too much time on trying to harmonise those, so we have one single document with everyone saying the same thing. I do not think that is very productive and it means the Department can get two different voices clearly. That is the general point.

The next thing I want to say is that the document has been seen by Education Committee, and in a moment Sue will explain to us, especially I should think on one particular point, what they have to say and we can take that all in as well. We have one more meeting of our working group, which is two weeks from now. So I would like to ask you to make your comments today on this. We will take delivery of all of those. I hope not to spend too much time debating this, but we can hear where the draft response we have prepared needs to be adjusted or refined in some way, or even changed the other way around, then please tell us now. We will take that on board and take it back to the group and do a lot more detailed work. It will be signed off by the officers later. If there are points where there is clear contention today, and no consensus view, I will make sure we take further views from you before the response is finalised. But this has been a quick exercise to do. We have Christmas in the way and Priya and her colleagues have done an enormous amount of extremely good work to get everything together.

I want to take you to one or two particular points, which we would like your views on today. The first thing we did, and the most important perhaps, was to invite the lead staff members for each area to identify areas where the proposed new standards differ from what the Society already says. That was largely to make sure we did not spend time revising our own policy, as it were, when that is settled. So we have tried, as far as we can, to reflect existing policy here. That should be quite gratifying to see how much the Department, in taking the lead on preparing these standards, has taken on board the points we have already settled here in the past. In other words, it stands very firmly on the shoulders of the Society's work over the years, and I think could not be in this form but for what we have done here. So the changes are not all that enormous. In some respects, there are significant changes and new things, but there is not that much that is out of harmony with what we have been saying already. Try and keep that in mind.

Some specific points. First of all, one from yesterday. We had a debate about language testing yesterday, and it was suggested that we get something in about that in our response. So in the section on the new proficiency standards, question 9, page 18. I will not give you the words right now, as I have not thought of them, and more sophisticated people can do that. But something in there about standards of proficiency, the importance of communication skills, effectively making the point about language gives us an opportunity to trumpet our views there.

I will take you through these and not stop for debate. Then you can comment on what you want to. On page 4, the definitions of patients and public is a very specific one put here in the glossary. We would like your views. We think broadly as defined it is okay. I have seen I think from the professional side they were happy with it, but you might want to comment on how helpful it was as a phrase, so please bear that in mind.

There is an enormous question which suddenly arises on page 9, which is: Do we agree with the idea of an integrated course, which is not an answer to which we can say yes or no.

It demands quite a lot of thought and more debate than we have had here in the past, or could have here today. I imagine the Education Committee will have comments on that, so we can take that from them. But in here is some background information, which might, as it were, hint towards the type of considerations we will put into our response on this. But we did not even attempt to start drafting a response on this until we had heard from you. So let us have your views on that.

There were one or two other points. The Pharmacy Order had not been laid at the time we were looking at this, so we could hardly comment on whether the proposals on CPD were in line with it. Now it has been laid, we can deal with it, so if you have points, we can take them away.

There is one point where the draft contradicts itself. Sorry about that, but it is a big piece of work. It is question 6 on page 6 about pharmacy-only medicines. The text of that states the Council's existing policy, which is that it is unhelpful for pharmacy-only medicines to be available by self-selection. We do not want to depart from that; indeed, we want to strengthen that. But by default, in the beginning of our answer, it says "agree". It clearly should not, because that clearly contradicts what the text is saying. We will put that right, so there is no ambiguity at the end of the day.

That is all I have to say. I do not know, President, if you want Council members to drag through it page by page. I am happy for people to make comments on their points, and we will take them away. We are not seeking to sign off the precise words today, because we cannot. It would be a laborious way to do it, if you wanted to do that. I think it is better that people make the points they want and we will note them and take them away.

The President: Do you want to start with the points you raised specifically?

Mr Alan Kershaw: We can take those one at a time. The first one of those would be the definition of patients and public.

The President: Are there any comments on that issue?

Mr Gerald Alexander: As a member of the working group, I raised this concern to Alan. It is more of a legal definition. First it appears in Annex B1 of the standards -- I think we have suggested in the response that the definitions and glossary should be attached to every group of standards. You will find that as they are printed at the moment, you will find that the glossary or definitions are not in each section, and they should be. But the issue of patients and the public is something I raised. I just felt there may need to be some legal advice that we may need to require. Having said that, if we do not actually take legal advice as a Council, I think it is right that we put in the response, that we are saying to the General Pharmaceutical Council, when they are constituted, that perhaps they should take legal advice on these standards, because we are concerned about the definition, and therefore it is for them. But really we should be telling them: "This is what we think." If you look at the definition of patients and public, it is reasonable within the context of the glossary, as is the definition of a patient. I do not know whether people have the definitions. If you do not have them, it is difficult to talk about it. If you think about yesterday's discussion, we did mention the Code of Ethics. There are seven principles, and now you have 15 mixed up standards, quite frankly, in the standards, conduct ethics and performance. They appear reasonably easy to understand in B1. I think pharmacists are going to find it rather difficult working their way through these documents. So from a simplistic point of view, I think pharmacists are going to have difficulty. But nevertheless this is what has been produced. One could argue if it ain't broke, don't fix it, but it is not our job to fix anything these days; the General Pharmaceutical Council are going to do that!

The definitions of patients and public says: "Patients and the public include any individuals or groups, patients, customers, clients and their animals, who use or are affected by pharmacy services; advice, or other services provided directly or indirectly by pharmacists, or pharmacy technicians." Within the context of the glossary, I think it is reasonable. But if you could imagine all of these 100 (and I do not know how many) pages of standards are going to sort

of guide any Fitness to Practise Committees in the future, if there was a challenge to a decision of a Fitness to Practise Committee, it would eventually end up in court. So what I am concerned about is how would a judge look at that definition. What does he think that means? He would look at a dictionary and look at "patient" and understand that, but the term "patient and public", would it be sufficient for a court to look at the definition in the glossary, or would it be the general understanding that the man in the street would understand? The question is: Should a pharmacist be responsible to a wider group other than his patient? Because if you read the first standards in Annex B1, it says: "Make patients and the public your first concern", which is very different to the current Code of Ethics principle of making the "care of your patients" your first concern. It is quite different, and I think it is well worth a discussion. My view is that I cannot really answer the question. It seems reasonable within the glossary, but outside of it would anybody really understand that definition? Would a court understand it and how would a court interpret that particular definition, because it is not a standard definition? It is not in the Oxford English Dictionary. Patients means one thing, and public another. When you combine them, okay you have included these groups, individuals, patients, customers and animals and all the rest of it, but I am not convinced it is totally clear.

Mrs Dorothy Drury: I do not know whether this is a good example, Gerald, but once in a pharmacy we had an incident where the lid came off a tin of Symag, the poison for rats, when we used to be able to sell it. And therefore we had to evacuate the premises. So that is where you are not just looking after your patient but the wider public.

Mr Gerald Alexander: That would be a public liability issue.

Mr John Gentle, The Treasurer: Do we know why the GPhC standard contains this difference, if our Code of Ethics currently says the care of your patient is primary, why have they expanded it? Presumably there is a reason.

Mrs Wendy Harris, Deputy Registrar & Director of Regulation: Perhaps I could help Council and remind you. Our Code of Ethics uses the term "patients and public" in there, so they are carrying on the language we ourselves have in our standards.

The Treasurer: So there is no change?

Mrs Wendy Harris: There is no change. I have suggested to Sarah that we look at the other regulators and see what terminology they use. Because listening to Gerald's point on legal challenge, if they are also using "patient and public," (**Inaudible**) -- -- Take it on because we assume they have also looked at that whether there is an opportunity for challenge or not. We will look at that.

Mrs Sue Kilby: It is really about a broader issue. When we discussed this at Education, we did not focus on this terminology. But the big concern was that we thought a lot was very retrograde. We like our current Code of Ethics, where we have the seven principles, and to leave it at that, rather than go down into more detail, which is the broad statements. I do not understand why the General Pharmaceutical Council is taking this backward step on their approach. That is one of key things we would like to get included or emphasised, with this whole response to the document. I am sure Nick has further thoughts on this area. Because this was one area we generally focused on, rather than getting into the nitty-gritty. We want a more broadbrush approach, so we do not get into these debates of what does X and Y mean as such.

Mr Gerald Alexander: Arguably the professional body I hope will continue to have a Code of Ethics. There is no reason why it should not, although in law it probably will not have the same status. Nevertheless, if you have higher principles, they tend to inform standards of conduct and behaviour and ethics and performance. So they should really be sitting higher than these standards of conduct, ethics and performance. So I think we have to think about where the professional high standards sit, and I think a code sits higher than a standard, and I think we understand that. But I suppose really the new regulator has no choice but to start from standards.

I just am concerned that really the proposal I would make is that the response actually suggests to the GPhC take legal advice on their definition, and it is for them to make that decision. Having said that, I think the professional body or the National Board is suggesting that we take advice. But my proposal in our regulatory response is that we actually state it clearly, that because there is some variation in our understanding, from my point of view I do not understand that term fully. So how is the average man in the street going to understand it? I think it is for them actually to take legal advice on what is written, otherwise they may be legally challenged at some point.

