

Hospital Edition

summer 10

# insight

The magazine of the **Pharmacists' Defence Association**



## Appeal reduces risk of conviction

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**Verdict on the new CPS guidance**



**Elizabeth Lee appeal**

Substantial progress made  
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# Chairman's letter

## Why we have challenged the precedents of the past

It shouldn't surprise me that some senior hospital pharmacy managers continue to explain to hospital pharmacists that they need not join the PDA; "Don't worry, the Trust's vicarious liability will cover you all" they say. Some have even told their pharmacists that in the event that something goes wrong, the Trust can be relied upon to provide legal defence for them.

What use is that I ask if it may not focus purely on the individual's interests?

There is no better case to demonstrate why pharmacists should be cautious about this employer message and that they should instead join an effective representative organisation that has a demonstrable track record in defending pharmacists in serious situations, than the case of Elizabeth Lee.

As many pharmacists will now know, we have managed to successfully appeal Elizabeth Lee's initial conviction and custodial sentence. It is important for all pharmacists to understand why this prosecution ever happened at all and why we at the PDA, with Elizabeth's permission were determined to use her case to challenge the status quo.

Since the late 1990s a number of high profile cases emerged where pharmacists that had been involved in dispensing errors, linked to the death of a patient but where gross negligence manslaughter had been ruled out, were prosecuted for offences under the 1968 Medicines Act. Such cases included what have become known as the 'peppermint water case' and more recently the 'Prestatyn case'.

No other healthcare professions who make errors at work face further criminal charges once gross negligence manslaughter has been excluded. The relevant practitioner is referred to their respective regulator to face professional proceedings. Not so in pharmacy, where the Police do, inequitably, pursue criminal proceedings for Medicines Act offences.

In addition, the prosecution in both these cases had been focused specifically on the individual practitioner and no significant attention was paid to the systems nor the working environments that they were required to work under. The person in the dock was a pharmacist, a pre-reg and even the technician – in none of these cases was it senior management or the employer.

**We have always believed that the Medicines Act was never meant to punish individual pharmacists in this way and that its interpretation needed to be challenged.**

The strategy we pursued in the Elizabeth Lee case is described on page 8, but this plan was only developed after lengthy brainstorming meetings where the legal, practice and pharmacy political considerations were all distilled many times over before we were ready. The plan did not just involve our appearance at the Court of Appeal, but required the garnering of support from within pharmacy, from other healthcare professions, kickstarting the debate about police protocols at parliamentary level and in government – a process that took more than two years.

It was necessary to research the detail of the Medicines Act and its origins and so we went as far as finding a retired legal specialist who advised the government on the original construction of the 1968 Medicines Act in the mid 1960s.

The fact that this strategy was vindicated was not only the result, in terms of overturning the original conviction, but is also referred to

in the very first line of the extensive published written judgement given by the three appeal court judges where they say that we;

**"raised novel [legal] questions on the construction of the Medicines Act 1968."**

(Full text of appeal court judgement at: [www.the-pda.org/judgement](http://www.the-pda.org/judgement)).

"But so what?" You might say – would not that be expected of any legal team supporting pharmacists?

Well no... actually, it did not happen when the pharmacists, the pre-reg and the technician were prosecuted in the 'peppermint water' and the 'Prestatyn' cases and there was no successful appeal.

And herein lies my point – the case of Elizabeth Lee was handled in an entirely different way. It did create important legal precedents which will reduce the risk of prosecution for pharmacists in the future. However, the legal clarification that it produced, may well increase the risk of prosecution instead for those operating a pharmacy – the Trust itself.

**Consequently, would a Trust funding legal representation for its employee ever contemplate mounting such a defence?**

This result occurred because the philosophy of the PDA is focused on the interests of the individual pharmacist and not that of the employer. Had we been concerned primarily with employer interests then we may not have spent more than two years in extensive preparations and significant sums in defending Elizabeth and we would not have set important precedents to benefit pharmacists - but not employers. Had the employer's interests been in primary focus then Elizabeth may have simply been advised to throw in the towel so that lawyers could then enthusiastically offer arguments in mitigation.

The case of Elizabeth Lee offers the profession many object lessons on safe practice; the importance of rest breaks and much more. It surely also makes a much broader point and that is that the interests of the employer and senior managers are not always the same as the interests of the individual pharmacist and that these distinct interests must be recognised and handled with great care.