Ms Seema Agha: My concern has been, from working with the professional side of standards, is really modern regulators are moving towards principle based regulation, which is light touch. I gave the example of RICS, which has reduced its code from 60 pages to 10. The GMC now has a handbook very much like this one, and my colleague, who is a lawyer there, says, "We can prosecute any doctor under just that little book," the guidance, if it is necessary. It is very simplistic. The patient should be able to understand, going on a website. "Right, what standards should this pharmacist meet?" They should be able to click on it. Even I struggle with all of that to me, thinking, "Actually, are you not creating defensive practitioners?" Because they will have to read the detail and wonder what -- actually, what I have brought to give to Heidi today is something called the Hampton Principles. It is about principle-based regulation. What they have helpfully done is shaded it. They have set out the principle and an explanatory note. It is there just on one page. It is only five pages and it is about regulation. This is what we should be reminding the GPhC, "This is your mission statement to us -- the world. Why have you departed from this, and why did you not set out what your regularity framework?" First of all, I want to get first principles, rather than have a tome. I want to see the context of it. So I want to know, where is your higher principals? Where does the code sit? Where does the standard sit? Where are the references?" I feel a bit lost, although I have done regulation for a while. If I was starting from scratch, I would think, "Where does it fit? Where is the jigsaw?" To representations, I have said, "We have done all this work at the Society. Why has this not been acknowledged anywhere in the consultation? Has there been a meeting with the Society to say, 'We recognise you have done this work. What has changed? Where is the evidence for change?'" I would say "Don't fix it, if it's not broken." There is only a nine-month gap, I understand, from when we did the codes to the rules to 'this' this huge great tome. I am sorry, but I think that is not light touch. It will create fear in people and I certainly would not want to stand up to anybody to defend myself. And that is another reason why I have asked for legal advice, because like anything else it is legal academic health check. Before we roll it out, this will affect my life. I need a check around it. What is going to happen if I end up in court? Have they got it right? I think this is something we need to education them on.

Mrs Kay Blair: My experience of regulation is more in financial services. As I am sure you know the FSA has certainly moved from principle-based, light touch regulation into much more detailed and proscriptive and intrusive regulation. That has obviously been because the previous approach did not work -- quite obviously it did not work -- and also because of a much better risk assessment. So when I looked at this and looked at the fact they were moving to much more detailed standards, etcetera I said, "Where is the risk assessment?" As Seema said, "Where is the evidence to say that this is required, that previous standards have not worked, and there is a need to move to this much more intrusive regulation?" And I do not see anything in the papers which actually answers these questions, so I do not know where they are moving to this approach.

Dr Tristan Learoyd: I don't understand why the principles are being addressed. We have seven principles there which have worked well since their inception, so why would they want to change that? Is this little more than a token of the GPhC's arrival, I wonder, because we have been an effective regulator for the past however many years. It seems totally unnecessary to change it, confusing to pharmacists and it will only backfire on them.

Professor Bob Michell: I think the important thing is to go back to the origin of all this, which was not actually a problem. The origin of all this was a political mantra: "Thou shalt regulate in the following way." The following way (the splitting of the Society) entirely contradicted the previous way, which had been fully accepted by same government (but for the change of

Prime Minister) as the model for the future of regulation, interestingly, by Sir Ian Kennedy, who now faces the problem of regulating MPs.

But the fact was that you had an excellent model for regulation. No shortcomings were identified. No explanation was given for junking it. Instead, it is politically incorrect to continue with the Society as it is, so "it shall be split!" Granted, politics has to supervene, but I fully support the comments that a new organisation should not prove its potency by inventing rules for the hell of it. And the only reason I want to comment on the point is that I would like to suggest that whether we include this in our comments as a dying regulator -- that is understandable -- but to me, what is much more important is that the same comments, or the same spirit, appears in the comments of the professional body. Because the professional body will be alive, shouting and kicking this time next year, whereas the regulator, in its current form, will be six feet under. So that campaign I think will need to outlive the current regulator: Us. I have a couple of other brief comments. Do you want them now or later?

The Chairman: Can we check with Alan? Do you have enough from the conversation, in terms of what has been said, to reflect upon?

Mr Alan Kershaw: Yes, I have had more than enough, President! **(Laughter)** That is absolutely fine. Our task was to look at what there was, and see whether there were things which were wrong in this, and which would not work. The point of principle that -- I have to be very careful not to overstate this case, otherwise we will weaken it -- bearing in mind that the draft code is only six pages of A4; it is not an encyclopaedia. If you want to see one of those, look at the -- see the Law Society, which is still 600 pages. But nonetheless, it is a point well made that I think it would be fair for us to say the code as redrafted drifts rather unhelpfully between principle and practice. We can make that as a general point. I would be very happy to take individual comments outside the discussion, so we are not here all day. If people have examples of things they think will not work, let Priya have them, so we can take them on board and explain examples of what we mean by that. We would rather that it came from you. I think we have to be very careful not to give the impression that we have gone from 7 principles to 15. There are not 8 new principles. There are not 8 new sets of rules. What they have done is broken up what we had, rather neatly arranged, and some things which were under headings have become principles in themselves. I think that is where the confusion arises. So it is not, in a sense, getting heavier in terms of new rules to obey. It is not expressing itself quite as crisply and clearly as we did with the code that we all worked on so hard a couple of years ago. That is a general point that I think we can make. But we have some examples in the text here, which illustrate that point. We would be very happy to have them, but let us not take up each others' time on those. Let us do that outside the meeting.

The President: If you hang on to those comments for a moment, Bob. We will introduce them into the conversation. Could I suggest that we move on to the second area, which was relating to question 14, on the integrated course?

Mr Alan Kershaw: Yes. This question comes from out of space into this consultation. It is really out of line with all the others. Because it is suddenly saying, it is a very big policy point, which there will be many approaches and many responses. We did not consider ourselves equipped even to start drafting a response on this, and we wanted to hear from Council members. But today I do not think we will refine it down to a yes or no answer. We want to look at material which will give us the bones of the pros and cons that we might put in this, recognising that there are different approaches to think. I know the Education Committee looked at this, and perhaps Sue might take us through what they said.

Mrs Sue Kilby: We did look at this. Basically, we were in a difficult position, because actually there is not any funding linked with this, and unless there is some additional funding we are in a difficult position to actually recommend anything as far as changing the core structure. You are probably well aware that we are looking for additional funding to increase the opportunity to work in practice, but this does increase the cost of the course. And so far, we have not had the additional money put into the course. If there was additional money, then obviously we could look at integration. And obviously the different educational establishments are looking at this already.

But it is difficult to say in the document, "Yes, we will go for integration," when they have not said there is any funding behind it. I think we came out and said that we believed that obviously there should be integration on the intellectual level, but so far as the physical running of the course, it is not quite such a simple matter. We had a brief statement and that has gone round the Education Committee -- or what is remaining of it, should I say -- and that obviously has been fed into Damian and Wendy and will go back to Alan for inclusive. But we have not gone into the extensive arguments about what needs to be considered in detail, when looking at course integration. Because we did not think it was appropriate at this time. Does Nick want to add anything?

Professor Nick Barber: Just to say that people will remember Modernising Pharmacy Careers, which is a subgroup of Medical Education England, which I am your representative on, which is an independent group advising the Secretary of State for Health on workforce issues in this area. Modernising Pharmacy Careers actually has a group actively looking at this at the moment. So it is a field of very active work. There will be an initial report looking at all education up to registration in January, at a fairly high level so this is a very active area being pursued at the moment. But as we said in our report in the Education Committee, obviously there should be intellectual integration, but to say much more without any resource will be very destructive, as it will not be able to be delivered.

Mrs Sylvia Hikins: Three quick points. Regarding how aggrieved we feel, okay this does smack of the sort of heavy-hand of the Department of Health, and the historical perspective. We might feel aggrieved, but I think it is best to leave that behind us. Because out there, if we put anything like that in our response, they are going to say, "Well, they would say that, wouldn't they?" I think we have to focus on the issues and hammer the points we feel are particularly important. Secondly, I am going to raise a little beef, which nothing can be done about, but we cancelled a Law and Ethics meeting, and we did not talk about this at all. So we did not have opportunity to discuss it, and I think that was a trick missed with the Society and that is a pity. Finally, on the point about integrated pre-registration, speaking as member of the Accreditation Panel who has visited over the last four and a half years well over 20 universities, there are great differences within the university community on this. It worries me that the final decision may be around funding, because the universities are being run as businesses, which has positive sides, but also worrying sides. I have not seen any great movement within the universities for integrating courses, and I am not sure whether they are all up to speed. I think it is wise not to have a knee-jerk response. I am relieved Nick said there is a national group looking at this. It needs to be well thought out before it is moved forward, and the present system replaced.

Dr Tristan Learoyd: Touching on point 14, and Appendix A, with respect to integration, and to answer one of the questions. Another reason why there is not a great appetite for integration at the moment. First of all, there is the infrastructure, which is complex, and the second one is the banding, moving from band B to A. It looks attractive, if you look at Appendix A, to move from £6,739 per student to £15,856, and we would all welcome. However, the problem comes where, if you move up to Band A, you are subject to caps on the number of students per school, and it may even lead to school closures. It will certainly lead to the closure of overseas courses that are operating at three or four of our schools of pharmacy. It looks an attractive proposition, but part of the reason is the funding behind it, and the drastic change that would have to happen behind the scenes. For example, my school of pharmacy has an intake of 250. That would not be sustained. If they change from B to A grading for the price, it would mean a reduction in the number of students we could take and that would have a net impact on the workforce.