I believe that in recent years, the profession has been herded by large employers and government to the detriment of the vast majority of pharmacists and that some representative organisations in pharmacy have given tacit approval by failing to act in support of their members. Why otherwise were the Responsible Pharmacist regulations that introduce new criminal sanctions for pharmacists not resisted? This imbalance must be addressed. Pharmacists must once more be enabled to practice with professional independence for the benefit of patients and not simply be controlled by company or NHS edicts.

**As articles in this magazine will describe, the PDA continues to work passionately, expending great efforts on looking after the individual pharmacist. This is at the very core of our identity and drives us whether it be in our defence work, in how pharmacists should be treated in the workplace, or in how best to shape the future of the profession.**

We ask that you support us.



Mark Koziol, Chairman, The PDA

# Stopping Remote Supervision – what next?

The supervision arrangements in hospital pharmacy are different from those in community pharmacy and there are some very good reasons for this. However, when the government seeks to develop legislation to deliver a supervision model for pharmacy that is meant to fit all sectors of practice, then we have to say NO THANKS!

Many hospital pharmacists are aware of what happened when the RP regulations were imposed on their hospital (see p22). Consequently, we say that the government's remote supervision proposals need to be replaced by something that has been thought through properly and that has been developed by the profession instead.

Last winter, the PDA's Stop Remote Supervision (SRS) campaign saw us back a group of RPSGB leadership election candidates. We thank all those pharmacists that supported our call to action as every one of those candidates was elected by a large margin.

Sadly, the launch of the new regulator, the GPhC has been delayed until September 2010, as a result the pharmacists that we all supported will not be able to take charge until then.

This is unfortunate, as the current council infamously chose not to back a call for the delay of the RP regulations in the summer of 2009 earning the mistrust of many members. Despite the fact that democracy has spoken, and pharmacists have made clear who they wish to be in control of their professional agenda, the current council has decided for its own reasons to cling onto power and through the RPSGB officers elections has not allowed any SRS candidates to take charge of the current RPSGB Council. We feel that the current council continues to generate ill will amongst the profession.



Lindsey Gilpin  
English Pharmacy Board  
Chair

**"We are totally focused on creating a new policy on supervision which puts the availability of pharmacist at the heart of the service and we invite the PDA to support this pan-professional initiative."**

Despite these setbacks, we are pleased to see that the member supported candidates will not be deflected from their objectives.

We have already been contacted by Lindsey Gilpin, the English Pharmacy Board Chair and invited to participate in a pan-professional review of supervision. This review will need to understand that the custom and practice in hospital and community is very different, as are various environmental factors such as staffing levels and expertise. We expect to be working closely with the professional leadership body as soon as the new leaders take over; in the meantime, we will be supporting and playing our part in the interim programme described.

## The Interim Programme

### July 2010

• PDA has already had early talks with the leadership of the new PLB and has been invited to take part in the pan-professional plan to resolve the Remote Supervision issue.

• Membership surveys will be undertaken during July, so that the views of pharmacists and the evidence is gathered to support the campaign.

### August 2010

• Based on member feedback, a Supervision Strategy day involving representatives of several pharmacy organisations to be held with the aim of producing a practical review of the current supervision regulations – an alternative to the current government proposals.

### September 2010

• Initial ideas to be published for consultation within the profession. Opportunities for direct membership dialogue via an open forum at the British Pharmaceutical Conference and other pharmacy gatherings. Direct focus group meetings with pharmacists to be held in various locations.

• Professional dialogue opened up using all available channels (e.g. internet, letters in the PJ, magazine features etc.) so as to gauge the support of the profession.

• Initial draft of the professions view on changes to supervision produced.

• Possible petition of the membership, if needed, so as to show the levels of support.

### October 2010

• A new supervision policy handed to the government and the GPhC.

This outline plan has the support of the PDA, and we will be working in earnest to harness the views of PDA members. Watch out for our on-line surveys, petitions and focus group invitations. We are determined to ensure that the policy on supervision is one that has been developed by the profession after a detailed consideration of how it is practiced in all of its different settings. Furthermore, whatever the result, we will never agree to a policy that allows employers to dictate what level of supervision is required, this must be a professional decision made by pharmacists in the interests of patients. If you want us to succeed then please be ready to offer your direct input and support when called for.