Professor Nick Barber: Can I add two things. You may want to think about the declaration of interest about what your school does.

Dr Tristan Learoyd: Okay. Do you want to declare yours and I will declare mine!
(Laughter)

Professor Nick Barber: I am an academic at a school of pharmacy,

Dr Tristan Learoyd: I am an academic at the University of Sunderland.

Professor Nick Barber: Do you still do the overseas course?

Dr Tristan Learoyd: Yes.

Professor Nick Barber: Which is one of the areas. What I did not hear is about patient interests. I think the whole point about this clinical engagement is about improving the care which we give to patients, and that our graduates are so much better able to deliver that. That is what my concern is.

Dr Tristan Learoyd: What you are saying is that, in that patients do come first. However, as it was alluded to earlier on, and as you well know, pharmacy schools are operated as businesses and need to survive. The patients always come first to pharmacists, they always come first to pharmacist academics and they always come first in the school of pharmacy, but they are run as a business.

Mrs Sandra Melville, Chairman of Scottish Pharmacy Board: I was going to raise this under the professional body's response, but because Alan specifically asked for comments on the issue, it is just as relevant under this heading. This is an issue for Scotland, because in Scotland there are two schools of pharmacy and neither of them are in favour of having an integrated course. In fact, both of them are quite against it. This does leave us with a problem in Scotland, because we are a net exporter of graduates. So if there is an integrated course in the rest of Britain and not in Scotland, there will not be enough pre-registration places. So that is a concern and I think we need, as a GB-body, need to take that into account. I am not sure if your national group includes representation from Scotland or not.

Professor Nick Barber: The Chief Pharmacist of Scotland is an observer in the Modernising Pharmacy Careers, as they are for Wales and Northern Ireland, and they have attended all the meetings. So we are very aware of the potential issues in carrying things through.

Mrs Sandra Melville: Thanks for that. The other thing to highlight is that it not just a business concern. And I understand the business view and the funding concern which is a valid one. But the schools of pharmacy in Scotland do not see it just as that. We have had lots of examples of the modernising medical careers, and the standards of training that the junior doctors have now I do not think anybody sees as being improved. So it is not just a business case, but a training issue as well. What I would say is that N E S and the schools of pharmacy could work together on this, and will be looking at it together. It is just to highlight that.

Mr David Thomson: Developing Sandra's comments, I think at this stage, with a timescale of a response back by 12 January, the answer can only be that we are not in agreement. The item requires a lot more discussion. An integrated development would actually impede the flow of students. Robert Gordon I think attracts about 20 percent of its student intake from Ireland. If you were suddenly to impose a restriction on further development, beyond the academic element, you could then limit the choice to the students to a particularly university. It is an item that needs much greater depth in discussion than can be contained in this forum just here.

The President: I agree it is a bigger debate, probably for another time.

Professor Bob Michell: When you have the discussion about integration, I really would urge you to base it on the educational part. Because I think page 15, where it discusses pricing and enviously cocks an eye at band A, is truly shallow and naive. Okay, with medical students and dental students there is a double stream of funding, because there is a certain amount of NHS funding. But the reality is that veterinary education is in there still. Veterinary education is substantially integrated these days. It varies between schools. Let me remind you that the sort of facilities that veterinary students need to have provided, and which need to be paid for out of that group A funding, for their training, include little toys like ultrasound, CT scanners, MRI scanners. The NHS is not paying for those.

The nurses. The in-house ward accommodation. There is no comparison between the sort of funding needed for that kind of clinical course and a clinical pharmacy course, however clinical it turns out to be. Can I make my other two points, which are brief and simple. First of all, question 6, open display of medicines. I think our comments there, because I was one of those who was on Law and Ethics when we went through this in great detail; the point about open display, and the reason it is a political concern, is to facilitate patient choice. The point about patient choice is that it should be an informed choice. And there is actually no point in open display if it is merely to look at a pretty box in which psychologists have advised on the colour and the design and subconscious associations, etcetera. At the time we discussed it on Law and Ethics, most people would not have wanted to pull the patient information leaflets out, and it would have been illegal to copy them, in order to have them displayed for the patients or handed out to patients. And so frankly, my view would be quite intransigently that unless the thing that really facilitates an informed choice by a patient, namely the PIL, is available to the patient, open display is a purely commercial advertising gimmick and it has nothing whatever to do with patient choice.

My other point is that I am on the Vet Pharmacy Group. I do not recall this being referred to them for comment. I think it would be wise, in the remaining couple of weeks, that they do have the opportunity, because there are certain aspects that might be relevant. For example, the animal cannot actually come into the pharmacy, or not the bit of the building which is called the pharmacy. There are ambiguity about which is the patient, because in veterinary medicine you have patients and owners to consider. It would be helpful to let them have sight of it.

The President: We will take that on board. Alan, on question 14 I think you have enough around the table to know where we are, in response to that.

Mr Alan Kershaw: Yes. I think the message we have is that we are in no position to say yes or no to this. It requires a great deal of debate. There is enormous diversity. We see no case for a single prescription for the way the course should be run across the country. There are funding issues, however significant they are. It has got to be worked out, if this is going to take flight. And beyond that, we will try to convey the flavour that that question really does not really belong in this consultation at all. The other two points are for information really. One was about question 6, to which Bob just referred, and where our response is not quite at harmony with itself. We will make sure it is. Clearly the message is we do not believe in self-selection and open display. Therefore we must make clear that the word "agree" is not the appropriate one. And the other one was simply the point on page 10, on question 17, where we are asked whether we agree that the standard framework provides a comprehensive approach to CPD, in line with the Pharmacy Order requirements. We could not answer that, because the Pharmacy Order had not been laid at the time. It has now. We will take away. If there are particular points that occur to members, perhaps they would let the office have those, and in the next two weeks we will take those in, so we can complete that part of the response. Other than that, we have heard the message loud and clear. I would point out that the section of the consultation about the Code of Ethics, is not wildly helpful, in that the only questions are one about whether there should be a conscience clause, and the other about whether we agree that the code, as drafted, applies to all sectors of pharmacy and pharmacy technicians. We have found it very hard to disagree with that, but we have made a lot more general points, some quite strongly. We will make some stronger still, in the light of today's debate.

Professor Nick Barber: You picked up on what I was going say, which was that we have not addressed question 7, because we started on question 1 and then moved over. I know you do not want to extend the thing too much, but I think there are one or two points to be made about the Code of Ethics which should be shared in the room. One is the one that we developed. The seven principles which we have is beautifully elegant and theoretically very robust. It is one of the best codes of ethics for professional groups that I have looked at. I do not think we should be messing with it. I think one of the problems with this system, which we have been pushed into, and people have pointed out the problems with the failure of thinking around that, is that if you are going to develop this sort of thing, or change it in certain ways, the way in which we have been asked to do it over the timeframe is completely inappropriate.

It took two years to develop this; the thinking started 10 years ago, at least. I think we can illustrate it with some points -- and I know you want details separately, Alan -- but I think it is worth sharing round the room, so people have examples to agree or disagree with. One is that these issues confuse means and ends, what we are trying to achieve and the way to achieve them. So delegate effectively. That is management 1.01. That is a means to achieving the ends, of looking after patients. Some of them are not logical, so I think item 1 "make patients and the public your first concern." You cannot have two potentially conflicting things your first concern. Either you go down the canteen route of having a categorical imperative, or you go down a series of principles and catalytical reasoning on case based, to deal with a specific problem. I think it confuses those two things. There is a tendency to pack in extra detail, to try and explain the thing, the concept, in the statement. And I think that would lead to confusion. So we had in the 7 principles: Show respect to others. Here, we have: "Respect the dignity, rights and beliefs of patient, the public and others." It does not add anything, and in fact it starts opening up issues rather than helping them. So I think there are many reasons why these are not very good, and I think the process by which we have been asked to deliver them is fundamentally flawed and not fit for purpose itself. And I think that argument -- whether the DH likes it or not -- is a rational ethical argument and needs to go forward.

Mrs Lorna Jacobs: On page 8/18, question 9, where it was suggested that we add something about language competence. Relating to the issue of language competence, the Department of Health have asked for evidence whether there is indeed an issue in fitness to practise cases -- of course, quite often the decisions relate to the standards that have been breached, and if it is not specified that language competence is a requirement, then the decisions from fitness to practise will not be worded in that way. So it would be difficult to get evidence to establish whether or not there is an issue, if it is not a specified standard. So I think it would be very helpful, if it was in there. I think it is a fairly crucial competence. And it would help to clarify whether or not there is an issue.

Ms Seema Agha: Because I came late I do not know if I missed 3 about GPhC embedding equality and diversity at the heart of everything it does. It is a bit early to say that. That might be their intention. I think as a regulator they need to think about what other regulators have done. This is much more also about professional behaviours around equality and diversity. So you would need to link this into a code. I think we need to do a bit more work around that specific section: how have other regulators dealt with equality and diversity, thinking to the future? Behaviour is one way they are looking at, because it is important to how people are treated by other professionals, or how a professional treats its patients, in a concept of diversity. I think I would like something a bit further than that, and something added in there, looking at what other regulators are doing. It seems that we have to help the GPhC to go where they need to go, because they seem a bit lost, in everything I have read. I agree with Nick. I think we are being pushed and you cannot squeeze in a big piece of work in 12 weeks. I think it needs to be said somewhere that we are somewhat disappointed that this work which has taken two years -- and I have said this in the professional body -- how can you squeeze it into a 12-week consultation and achieve an outcome that will be fit for purpose for the future. I think those statements certainly need to go in there.