To comment on this article please go to [www.the-pda.org/is/112](http://www.the-pda.org/is/112)

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## RPSGB must not be controlled by the pharmacy multiples says PDA



RPSGB Headquarters

From 2011, membership of the RPSGB will become voluntary leaving pharmacists to effectively vote with their feet. The PDA continues to be supportive of the concept of a strong professional body, especially since pharmacists going forward will increasingly need practical support to enable them to deliver new patient facing roles.

Obviously, there are concerns at the Society about how many pharmacists will join voluntarily as this will determine the income streams that will ensue and consequently, how many staff may be employed. The

Society has perhaps rather anxiously stated that it hopes that around 70% of currently eligible pharmacists will join. However, concerns are now emerging about the idea that some of the large community pharmacy multiples will automatically pay their employee pharmacists membership fees. The proposals that have been announced by several of the large

multiple groups have all stated that they will review such funding going forward.

According to Mark Koziol the PDA Chairman;

**“I believe that the large pharmacy multiples have controlled the professional agenda for far too long. There has been little in the way of strong representation for community employees, hospital, primary care, academia and industrial pharmacy. The emergence of a new professional leadership body is a perfect opportunity to redress that imbalance. However, if the multiples are allowed to be responsible for a substantial chunk of the Society’s subscription income, then there**

**is a distinct danger that the RPSGB will simply become a mouthpiece for these large organisations and not become the professional leadership body for pharmacists that we all hoped for. I know that RPSGB staff will be concerned for the sustainability of their incomes, however a model that sees the profession effectively controlled by large multiples, could well harm the RPSGB by damaging its leadership credentials. This problem is seen in other organisations. We need the members to genuinely want to join the new body and to be active and whilst the employer funded model may seem attractive, if many pharmacists are only in membership because of their employer’s programme then this could be disastrous.”**

Continuing he said;

**“We need the new body to speak up for and be accountable to its pharmacist members across all the sectors, and it should do so without fear or favour. After all, we all know only too well the golden rule – he who has the gold, makes the rules. What the new body does not need hanging over it, is the prospect that if it does not support the multiple agenda, then it may, at the stroke of a pen, lose significant income.”**

The PDA is set to meet with the new RPSGB Chief Executive and the President of the National Assembly in September and this will be an item on the agenda. Pharmacists that have strong views about this matter should make them known to the PDA.

To comment on this article please go to [www.the-pda.org/is/113](http://www.the-pda.org/is/113)

## Disciplinary Committee Chairman oversteps the mark

In its submission to the GPhC regarding the rules that it will be using when it begins to regulate, the PDA was critical of the current investigation processes used by the RPSGB and the hearings of RPSGB Disciplinary Committee calling them **“unnecessarily time consuming, cumbersome and costly.”** These unnecessary costs are having to be met through pharmacist registration fees.

The PDA believes the costs of hearings could be significantly reduced in a number of ways. Two examples would be:  
Using the discretion of the Chair to move

proceedings on to the next stage without further and often lengthy committee deliberation if the facts are admitted and the pharmacist has accepted that their fitness to practice is impaired. Ensuring that chairmen do not operate outside the rules and extend hearings unnecessarily.

The PDA has recently been involved in a case where the RPSGB’s lawyers have presented their ‘prosecution’ evidence against the pharmacist; our member has admitted the facts and has agreed that their fitness to practice is impaired. Everyone expected the

Disciplinary Committee to issue a sanction and that that would have been the end of the matter. However, everyone was surprised when the chairman instead decided to instigate a further investigation, hence prolonging the case and increasing the cost.

The PDA has discussed its views on disciplinary rules at a recent meeting with the Chairman and Chief Executive of the GPhC. Full details of the PDA submission are available on:  
[www.the-pda.org/gphcrules](http://www.the-pda.org/gphcrules)

## PDA establishes office in Scotland

**As membership of the PDA continues to grow, more and more cases are being handled in Scotland and as a consequence, the PDA has now opened an office in Edinburgh.**  
According to Mark Koziol, PDA Chairman;

**“Unlike handling cases on behalf of members in England and Wales, when we handle employment and other legal disputes on behalf of members in Scotland, we are often dealing with the impact of different legislation. Because Scotland is a different legal jurisdiction, we are increasingly seeking advice from Scottish legal sources and Scottish organisations. We have therefore decided to open a part time office in Edinburgh so that we can get closer to these issues and be closer to our members.”**

From a strategic perspective, the fact that healthcare provision is administered and organised differently in Scotland than it is in England and Wales, provides the PDA with additional opportunities. In particular, the PDA believes that some of its strategic objectives around the recognition of the individual pharmacist as an NHS contractor is a model that is more likely to be explored in Scotland first, ahead of a more general UK deployment.

He further continued; **“We will be looking to work more closely with our members and also with the Scottish government, healthcare bodies and pharmacy organisations to support the individual pharmacist contractor model. We are keen to explore novel and more beneficial approaches to pharmaceutical care that**



**will provide our members with varied career paths and will also deliver greater value for money for the taxpayer.”**

The PDA Office is based at;  
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## Non Pharmacist managers may harm patients and must be regulated.

In its recent submission to a GPhC consultation on standards – the PDA called for the GPhC to register non-pharmacist managers and directors of pharmacy companies in the future so that they could be struck off if their decisions harmed patients.

The good news is that the Patients Association is singing from the same hymn sheet and has asked for much the same approach to be taken in the Health Service generally.

The comments from the Patients Association came after a report published by Bournemouth University in June highlighted concerns being expressed by surgeons.

When they were asked about what gets in the way of patient safety, many said they did not feel in full clinical control, because of pressure from managers to reach targets.

One of the respondents warns against bowing to these pressures: **“Don’t be seduced by management into making do, thinking you are being heroic; you’re not, you are just being dangerous.”**

The author of the report observed; **“If anything goes wrong they [the healthcare professionals] are held responsible but they are not in charge. The key is the influence - and often the malign influence - of managers who are concerned with meeting targets.”**

The healthcare professionals questioned could so easily have been pharmacists commenting on the way they are pressurised into performing MURs or the way they as responsible pharmacists are required to inherit the liabilities when they are not given the authority or control.

In a statement the health secretary for England, Andrew Lansley, said the report highlighted a point he had made repeatedly;

**“Patient safety must come first, that means allowing clinicians to focus on the patient’s treatment, rather than the dictates of managers. That’s why we will abolish top-down process targets and replace them with outcome measures, which drive improvements in the quality of patient care.”**

The PDA will press the regulator to ensure that non-pharmacist managers are held accountable in situations where their conduct may cause harm to patients. Furthermore, the PDA continues to defend members against the imposition of inappropriate top down targets – such as those set for MURs.

Full details of the PDA submission are available on:  
[www.the-pda.org/gphcstandards](http://www.the-pda.org/gphcstandards)

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# The RP Regulations 9 months on

Since the Responsible Pharmacist (RP) Regulations came into effect on 1st October 2009, pharmacists have been struggling to come to terms with their new legislative and professional responsibilities. As part of our support to members we have represented a number of individuals through company grievance processes, when they could not get answers to the many questions they had asked.

These grievance meetings tend to have a common pattern, in that company managers do not provide answers at meetings, preferring instead to seek "Head Office" advice. Head Office advice often takes months to arrive and in one case the grievance process took five months to answer the questions. We are of the view that they are treading very cautiously because they recognise that the true impact of the RP regulations upon their operations may have unwelcome consequences to their levels of control and also potentially a significant increase in their costs.

Nevertheless, from the responses gained to the questions recently put, the PDA can now update all members on the latest employer interpretation of the RP regulations.

**"The DoH has conceded that the RP should not remain signed on during a rest break as this is in conflict with the Working Time Regulations."**

## Rest Breaks

Alliance Boots has provided the most clarity in this area and confirms that it does not direct its pharmacists to remain "signed on" during rest breaks. The most recent response that we have had on this matter recognises what the PDA position has been all along which is that for a rest break to be taken lawfully (under Working Time Regulations) then the worker must be enjoying an uninterrupted break, they must not be contactable nor be required to remain on the premises. The Boots advice unequivocally states; *"The decision as to whether to remain signed in or to sign out as RP during such times [rest breaks] remains with the individual pharmacist."* *"No action will be taken against an RP who chooses to sign out during his or her lunch break."*

This position is welcome, but it is a great shame that Alliance Boots do not encourage signing off at break times and instead qualify their guidance by going on to say **"Whilst any RP has the autonomy to decide to sign out during their lunch break this may affect the number of stores in which they can be offered work, or the number of suitable shift patterns."**

It is disappointing that after reinforcing the right for an RP to sign out and take a proper break, Alliance Boots then produces a situation which creates pressure for pharmacists to abrogate their statutory right to a physical and mental break by intimating they may face a limitation in employment opportunities if they sign out whilst doing so.