Mr Martin Astbury, The Vice-President: I thank Alan and his team for their very efficient production of this paper in such a short space of time. I thank you also for the clarification on question 6, and am pleased we will be lobbying for the status quo for patients on the self-selection issue. I will support everything here apart from the bit regarding proficiency. I will come back to the reason why I am concerned on that one. Before, I will cover a couple of additions I would like to see in our response to question 4. I hope these will be uncontentious. I quite like the standards that the GPhC have put together her on superintendents of premises. I think their aim is to cover all the risks and potential risks that can happen within the pharmacy. But if that is their intention, to try and cover all of those things, they have missed about four other things, which I think they need to cover. I would like to see strengthening around these issues. One is that there should be an obligation for the superintendent to set minimum staffing levels. I am not saying within the standard you are going to state what those staffing levels are. That is not appropriate for a standard. But there should be an obligation that the superintendent does actually set those levels.

That is an absolutely vital part of the whole jigsaw. The second part would be obviously we have gone on, and in the summer we made a very strong statement around rest breaks. There is nothing here about rest breaks. So I would like something weaved in to remind people of the obligation for rest breaks. A third one would be around performance targets, either set by the superintendent or by people who he has delegated authority to, that they must not detract from patient safety. I will leave it for the people who write the standards, but there needs to be something regarding that point, anything that is set from above. If he is going to delegate authority to non-pharmacists to then delegate to technicians and/or pharmacists, then that obligation goes back to him. He has to make sure that those targets are appropriate. The other one that you may feel is contentious, which I do not feel is, is around whenever a pharmacy is operating without a pharmacist, then that should be advertised. In order to ensure public confidence in the profession -- which is why I think it should be in the standards -- need to know, if that pharmacy is open and there is not a pharmacist there, they need to know that. I believe that should be an obligation within the standards, to ensure that patients know. I think it came up yesterday in conversation. They need to know when a pharmacist is or is not actually there. Those are my four recommendations. Do you want me to cover proficiency now?

The President: Hold that one for a moment. Any comment on the four issues Martin raised?

Mrs Dorothy Drury: I was on the Committee and I did say that the staffing issue did come up.

Mr Alan Kershaw: Yes, it did. I recall drafting a phrase to cover it. I cannot find it at the moment, but we certainly took it in. In so far as we can, I think it would be idle for a general standard like this to try and express numbers or minimum. We have to state the principle that staffing has to be adequate.

Ms Priya Sejpal, Professional and Regulatory Ethics Manager: On page 11 of the draft, we have said standard 9: "We suggest the insertion of a statement spelling out the duty to ensure that there is sufficient staff present to fulfil all necessary functions to protect patient and public safety and to comply with the requirements of the pharmacy's SOPs."

Mr Alan Kershaw: I am happy if members want that strengthened and highlighted elsewhere. I am happy to do it. It is a fair point.

The Vice-President: I know and like the wordings, but I believe it has to be said specifically that those things have to be appropriate. They have to set an actual limit; that the superintendent has an obligation to set something which is appropriate to those individual pharmacies, where it is in black and white. An example I would give -- whether it is a declaration of interest -- working in a supermarket environment. I do not think there is a problem in the one I work for, but in a supermarket environment, for example, (I know it happens in other companies) if a superintendent sets an actual minimum staffing level, it makes it very easy when you are speaking to a non-pharmacist, who is actually your line manager, for you to be able to ensure that you have the correct staff to be able to operate; that they will not be stealing people away from the pharmacy to cover other things. It does not just happen in supermarkets, but it happens in large companies as well. By making the obligation on the superintendent -- I think actually the wording that we have probably means that they should do that anyway, but I think this makes it absolutely explicit that they have that obligation.

Mr Gerald Alexander: Picking up on Martin's point. The answer in question 3 we put in, I think I might have helped with this bit. It says: "Records of the accountability structure we believe should be maintained." So we are suggesting there is an accountability structure in the company, leading down from superintendent, to the area manager, to the responsible pharmacist and to the pharmacist in charge. Standard operating systems vary from pharmacy to pharmacy, and the same task can take longer in one pharmacy than in another. In effect, if the standard operating system is, if you need someone to check or something like that.

Arguably it will be rather difficult for a superintendent to decide on the minimum numbers of pharmacists or staff in a pharmacy from that perspective, unless you analyse in detail the standard operating procedure. So I think that a standard, as we have suggested, that if you have a record of an accountability structure, people have to justify if something goes wrong, why it has gone wrong.

And because you have identified a group of people through a structure, that should be adequate for the standard. That was my view at the time. I understand your point of view, but I think you are trying to put too much detail in a standard.

Professor Nick Barber: I agree with Gerald. I think technology is coming in, which will change the way things happen. It is difficult to be proscriptive about these things. Therefore you need some flexibility in the wording. And also, regulation is intended to be more outcome based now. So it is about achieving ends, rather than focusing on specific types of means. I do not see any reason why we should tell people whether a pharmacist is physically on the premises or not. What end are we trying to achieve? If they are running a safe service, that is fine. If someone wants to have the pharmacist's advice, they do not physically need to have them in front of them sometimes for that to happen, or they just find they cannot get that advice at that time, so they go elsewhere. I think trying to put rigid statements about that in I do not think is particularly helpful and constrains us for the future.

Ms Priya Sejpal: Just on the point of notifying, putting an advert about the pharmacist not being in the pharmacy. That was something that was raised by the steering group which developed the Responsible Pharmacist standards. It was decision they felt they were not able to make because it fell outside of the terms of reference. That point was discussed at Law and Ethics and I remember the Committee felt that actually that was probably a more suitable debate to be had when we get to the point of looking at supervision rather than now, because to say to a member of the public that there is no pharmacist present, when in fact the RP is absent, in charge, contactable and able to return, could potentially be misleading. So the conversation at Law and Ethics earlier this year was that that was something which needs to be explored, but not at this stage, but in the future when we look at the whole supervision debate.

Mr Steve Acres: I want to reinforce what Gerald said. We did have some discussion around the table, and we agreed that there was quite a wide variation in the way services were delivered, and it was not possible to be that proscriptive in our response.

Dr Tristan Learoyd: I sincerely hoped we would not get on to remote supervision, and that hazardous barbaric proposed legislation which would risk patients' lives and pharmacists' jobs everywhere. However, the point I want to get on to is proficiency under Annexe C. The point I want to make is that I feel as though Annexe C circumnavigates supervision. There are a couple of points in there about checking, technicians' final checks, and there is very little about supervision in there. Personally, I do not feel I can approve that part of it, because it has not approached supervision face on in a proper debate. It is working its way around the edges, to impose a set of rules or a set of standards which are not being properly discussed on this Council.

Professor Bob Michell: You really have to look at this from the point of view of honesty to patients. I fully support Martin's view. It is not about the efficient running of a pharmacy, or looking to the future. I am happy if you believe you can deal with prescription or whatever it is with the RP adequately via IT. If that is the future, I am happy with it, but there is a fundamental point of honesty. If someone walks into a pharmacy and says, "I would like to discuss something with the pharmacist," they must know what is happening is that they are talking to the pharmacist and not someone that the pharmacist thinks can equally well answer the question. If the owner of an animal goes to a veterinary surgeon and says, "Can I see the vet?" It may be that they will say, "Sorry. Mr X is not available. Would you like to speak to the nurse?" What they cannot do is have the kennel maid come out and advise them and they go out none the wiser whether they spoke to a veterinary nurse or a kennel maid. If you go to an outpatients department in a major hospital, plenty of work is done by nurse practitioners, but every patient knows whether they are seeing a nurse practitioner or not.

Either you have to make it clear when a pharmacy is quite reasonably operating in the absence of a pharmacist. And then I will come back another day and ask my question, or maybe not. Or more fundamentally, solve the problem, as we said yesterday and as we have said for years and nothing happened: Pharmacists must have a unique badge that they must wear when dealing with the public. If veterinary nurses can do it for public protection, why can't pharmacists?

Dr Catherine Duggan: Sorry for the delay in my response to question 14. I agreed with the need for a wider debate on this, and I think the question itself is unhelpful in its limitations. "Do you agree that we should have integration?" implies that that is a kind of dichotomous response. The debate needs to be broadened out. We have got some policy issues here that have meant that universities have responded to widening access for years, and there are different forms of education delivered, as was said and as was evidenced by the accreditation process. However, we should also be mindful of the fact that we are, through our undergraduate degree, developing a workforce about safe patient care. We should not really only be thinking about the course we deliver in universities. It is a stepping stone for someone to move forward in their professional life. Perhaps we ought to think about this as workforce numbers, and start looking at how many graduates do we need in the system to deliver effective patient care across all sectors subsequently? And maybe across our different countries and our different sectors we can look to our medical colleagues, who have looked at this for years. I think I am right in saying that, for one of the first times in our profession we are going to be having more graduates than pre-reg places allow, and that is an unethical (if I may say it) situation to be in, despite the fact that we are widening access to education in that having a pharmacy degree allows access to other careers. We understand that. But if you are talking about a workforce for patient care, whether it be in industry, academia, hospital or community, surely it is tantamount on us as a Council to start thinking about workforce: numbers in, numbers out and where people go. We need to do that in the round. I would welcome some consideration about a wider issue of workforce planning which, longer term, should go hand in glove, regulator and leadership body. We should lobby for more places, if we need a greater workforce. But also we should think about the graduates that are exiting our universities, and what we are leading them to expect, by allowing access to more and more courses. It is a point I feel quite strongly about. And a declaration of interest, the School of Pharmacy, University of London and Chair of UKCPA, so more clinical in my perspective is important.