## Rest Break Procrastination

After considerable pressure applied by the PDA's legal team onto the Department of Health, in November 2009, the DoH and its lawyers conceded that the RP regulations had not taken into account the wider employment legislation. The DoH agreed that the RP should not remain signed on during a rest break as this was in conflict with the Working Time Regulations, which requires rest breaks to be periods where a worker must be enjoying an uninterrupted break, they must not be contactable nor be required to remain on the premises. Since then, the plan to find a professional solution to this quagmire was handed to the RPSGB.

However, in the two meetings to which pharmacy body representatives were invited, no meaningful progress has been made. The PDA is now receiving little in the way of progress reports when it pursues the RPSGB for information. It is a great shame that the RPSGB managed to clarify that large multiples could operate certain aspects of their business before the arrival and after the departure of the RP in August of 2009 and yet it appears to be still the issue that most affects pharmacists and impacts upon patients, that of rest breaks, is a matter that it is procrastinating over nearly one year later.

## Responsibility & Liability

It appears to us that the largest employers do not accept that being an RP brings significant additional risk or changes liability, nor do they accept that the RP regulations involve any changes to express contractual terms of employment. We are not aware of any increased pay awards for this new role. Consequently employers have chosen not to consult with their pharmacist workforce. However, employment disputes being handled by the PDA suggest that the "No Change" approach prevalent in these organisations is in reality a façade.

## Employment Risks

In one case, two pharmacists working at the same pharmacy were called into disciplinary meetings due to allegations they had both gone home at the end of their shift, but before all the care home business was finished. The pharmacy had been very busy that day and they only learned about the care homes late on, leaving no time to complete them. The RP received a final written warning because of his RP role and the other (non-RP) was given a lesser sanction. This case suggests that employers might view the RP as having a greater responsibility when considering allegations of a disciplinary nature.

The PDA organised an appeal against this decision for several reasons; one being that the disciplinary letter confirming their sanction was produced days in advance of the actual meeting. Disciplinary meetings are supposed to be impartial, have no predetermined outcome with the disciplining manager reaching a decision based on the facts and any mitigation brought up by the employee during the meeting. Clearly the letter exposed the company processes as a sham and it had no option but to grudgingly rescind the action, otherwise it would have faced costly litigation from the PDA for such a gross failing.

Another large multiple was struggling to find evidence to prove that a long serving pharmacist was responsible for a customer's medicine going missing from the pharmacy a few weeks earlier, when it wasn't delivered. The pharmacist was adamant she did not see it after checking it. After four stressful meetings, the company took the new approach that as the RP on duty at the time and that therefore she was responsible for securing the safe and effective running of the pharmacy she was responsible in any event for the pack going missing.

## Contactable Pharmacist

Alliance Boots have clarified the role of the "Contactable Pharmacist". If an RP whilst signed on, but absent, is not contactable or able to return within reasonable promptness, another pharmacist - a "Contactable Pharmacist" must be found, according to the regulations. This other pharmacist must be "available and contactable" which the company define as meaning s/he is contactable by telephone and available to attend to matters brought to his/her attention by the pharmacy team who are still on the premises. The Contactable Pharmacist may need to get to the pharmacy within reasonable promptness in serious circumstances. The company has clarified that this 'other' pharmacist may decline to be the Contactable Pharmacist and in any event there is no additional remuneration or recognition for this role.

## Liability

Numerous members report that whilst they are not yet signed on or signed on, but absent, members of staff are engaging in activities that are either unlawful under the regulations or have the potential to attract the attention of the regulator. It is clear that many members of staff are confused by what can and can't be done in the absence of the RP.

The NPA has continued to pronounce that the RP regulations do not change any relationships between employer and employee.

However, wearing the hat of being the pharmacy insurer, the NPA may be taking a view that is not consistent with that approach. During one recent civil claim, it argued that the RP on duty at the time the prescription is handed out (not when it is assembled) is 100% liable in the event of the wrong medicines being handed out to a patient. In this case, the pharmacy owner (an NPA member), made a dispensing error which was missed during the checking process, then bagged and left for collection. The patient called to collect it several days later, when another RP was on duty. The patient took some incorrect medication and claimed compensation from the pharmacy. However, the NPA passed this claim directly onto the RP, arguing that under the new RP regulations, the RP should be held responsible. The PDA has already settled the 100% liability (in excess of £4,000) and we now intend to legally challenge the NPA for a fair contribution to these costs.

Whilst this episode in itself, does not signify that there has been a wholesale policy change at the NPA in relation to RP liability, it nevertheless is the first time in our experience that the RP regulations have been cited as a justification for passing 100% of the liability across to another pharmacist, where the error was actually committed by the owner some days earlier.



RPs left with some difficult options

## Professional Autonomy

Prior to the RP regulations, many pharmacists found that non pharmacist company managers readily interfered with and even countermanded their professional decisions. This has not abated since the introduction of the regulations despite the enhanced autonomy the regulations were supposed to give. RPs are frequently pressurised to change their minds when they attempt to close the pharmacy rather than to continue operating with unsafe resources. Requests for additional staff and resources by the RP so as to secure safe and effective operations are often denied or ignored.

A supermarket recently dismissed a pharmacist RP who exercised her professional judgment as RP and decided that a member of staff was neither competent nor capable of working in the dispensary. The supermarket decided that the aspiring dispenser's 'right' to be trained under their dignity at work policy, overrode the pharmacist's professional decision on how best to satisfy a statutory responsibility to secure the safe and effective running of the pharmacy. The involvement of the superintendent did not provide support to the RP and merely reinforced the corporate view that the RP must work with this person or be dismissed, even though the pharmacist had used objective criteria to demonstrate that this aspiring dispenser was incompetent and a risk to patient safety.

## The Hospital sector

A more detailed analysis of the RP position in hospital pharmacy can be found in the Hospital edition of Insight on pages 22 and 23.

## What is the point of the RP regulations?

The PDA continues to support members in many individual cases of RP conflicts providing support and assistance where possible. However, the question that is now presenting itself is that if a Stop Remote Supervision campaign is able to forestall remote supervision, then what exactly is the point of having the burdensome RP regulations at all? They are neither in the public's nor in the profession's interests. The PDA will be asking the government this question as we move forward and as the Remote Supervision issue is settled one way or another. At that point, we will be seeking membership support. Beyond that we believe that there is much to demonstrate the caution with which employer led pronouncements on the effect of RP regulations should be regarded. Should pharmacists have doubts or concerns, they should seek advice from the PDA.



# Substantial progress made as a result of the Elizabeth Lee appeal

**The practice that has developed in the last decade for the Police to use the 1968 Medicines Act to prosecute pharmacists once gross negligence manslaughter was excluded was a trend that the PDA was determined to stop, when Elizabeth Lee faced her initial trial in April 2009.**

**The only appropriate course of action, in the view of the PDA, was that if gross negligence manslaughter offences had been ruled out following investigation then the entire matter should then have been referred to the RPSGB and handled as a professional disciplinary and not as a criminal matter.**

Although the PDA had dealt with several potential gross negligence manslaughter cases against pharmacists before, the case of Elizabeth Lee was the first one involving the PDA that was actually going the distance, in this case to a High Court.

Previous court cases, such as the peppermint water and the Prestatyn cases, which involved Medicine's Act offences had all been managed by legal teams established through employers. Consequently, this case provided an opportunity to create important legal precedents which would potentially protect pharmacists in the future.

When Elizabeth Lee went to the Old Bailey in 2009 to face two charges under the 1968 Medicines Act, the PDA's defence team argued that she should not have faced either of the charges as they simply did not technically apply in the case of a dispensing error.

**The offence under Section 85.5** – for attaching the wrong label to the medicine, was not an offence that could have been committed by Elizabeth Lee as technically this was an offence that could only have been committed by a pharmacy business.

**The offence under Section 64.1** – for providing the wrong product, was a section of the Act that the PDA argued was specifically designed to be used in situations where an adulterated product or a product of a poor quality was supplied and not at all designed to be used in dispensing error situations.

Had these arguments been accepted, then she would not have been convicted, furthermore, in the future, other pharmacists would have been spared the experience too, as the Police would not have been able to use the Medicines Act in the way that they had previously.