Mrs Alison Moore: On questions 9, 10 and 11 (papers 8 and 9). These are the ones about the standards of proficiency. It is a question really about what the standards of proficiency are there for. Are they enabling, to say: These are all the things that a pharmacist or a technician could do, and therefore if they do them, this is how we are going to regulate them? Or are they standards saying: This is what we expect pharmacists and technicians to be doing. Therefore they need to be trained to do those tasks. Because I think our response would be very different, depending on what the standards are there to do. For example, there are things in there that say a technician might have responsibility for setting up SOPs to ensure the safe running of a dispensary. In the average community pharmacist, a technician will not have the responsibility for setting up SOPs. That will be the job of the responsible pharmacist. However, in a busy hospital pharmacy, a technician might be the dispensary manager, and it might well be their job to do that. What I am asking is, are these things that say, "if a technician were to do this, this is how we would regulate them and expect them to behave?" Or is it a list of things that says: "These are all the things we would expect a technician to do. We need to change the training so they can do it?" because we have not had that debate, if it is the latter. If it is enabling, I am happy with that.

Ms Yvonne Liddell: I wanted to go back to Martin and Bob's point about pharmacists wearing a badge, or people wanting to know when the pharmacist is present or not. We did agree with the responsible pharmacist that in the two-hour scope, they are contactable remotely. But if a pharmacist is on a rest break, and someone comes in and says, "I want to speak to the pharmacist," I would hope that all technicians, pharmacy support staff and counter staff are sensible enough to say, "I am not the pharmacist. The pharmacist is on a break, or not here right now. Would you like to come back," or "we can contact them for you." I have never come across anyone who said, "Could I help you?"

If they say they want the pharmacist, that is what they get. That is what we have always been taught from day one. You do not answer, if someone says, "I want the pharmacist." You go and get the pharmacist. You do not pretend you are or you are not. So wearing a badge, I do not see what difference it is really going to make at all. I think if the Responsible Pharmacist is here to set the standards, we cannot now say the responsible pharmacist has to display a badge to say you are a responsible pharmacist. They will just get annoyed.

The Vice-President: I would agree. I have never come across anyone I have worked with -- I would make sure they know. I want to make sure is that job of the counter assistant, or technician second, is made easier. Because at the moment people will take lunch breaks at different times. People will go absent now -- because you can go absent now at any time of the day -- at different times. It is the public turning up and expecting to have a full service offered them, and that not being available, is what will damage the whole profession. In respect of themselves, you will do that, but let us make it easy, so it is advertised. So people know, when they turn up that the pharmacist is not there. That surely makes your job so much easier to respond to.

Professor Bob Michell: I am sorry. I am not going to name chapter and verse, but I will tell you that in no case was it a multiple pharmacy. But I know of three instances where people want to discuss something with the pharmacist, and I have said to them, "Go in and say you want to talk to the pharmacist." And it is so disarming, when there is a helpful face in front of you that says, "Can I help?" And in each of those instances, the very willing helper was not the pharmacist, and they did not say so. Can I make my final point, which is a more general one and is different. Early on in this debate, some extremely important points on current philosophy of regulation, and the process by which current standards evolved were made by Nick, Seema and others. The problem with those points is, first, they look a bit like sour grapes from the old codgers, as they give way to the new team. And secondly, that this Society is still open to the same criticism that leads to subdivision. In other words, it is a conflict of interests. It is a pharmacist organisation. What I would like to suggest -- not necessarily for us to decide now, but perhaps for the officers to reflect on and others -- is, I wonder if it would be helpful if, as well as the responses that we plan, on these particular matters of the way the existing code evolved, and the general philosophy of regulation, whether the lay members might write separately and comment specifically on those issues, driving home the point that this is not sour grapes from pharmacists. This is the existing custodians of the public interest giving a view to the future custodians of the public interest.

Mrs Kay Blair: I think I disagree with the fact of asking fundamental questions about the approach to standards and asking for the risk assessment and the evidence behind a proposed major shift in standards is actually sour grapes. I think it is a very valid question to be asked. Whether it is only asked by lay members or the whole Society is for others to agree, but I think it is a fundamental question behind a move in these principles and standards.

Ms Marcia Saunders: I agree with Kay on that. I think it is possible to construct a response. It should be from everyone, because the lay members are not the only custodians of the public interest. That is our sole role, but all members of the Council have that responsibility, and I have always been a little bit nervous about separating the lay members from it. But I think it would be possible to construct a reply and phrase a response in the way Kay is suggesting, that could point out that the lay members as a group were unanimous in their support for this.

Mr Alan Kershaw: I am happy to take the advice of Council on this. I am not sure a separate response is necessarily going to achieve what we want. I would be very happy for the group to incorporate that sort of view, making it clear that the lay members in particular advanced this position. I will not feel affronted if lay colleagues, including me for that matter, want to write a joint letter and decide that is the way to do it. It may be far more effective to put it in the same document. We will be a separate rather more strongly worded response from the professional side. That will be enough for the professional side. But in this side, we need to make clear we are speaking together, but the lay members want it to be known that they are not giving way to the professionals on this.

The President: I think we will leave it to you to decide, Alan, in terms of integration into your regulatory area, or a separate letter.

Mr Alan Kershaw: If we could achieve that I would be very happy to add a passage in to make that clear. It is not to take away from the strength of what Bob and the others were saying. It is a perfectly valid view, and there is plenty of space in this to put it. We are answering the questions and saying other things as well, because the questions themselves do not give us the chance to say them, so we need to say them in addition and that is fine.

Professor Bob Michell: I wanted to come back to Marcia's points. I fully realise every pharmacist member is interested in the public interest just as the lay members are. The point I was making was in the public perception, the pharmacist members -- in public perception -- have a big axe to grind. The lay members do not. That is all. They are neither tainted by a vested interest, nor can they be perceived to be tainted by a public interest. I am not implying that the pharmacists, as Gerald has shown on many occasions, do not have the public interest at heart. Pharmacists do, of course. They care above all for their patients, which is the excellent feature of their code of conduct.

Ms Marcia Saunders: Can I say, Bob, we are in complete agreement.

Professor Bob Michell: We are in public business, and I would not like it to be reported "lay member says pharmacists are not interested in public interest."

Ms Marcia Saunders: I did not think for a moment you meant that.

Ms Seema Agha: Just for the record, I will read a paragraph from the Hampton principles, which might summarise what we are trying to achieve. It says: "Regulators should identify and explain the principal risks against which they all are acting, and they should, in consultation with regulated entities and other interested parties, set and publish clear standards and targets for their service and performance." It sets out: "These standards should include regulatory outcomes, capturing the principal risks and costs of regulated interventions and the perceptions of regulated entities and other interested parties and proportionality of effectiveness of regulatory approach and costs." I think in essence, in my response, I think we should remind them that they need to do this bit of work. I do not think they have gone anywhere else. There is nothing in what they have published, that they have actually done some research around where regulation is going, and I think I would read this bit back to them.

The Treasurer: On a couple of points Martin was making before. It seems to me that it is a pity that these codes and standards cannot be applied to all NHS dispensing contracts, because it is in so-called dispensing doctors' surgeries, where people in white coats, citing a myriad of NVQs and cycling proficiency test certificates, appear either by the sin of omission, or sometimes by deliberate deception, to be a pharmacist. That is where the public are genuinely being misled. Ever since I have been on the register, 20 years now, pharmacists have had to display their certificate in the dispensary on open and public display, and the current regulations replaced it with the responsible pharmacist certificate, which is not quite the same thing, because not every pharmacist working would be the designated responsible pharmacist. But you have to advertise your presence. Surely if you are not going to be present, you have to advertise the fact that you are not present. So the fact that a pharmacist is not there is surely a corollary to the fact you have to advertise the fact that a pharmacist is there. So I think that is wrong in the current standards and it should be there. In terms of minimum standards, we [have] so many SOPs to deal with now. Some companies have upwards of 30 SOPs, which cover a whole range of services, some we were designated to call enhanced services in community pharmacies. It seems brazenly wrong not to lay down minimum standards. This code has been described as more restrictive, as more prescriptive. So for them, in terms of public safety, not to lay down minimum standards, when all kinds of new range of services are being provided from community pharmacies seems to be strange. For instance, a pharmacist who might have to provide EHC, weight management services, warfarin clinics, bone density clinics and dispense may be asked to work without any support

staff whatsoever. That is simply to say in some of the SOPs that these advanced service cannot be provided unless there are some qualified support staff. It is not being very proscriptive about laying down standards, but it is laying down the principle that there should be some kind of minimum standards operating in pharmacies. It seems to me to be outrageous that these things are not being specifically stated in this code, in the way it has been written.

As a general comment, I would be happy to see some kind of preface go in with our response, that collates some of the comments that have been made today. Seema started by commenting about the Hampton principles and light touch regulation. Kay commented about some modern regulators being more proscriptive. She made the point herself that the FSA is a failing regulator. The Pharmaceutical Society is not. Our teacher, the CHRE, has given us, as the pupil, top marks, time after time, for the way we have regulated the profession. To the best of my knowledge, there is no patient group that has ever complained about our Code of Ethics or complained about the Code of Ethics as it stands now. The real blaring error, the real big mistake, that the GPhC has made is that the GPhC has failed to establish the need to rewrite the Code of Ethics. It has failed to establish the need to rewrite these standards. It is patronising and demeaning to us not to bother to explain why this is being done. I find it deeply disappointing, because of the quality of work and the time that was taken to do all of this. And then we have the fact that we are told we have a new independent regulator, yet the new independent regulator's codes and standards were all written months before the new independent regulator was even appointed. So they have done a fantastic job to write these standards before they even met for the first time! The underlying message there is that the new "independent regulator" is actually a clear agent of government, and it seems to me that is not the way forward. That is not the way this new body should stand, and it is a real insult to this body, and the profession as a whole, the way they have carried this out. I appreciate Bob's point and the nuances between if the lay members respond, does that mean pharmacists cannot do governance, kind of thing. Graham Phillips would be absolutely delighted with Marcia's comments. I am sure he is turning in his Council grave now, so to speak, in the light of certain comments that have been made. But it seems to me that it is not a question simply of self-interest, or a question that we were failing. It is the opposite; that the CHRE, for one, was giving us top marks. It was praising the Society. It was not that we did not do anything wrong; it is that we did almost everything right, in terms of regulation, from a regulator's point of view. That is what is really disappointing. Sylvia said, "they would say that, wouldn't they?" Well, don't ask pharmacists. Go to the CHRE. If the GPhC wants an opinion, it can go to the CHRE about our code and our standards and ask them what they think, because they do not have the self-interest of pharmacists.

There have been comments around the table. I think the members and pharmacist registrants would appreciate it if our response was prefaced with some comments along the lines I have just stated, which is really a summary of the comments that have been made around the table, so I think that would meet with general Council approval.

The Chief Executive & Registrar: Could I support John's suggestion? There have been a number of points, and Alan referred earlier to the fact, there were several issues which the working group wanted to address, that were not actually prompted or provoked by the questions themselves. I think there are a number of up-front points in a preamble that would pick up on the Hampton principles, quite possibly, the confusion of means and ends, the question that Kay has raised about the evidence for change. I would suggest that is one place where we could emphasise the role of lay members in the drafting of the response, and pick up on the inappropriateness of some of the questions, such as the integration of the MPharm and the pre-reg year, which is a much bigger discussion, and obviously touches on NPC, and other work that is going on at the moment. If we were to do that and have a preamble, it would also enable a mirroring of the shape of the professional response, which has the preamble in your packs, the Council papers. I think that would be a very good approach which would allow the two to be equally weighted.

Ms Marcia Saunders: I would like to support what Jeremy says, but on the issue of mirroring the professional response -- I am saying this because I have to go in 15 minutes,

and we might not get there. In the beginning of the professional response, there are three roles that are described: Leadership -- I cannot remember what the three are. It is leadership, professional development, education, support, professional networking and publishing. What is missing is any reference to the role of the professional body in engaging in the development of standards, which is exactly what you are doing now. And also in challenging the profession and engaging with the sort of things that modernising pharmacy careers is doing; modernising and developing the role of pharmacy. I think that slightly weakens the professional response, and it would be shame if we did not talk about this engagement.

Mrs Margaret Allan: A slightly different point, on question 19. It was something that was raised at Education Committee. We had a bit of debate about it, so I wanted to bring it up. We had a query around the fact that the statement is "return to practise". And actually, what "return to practise" means, in that we made the comment should it potentially be "return to register" rather than "return to practise." Because if you are actually registered, you would still be doing CPD. And in the descriptions of CPD that actually ensures that you are competent to practise, by doing your CPD, within whatever scope of practice you intend to work in. Therefore, is it not "return to the register" rather than return to practise, because practise does not really describe what we are talking about. That was a comment from Education Committee.

Mrs Alison Moore: I asked a question before and I think it got lost because nobody answered it. The point I was asking for was were proficiency standards there to be enabling, or are they there to be aspirational? Because there is quite a big difference between the two. I think our answer to the questions here should be different, depending on what their purpose is. If we do not know, can we find out before we decide on our answer?

The President: Does anybody have a view on Alison's question?

Mrs Wendy Harris: I do not think there is actually a specific answer, in so far as I have never heard the department or designate GPhC talk in that term. We have had to look at them being enablers because otherwise as a regulator we could not enforce them. We need to be able to have that professional judgment exercise. We cannot take it down more than that. I am not aware of anything written or drafted or described in the way you have developed them.

Mrs Alison Moore: If it were possible to consider putting within our response to say we are happy with these standards, as long as they are written in sense that they are enabling.

The Vice-President: I still have a concern. The response Alan's team have put together is excellent to the standards. I am not criticising anything we have produced here. My criticism is that I do not believe the GPhC or whoever is actually consulting on this proficiency at the moment. This is putting the cart before the horse. The example is at the bottom of page 7. We have stated: "A clear statement of what those holding different categories of registration can be expected to do." Yes, it is important, but what that is saying is that we realise these standards are actually saying what everyone can and cannot do. But what that is doing is actually circumnavigating the whole discussion around supervision that the profession needs to have. We need to have the debate about supervision to work out what people can and cannot do. Once you have done that, you write the standards that enable people to do what the profession wants them to do. This is actually opening up and allowing people to do things before the profession has actually decided how it wants those standards written, and that is certainly my concern. Maybe I have not read in depth sufficiently to be able to know, like Alison says, whether it is an enabler or not. But at the moment I have enough concern that I believe this is putting the cart before the horse. Therefore I want it noted that I am against the GPhC. I am not against what we have produced, but against the GPhC going out on those standards at all.

The President: I am sure the working party could make that clear in the response.

Mrs Dorothy Drury: I agree with Martin's phrase, the "cart before the horse" on supervision. We have not got there. I agree with Alison. We can be enabling. That is what we are trying to do, but not to pre-empt, which is where I am with Martin.

The President: Good luck Alan! (Laughter)

Mr Alan Kershaw: Thank you, President. I appreciate a very positive and I think temperate debate. It is very helpful to us. There are one or two things I want to say. The point about standard of proficiency is well made. We were expressing some welcome for the fact that a statement is being contemplated which I think every regulator ought to have, which is a statement of what the register means. That "A pharmacist is someone who can ..." "A pharmacy technician is..." and so on. That is good in itself. I think the point about timing and supervision is well made. We will introduce those notes of caution into it, to say this is something which is out of the blue -- it has dropped from the sky -- and here we are. We think they need to work this through very thoroughly with the profession before implementing it. However, the principle of having such a statement is right. I think in some of the comments that have been made, we have picked up good examples of things. I think in our response we need to be very careful not to take it make broken-backed. We cannot, on the one hand say -- well, we can, but I do not think it would be a very good idea -- that it should be principle based, and not drift into practice, and not talk about operational stuff. And, on the other hand, start talking about badges, and what have you. I have no problem with the idea of badges. But the principle we must enunciate -- principles around "The patients must be safe. The professionals must be accountable. The patients must know what they are getting and be able to get what they want," and so on. That is the kind of thing we should say in the tenor of this, rather than getting into the operational bits and pieces, important as they are. I think we will weaken our own case about the Code of Ethics, if we do that. That is an important point to make.

The other thing I want to say is that we seem to have had some very broad-brushed comments here about "the standards". Actually, there is quite a lot in here we have not talked about in detail; mainly because we do not have to. The new standards for the delivery of education have not been commented upon. I know the Education Committee have had input into that anyway, and they have not raised issues about that. There are good things we can welcome.

My personal view of standards for pharmacy owners and superintendents is not one I would start redrafting without a box of matches, because I think it is appallingly written. I am sorry if that offends anyone, but it is. It is the one, out of all these, which sticks out as heavily regulatory, heavily negative and it is a guide on how to get into trouble. Whereas the rest are guides on how to do the right thing, whether they have got that all right is what we are going to comment on. However, it is hard to say that the things in that standard are actually wrong. They are all things which apply. The way it is cast, we want to make the point that it should be positive about how to do the right thing.

So there are different flavours in the way we respond to different documents, and we will reflect that. The last thing I want to say is that we will listen carefully to the debate, which I hope perhaps does not have to be as long as this one, on the professional side of the response, because there will be ways in which we can pick up flavours from that, which may be helpful to us as well. So we will try to end up with a document that is not disintegrated; it is one which will hold together, but recognising there will be two different perspectives in it, which is quite right and proper. We will certainly make clear how strongly the lay members feel about particular aspects, in order to bring out that this is not professionals defending themselves. They are quite capable of doing that on their own.

The President: Thank you Alan. The reason I let the debate go on for so long was so that the second debate might not need to be as long as this on the professional debate. Can I check that Council are happy that officers sign this off, given time constraints? Thank you Alan, Priya and all the members of working group. We really appreciate your attention to this one. Thank you.