At the original 2009 Old Bailey trial, following an initial not guilty plea from Elizabeth Lee, the PDA's defence team approached the bench prior to the start of the hearing to put their legal arguments. However, the judge made it clear that it was unlikely that these arguments would succeed. It was obvious that any jury made up of members of the public would be influenced by the judge's directions on points of law which would have significantly reduced the chances of success. This created a further risk: had



Elizabeth Lee been found guilty after initially pleading not guilty, then she would have received a more severe sentence. Consequently, in a tactical move, the plea of guilty was entered for the Section 85.5 offence (wrong labeling), so as to enable these arguments to be heard in a higher court, the court of appeal.

Elizabeth Lee was therefore convicted for an offence under Section 85.5 (labeling offence) but the judge left the 64.1 offence in abeyance.

No one imagined that despite a guilty plea, which guarantees a 'discounted' sentence from the court, the judge would then give Elizabeth Lee a custodial sentence. This development was to result in substantial shock waves reverberating throughout the entire profession of pharmacy and beyond.

## The Appeal

The original strategy and legal arguments were maintained and on May 26th 2010, the Appeal of Elizabeth Lee was heard by three senior judges at the Royal Courts of Justice.

Added now to the list of objectives, was the task of overturning the custodial sentence handed down in the original hearing and also to ensure that this was to be the last court appearance for Elizabeth Lee.

## The Success

After a considerable legal argument between the defence and the prosecution, the Appeal judges stated that (and we quote) **"this was a case that has succeeded in raising novel questions about the construction of the Medicines Act"** and they agreed with the PDA's 'novel' construction. Consequently, they quashed Elizabeth Lee's conviction and as a result, her custodial sentence was automatically erased.

The effect of the way that we asked 'novel questions' about the construction of the Medicines Act and the fact that the Appeal Court judges agreed with us is that it has been clarified that offences under Section 85.5 can only be committed by owners of businesses and not by the pharmacists that they employ (whether employed or self-employed). That same legal construction does not just apply to Section 85.5 of the Act, but also to other sections as well, such as Sections 52, 65.1, 65.2, 85.3 and 85.4 and these describe various other offences that employees and locums would have previously been exposed to that they will no longer be.

As a result, in future, if a pharmacist attaches the wrong label to a dispensed medicine (or other offences described in the additional sections above), then they will no longer be vulnerable to criminal proceedings, and they should potentially only face professional disciplinary proceedings.



## The Disappointment

The Section 64.1 offence (for providing the wrong product) that had been considered at the original 2009 Old Bailey hearing had been left in abeyance. At the Court of Appeal, it was put to the judges that they should consider leaving the Section 64.1 offence in abeyance. This was because Elizabeth Lee had never pleaded guilty to that offence at the first trial. But also and more importantly, because we had been led to believe that new protocols were to be released imminently by the Crown Prosecution Service. These protocols would ensure that pharmacists who commit one-off dispensing errors which are related to a death and where investigations rule out gross negligence manslaughter should be referred to the RPSGB so as to face professional discipline and not criminal proceedings under the Medicines Act.

Had the judges agreed to this proposal, then Elizabeth Lee would have been able to leave the court with no criminal conviction to her name and this was the whole aim of the PDA's defence strategy.

## "We succeeded in raising novel questions about the construction of the Medicines Act."

However, the Crown Prosecution Service lawyers in a surprising revelation argued that no such protocol was imminent as discussions between the various parties that were working on it had reached an impasse. The impression created was that it could even take a year to resolve. Furthermore, they indicated that if the judges did leave the offence in abeyance as requested by the defence team, then they would in any event instigate a fresh prosecution and trial for offences under Section 64.1 of the Medicines Act.

Even though the PDA's team had legal arguments to defend such action, if it came, this was not a viable option as it was no longer appropriate to expect Elizabeth Lee to wait another long period to face the prospect of more court appearances, nor (quite understandably) did she have the desire to do so.

Consequently, under an established legal procedure the prosecution asked the judges to substitute the Section 85.5 offence with the Section 64.1 offence and with the agreement of Elizabeth Lee the judges did this. As far as sentencing was concerned, the judges stated that they agreed with our arguments that the original sentence that had been initially imposed was manifestly excessive and they ruled that the penalty should be a fine of £300 payable within 28 days.