*[Council
agreed*

- i. that the comments made by Council members be incorporated into the response; and*
- ii. that the Officers Group sign off the response prior to submission]*

We are going to have the professional response.

The Chief Executive & Registrar: Council, the Boards believe that the staff lead should be Lyndon. It is a good example of how one country director can lead GB-wide. He has done that very successfully. Lyndon, for family reasons, is not able to be here today, so Howard will lead on this.

Mr Howard Duff, Director of England: Council asked the Boards to develop a professional side response to the consultation. And Boards are looking for Council to understand the tone and context of the approach we have taken to date. The paper is seeking the agreement from Council to delegate the sign-off on the professional side response to Board Chairs. Obviously we would welcome any individual thoughts from yourselves about this, and we have picked up a lot already from the discussion, which does chime and echo with a lot of the tone and content on what is on the professional body side, particularly, around the timescale of it, which Seema mentioned. I think it is not a great time to have a 12-week consultation over the Christmas period. Issues around the educational variability of delivery being left with the schools of pharmacy. And I think Catherine mentioned the dichotomous response. In fact, that is very much teased out in response, in our response to that particular question. It is in a dialectic format. It is not a single; it is a discussion, is it not? And Nick's point on the elegance and robustness on where we are with the Code of Ethics. We are being very assertive with this and quite rightly so, I think. And I really got a sense, listening to the debate, that we are in the right place with that. Just another one around question 19. We have picked up, is this a return to practise or return to register, and in fact it then becomes that this is a fitness to practise issue about how you declare yourself fit to practise. So I think there is a lot of commonality. Just a few notes from Lyndon about the process that we have been going through. The process for developing the consultation response has been led in each of the countries by Heidi Wright, Amy Griceman and Jocelyn Parks. That has been co-ordinated by Lyndon. Every National Board member has had an opportunity, and has been invited to respond to the consultation questions. I have had quite a lot of individual responses from various board members with various expertise. The three Boards have individually discussed the main issues at formal or informal board meetings. We have brought together a three-board working group, with five members from England and two each from Scotland and Wales, who could not get together by video conference in mid-November. So a collation of all the Board members' responses to the questions was presented at the meeting. What you have in the pack is a sense of the tone, and some of the ideas that we are coming from. We have not provided as yet the individual answers to the question, as I do not think they are fit to show you at this stage. But we want you to understand where we are coming from, which will inform how we go through and answer the individual questions. Although we will not be limiting ourselves purely to answering the questions.

The next draft response we have presented, which will be an iteration of that, will be presented to the next working group which will be on 4 December. We will be seeking the input of Professor Sheila McLean, who led the review of the Code of Ethics in the original post, and there may be an appendix for her views, which we would include. Subject to the October Council decision, we have the ability to seek legal advice, if we find it necessary, in light of any of the points that we have. We aim to have a full response after the deliberations on 4 September, which will be iterated in a final document, which we would ask you to allow Board chairs to sign off on 8 January, ready for submission by the 12th.

Dr Catherine Duggan: I would like to say that I really liked this document. I know it sounds a bit wishy-washy, but it is well constructed and clear and very to the point as well. I welcome that. However, I wonder whether much of the debate that we had before touches on -- of course, it overlaps, and we, as Council of the current RPSGB, are overlapping in our consideration of leadership and regulation.

Might be worthwhile pulling out, rather than rehearsing lots of notes and commentary again, the pertinent issues question by question, to make sure it captured the tone and some of the comments that came out earlier on.

I am sure you are going to do that, Howard, but it might be worthwhile saying it. I really welcome this and it shows that the de-merger is well on track, as we are able to look at this quite objectively. But make points that are assertive; not strong and aggressive, but assertive. I welcome it.

Mrs Dorothy Drury: I would like to agree. I particularly like page 5 / 5: "In principle the new professional bodies disagree with being limited." I think that is very well put. Thank you.

Mrs Sandra Melville, Chairman of Scottish Pharmacy Board: I would like to back up exactly what Howard says. It has been very interesting listening to the debate on the regulatory response, how much alignment there has been in the broad principles of this, in a lot of the things about not having to start from scratch, when we have been a regulator for all this time, about it not being principle based, about it being too prescriptive. These are all things we have picked up. We have this unusual model where we have two different responses to a thing, which is quite new to us, and we have found that there is quite a lot of common ground. I think that actually is not surprising, when you think that the Code of Conduct says whatever side of the blanket you are looking at this from, you are putting patient care first. I think that demonstrates that very well. So I hope Council will agree that the Board Chairs can sign this off. Steven, I would like to congratulate you on your chairing. I have a lot to learn from you, in "We will do this before coffee!" (**Laughter**) But, my understanding was that we were going to go through the detail of it. That was my understanding anyway. I think it has been very interesting listening to the detail of the comments from the regulatory response.

Mrs Lorna Jacobs: Can I offer a point of clarification? It is going to be clear that this is a response from the National Boards, so we, as Council, are being asked for the Boards to sign off on their National Board response. I did not want it to be muddled as a Council response, because I would not say (without having the answers) there would be more needed, but I am very happy that it is the National Boards' response, and they therefore have the responsibility to sign it off.

The Chief Executive & Registrar: That is absolutely right, Lorna. Although Howard made the point that the work is still going on the responses to the detailed questions, we also felt it was not appropriate for the Council to go through the Boards' detailed response to those detailed questions, if Council is true to its commitment to delegate that responsibility to the Boards for the professional response. There are a few instances in this preamble, if you like, where we rely to "the Society". I think we need to be clear that we are really referring to the National Boards of the Society. Your point is well taken and we need to make that distinction absolutely clear. If we can have those counterpointed responses which, as Sandra says, are not as far apart as we might have expected them to be, then I think that would be a very good two part response.

Ms Seema Agha: Going towards the future, there are some important statements about the new professional body looking forward to working closely with the regulator, being consulted and something about future messages as well which are positive. I still think some of it has not been captured in here. One thing I suggested was a bit more of a chronology about the work the professor had done, and a bit more on how we got here. Not a long story, by a succinct one, and how we have been very much at the forefront of leadership in regulation. And as a professional body, how seriously we take regulation. I think those messages need to be tightened up in the introduction and the preamble in how we got here: "Here is our journey, it is very recent now. It has actually been thought through and it has been done very well. In the future we will look forward to working with you continually and dialogue with you." So that they know that – "we might feel negative, but we are still wanting to talk to you. We have to talk to you!"

Mr Howard Duff: We have to bear in mind that this consultation is being carried out by the CHRE, not by the GPhC. So I think we have an opportunity to “cuddle up” to the GPhC constructively, whilst still being assertive with CHRE.

Mrs Lorna Jacobs: Just a quick point about how thorough we have been in doing it. I wonder whether actually that could come as an appendix, because then it could be put in more complete detail, without sounding so “Well look how we did it better!” kind of thing.

The President: Let us allow the working group to decide how best to play that. I would like to thank the members of the working group, and acknowledge the support of Seema as well in that process, alongside the representatives from the Boards. Just for the record, can I ask Council to agree this response is signed off by the working party of the members of the three Boards? **(Agreed)**

The Chief Executive & Registrar: Could I take you back to the discussion before coffee for a moment? You would have seen an email about the procedures for education and registration, which have recently gone out to consultation. My suggestion was that our response to those procedures should be added to the remit of the Council working group on the regulatory side and the National Boards working group on the professional side. Is Council happy for that responsibility to be added to their two remits? **(Agreed)**

The President: We have moved item 17 into confidential business. Two papers into confidential. We are going on to 18, paper 129.

Mr David Thomson: Can I declare an interest as Chair of the Trustees of Pharmacy Support?

Mr Bernard Kelly, Director of Commercial Services & Resources: The purpose of the paper is twofold. The first is to authorise the release of up to £100,000 from the Emergency Fund for the relief of pharmacists who have been directly affected by the recent floods in parts of the country, but also for that money to be used, where appropriately, for any other relief of distress that may be caused by adverse circumstances, such as the flooding. We would also like to ask that the handling of any applications under this fund is delegated to Pharmacy Support, who have both the administrative systems and the experience in actually discerning when funds such as this should be distributed? We hope there would be sufficient publicity arising from this that it would encourage applications from those affected to access the fund.

The second objective of the paper is to authorise any unused elements from the Emergency Fund to be transferred to Pharmacy Support and effectively the Emergency Fund be wound up and consolidated with Pharmacy Support. These funds have been available for some considerable time. Originally it arose as a result of an appeal to members back in 1953/54 when we had terrible floods in the east of the country, when many people were killed. It has been added to over the years. And one of the problems one finds with funds such as this is, because they are set up for specific circumstances to serve specific people, getting applicants to come forward for these funds is often very difficult. So we regard the opportunity to actually publicise what the Society is doing in releasing these funds as a great hopefully encouragement for people to put themselves forward to access the funds. Basically, I would say that is really what we are trying to do here. We have been trying to clean up the subsidiary funds, such as this, for some considerable time. We have made great progress and this is probably one of the last stages of being able to consolidate a number of minor funds into one over-arching fund, which eases administration and makes it more efficient.

Mr David Thomson: Thank you, President, on behalf of Trustees, to acknowledge our gratitude and thanks for this level of support. My question is can the process be actioned now to transfer funds across, rather than wait to December 2010? The reason being that Pharmacy Support is already engaged in this work, and perhaps there is a risk of an element of competition being seen and confusion, if two organisations are coming in with the same ambition, and the advertising or promotional element from the Society’s perspective could still be gained by transferring the money across at this stage.

Mr Bernard Kelly: There is slight detail delay, which is why we have December 2010 in there, which is to do with gaining Charity Commission approval, for effectively what we are now doing is subsuming the Emergency Fund into Pharmacy Support. The money that has been released, £100,000, or has been requested to be released, will be made available to Pharmacy Support for them to use in relieving distress where necessary. The delay is purely one of getting Charity Commission approval for the proposed course of action.

Mr David Thomson: Perhaps I could suggest that the approach is made as a joint approach by the Society and Pharmacy Support. The concern being the potential for confusion amongst potential applicants, if two elements seem to be competing for the same target audience.

Mr Bernard Kelly: That is why we have proposed that the £100,000 is made available to Pharmacy Support for them to process any applications, so we would not have people coming to the Society directly. Anybody that came to the Society directly would be directed to Pharmacy Support, who would then avail themselves of the £100,000 that is available.

The President: There may be some confusion, because the paper I have talks about the officers in recommendation 1.

Mr Bernard Kelly: I am sorry for that confusion. The reason we have updated the recommendation is to take into account some conversations we had, since this was first floated and the paper distributed to Council. For the reason, we pointed out -- and for the workload that would already be on the officers, it would seem appropriate that we use Pharmacy Support, who are used to doing this sort of thing, to act as our agents on the spot.

The Chief Executive & Registrar: Could I emphasise that there is no -- absolutely no -- intention of the setting up parallel streams of activity, to use your words, David, no competition at all. Quite the reverse. The working assumptions we have had with Pharmacy Support of collaboration between that body and the professional body still hold good. This is a practical example of how this could be made to work in reality, where funds are released to an organisation, Pharmacy Support, that has the infrastructure and the processes to be able to disperse them properly. That is what we would like to see happen.

Dr Catherine Duggan: Thank you, Steve. I welcome this paper, but I just suggest we might communicate it sensitively; whilst the floods at the moment have been unprecedented in their severity, there have been floods in the previous couple of years that caused havoc in other parts of the country, and we would not want to be seen to be preferential in any way. So perhaps how we communicate this needs to be done sensitively.

Mrs Sue Kilby: I am not sure what was in the paper. If this money is coming from the Society to Pharmacy Support, and I have every confidence that they will manage it appropriately, it would be useful to have some rough idea or guidance of the type of way it is used; not details of individuals and where it is going. But because I think one of problems is that I do not think people know what they can put in a claim for, through Pharmacy Support. It is getting understanding as to what might be appropriate. I will be guided by David as to what his thoughts are on this area. But for myself, sitting on Council, I am not sure what is happening there.

Mr David Thomson: I think we have made contact through the local branch secretaries and indicated that there is support available, in whatever form it is needed. We have not limited it. We still await applications I think at this stage. The issues are wider than just Cumbria. There are issues in Dumfriesshire and other parts of the country as well. The help might be purely advice and direction as to where appropriate help can be gained. It may be financial. I know some situations where people may require help with excess payment in insurance claims, so people might need help initially to process their claims. We would look at each case individually and offer appropriate help that is needed.

Mrs Alison Moore: I should declare an interest, in that I probably know personally some pharmacists involved, both in Cumbria and Dumfries and Galloway. I wanted to emphasise David's point. It is not just Cumbria that was affected by the flooding.

The Treasurer: Just to comment on the date of December 2010 mentioned in point 2 of the summary of decisions and Dave's comments about the date. Am I right in assuming that the funds can be transferred for this emergency fund, so they can be allocated to the Benevolent Fund and accessed by pharmacists now or very soon. The date of December 2010 is simply the date to wind the charity up. So the December 2010 date is not the date at which the funds can be accessed. They can be accessed immediately.

The President: Correct. Could I ask Council to agree this proposal? **(Agreed)**

[Council, acting as Trustee of the charity

agreed

- i. *that the sum of £100,000 be made available immediately to be applied at the discretion of Pharmacist Support to provide financial assistance and support to any pharmacist in distress as a consequence of the recent floods in the country, or any similar occurrence in the future; and*
- ii. *that the balance of the funds in the account of the Emergency Fund as at 1 December 2010 shall at that date be transferred to the Trustees of the Benevolent Fund ('Pharmacist Support', charity no 221438-1) to be applied as part of its general funds.]*

Any other business

I have three items. If I could ask Jeremy to talk about the first of those three.

The Chief Executive & Registrar: This is the appointment of two Society nominees to the Board of Governors of the College of Pharmacy Practice. Council members will be aware of discussions we have had with the College and moves towards integration of the College's key functions into the professional body. As part of that process of discussion, we have agreed with them that two Society nominated individuals should join their Board of Governors. We sought expressions of interest from Council members. We have had three expressions of interest, and the two individuals are Professor Nick Barber and Sue Kilby, who will be joining the Board of Governors of the College of Pharmacy Practice, and their Chief Executive, Ian Simpson, will join the Transitional Working Group. I think that is a very positive move forwards to the integration of their functions into the professional body.

The President: Thank you, Jeremy. I am asking Council to ratify that. **(Agreed)**

The Chief Executive & Registrar: A point of information from the Appointments Panel for Council to note.

The President: Thank you, Jeremy. John, following our conversation about BPC yesterday.

The Treasurer: Council will be aware of pending decisions that need to be taken with regard to the 2010 BPC around the venue. Because the team need to complete some site visits, the dates and the projected cost we have are held up until 11 December. These decisions need to be taken in the next two weeks, but cannot take place until the team have undergone site visits of the venues concerned. So we ask Council to give the officers the power to make a decision on their behalf, once those site visits have been completed and the team can make a recommendation.

The President: Are Council content with that? **(Agreed)** The third related to Catherine, who has just left the room, so talk amongst yourselves until she reappears. **(Applause as she re-enters the room!)**

The President: You left at the wrong moment! Not a Council meeting goes by these days without saying farewell to somebody. And today's person we are saying farewell to is Catherine. I would like to say a few words in public business, so it goes on the record. It does not seem long at all since I was welcoming Catherine to Council, but today is her last

meeting, as a Council member anyway. Luckily, as you know, she is not deserting us. She is taking up the post of Director of Professional Development and Support early in January next year, where she will bring significant experience, as well as bags of energy and enthusiasm to this important role. I know from talking to a number of people, she has already started getting involved with the work of the Society, has begun to support and form relationships with those who will be working closely with her in the New Year.

Catherine combines strong strategic and policy thinking, with a clear sense of professional support that pharmacists need in their daily lives. She is also very collaborative in her style and I know that your people are already looking forward to working with you, Catherine. Catherine spent her early career in community pharmacy, and has since become a highly respected practice research and policy specialist. As well as working in frontline NHS roles, her achievements include developing ways to measure patients' medicines information needs and improving inter-professional communication across health care. She has been very closely involved with the UKCPA and I know they will miss her contribution, her enthusiasm and her leadership. She has also been an active member of the English Pharmacy Board since June of last year, shortly after being elected to Council. Her contributions have brought experience from many areas of work, about which Catherine always speaks with passion as well as authority. Her extensive networks are always brought to the table for the benefits of the Board's activities, and her approach has always been refreshingly collaborative. I know that the English Pharmacy Board all wish Catherine the very best for her new role. I have to say as the English Pharmacy Board representative on TWG, Catherine has been exceptional in her work within both professional networking and professional development and educational workstreams. In these areas she has put a considerable amount of her personal time and effort. Catherine brings a lively, energetic and fresh approach to TWG. A prime example of this is the modern youthful terminology she introduces to the team ---

The Treasurer: *Init!* **(Laughter)**

The President: An item relating to the use of Wifis stayed on the action list for a number of meetings, was largely down to the confusion as to what it was, and what we were supposed to do with it! **(Laughter)** Although Catherine has been a member of the Science Committee since she joined the Council, she only chaired the Committee twice, before she was appointed Director of Professional Development and Support. However, Catherine does not get away from science that easily. She will head up science and research within the professional leadership body. Catherine will be remembered by the Committee for her enthusiasm and faultless chairing of meetings, which now last an hour longer than the previous chair! I wonder why! I was told that Catherine was delighted with the choice of hotel she stayed at in the October Council meeting in York, as she declared that her aim was to replicate the atmosphere and feel of the Hotel Du Vin in the house she is currently doing up close to Alexandra Palace, a work that she declared had been in progress for several months, but was still no closer to completing. A tartan carpet, red walls, green sofas and heavy velvet curtains of the library of the hotel may give you an idea as to some of the style – sounds like a nightmare to me, Catherine! **(Laughter)** Anyway, on behalf of your colleagues on Council, I would like to say a huge thank you for the fantastic contribution you have made to our discussions. It has been a demanding time for us all, but so often made lighter and more enjoyable through your insight and sense of humour. On a personal note, I would like to record my appreciation for the fantastic support for me, and I know everyone here wishes you all the best with your new responsibilities. Have a very restful Christmas, because we need you firing on all cylinders in the New Year. Thank you, Catherine. **(Applause)** It would be unlike you to respond!

Dr Catherine Duggan: You have done it, Steve. I am speechless!

The President: We will now move into confidential business.