## The Result

- The original conviction of Elizabeth Lee for offences under section 85.5 of the Medicines Act have been overturned.
- Pharmacists (unless they are owners) should not be charged with such an offence again (nor for offences under Sections 52, 65.1, 65.2, 85.3, 85.4).
- With the appeal against the Section 85.5 conviction successfully upheld, the custodial sentence originally received by Elizabeth Lee is automatically overturned.
- The substitution of the Section 64.1 offence resulted in a conviction, but with a fine of £300.

- The judges agreed that Elizabeth Lee's original custodial sentence was manifestly excessive.

## Unfinished Business

As a result of the PDA's strategy substantial progress was made, not just for Elizabeth Lee but for the wider profession. Nevertheless there is a sense of frustration and a feeling of unfinished business at the conclusion of this episode. Elizabeth Lee still has a criminal conviction and the PDA's aim was to have all criminal sanction

removed. Although some personal difficulties have been removed for Elizabeth as a result of her successful appeal against Section 85.5 and the custodial sentence being quashed (like visa applications to certain countries or job applications for example) there is still the question of whether an offence under section 64.1 of the Medicines Act (wrong product supplied) is appropriate in the event of a dispensing error. However, in the event that another PDA member should be unfortunate enough to face such a prosecution, then the PDA will not shirk from the task of taking up the legal challenge.

## The mission to decriminalise dispensing errors continues

Following this case and directly because of the surprise revelations about the alleged impasse over the Crown Prosecution Service protocols, the PDA applied significant pressure to both the Chief Executive of the Crown Prosecution Service and also to the new Pharmacy Minister, Earl Howe. Through previous dealings with Earl Howe on both the Elizabeth Lee case and also on Remote Supervision, the PDA knows that the new Pharmacy Minister shares our concerns. This pressure has been amplified by further letters from parliamentary supporters such as Baroness Cumberledge who is the acting chair of the All Party Pharmacy Group.

## A twist in the tale

In a further surprising twist to this tale, the long awaited protocols (described in the next article) were finally and suddenly released not one year after the Appeal of Elizabeth Lee, but just three weeks after. The reality about the delays turned out not to match the report given by the Crown Prosecution Service to the judges in the court of Appeal and we cannot but wonder what the judges would have decided about leaving the Section 64.1 offence in abeyance had they known that they were indeed just about to be released.

**This last development has created many concerns within the profession and what it undoubtedly shows, is that the world of healthcare practice can truly be a hostile place. Members can be reassured that the PDA has already written to the Appeal Court judges and brought these 'developments' to their attention. At the time of going to press, we await a response.**

# The long awaited CPS Guidance



**On 21st of June 2010, just 26 days after the Elizabeth Lee Appeal Court hearing, the Crown Prosecution Service published its dispensing error guidance to prosecutors.**

The PDA put the idea of a CPS protocol to the government in the aftermath of the custodial sentence given at the original trial. The protocol was to apply in cases of one-off dispensing error that involved a death, but where gross negligence manslaughter had been excluded by a police investigation. The intention was to ensure that rather than instigate criminal proceedings, the Police would hand such matters to the professional regulator, The RPSGB, to take any necessary action.

Whilst the guidance contains some modest improvements for pharmacists, it also contains bad news, additionally, parts of the guidance simply do not reflect the reality of pharmacy practice.

## We examine the detail of the guidance.

### THE GOOD NEWS

- **The new February 2010 Code for prosecutors**

The main code for prosecutors was actually updated in February 2010. This already provides some additional protection from prosecution for pharmacists. It may have even been informed by the political furore around the Elizabeth Lee situation. Within the list of tests that prosecutors should consider when deciding to prosecute or not has been added a brand new test which states; **“that the suspect has been subject to any appropriate regulatory proceedings.”** This new test is a public interest factor weighing against a prosecution. However, professional disciplinary action is taken after criminal cases have concluded, so this new test as it stands would have been unlikely to offer any assistance. However, the pharmacy legal guidance published on June 21st, adds more comfort, as it states; **“Has regulatory or remedial action been taken (against a pharmacist or technician), or is it likely to be taken?”** The addition does give slightly more comfort. If the pharmacy regulator has given notification of an intention to take regulatory action, then this may reduce the chances of a prosecution.

- **Notification of the Medicines Act review**

The guidance states that the forthcoming review of the Medicines Act is expected to change how it deals with human error in a pharmacy and it sets a timeframe for the changes for 2012. Despite stating that until the law is changed, the existing code and pharmacy legal guidance should be used, we believe that the very existence of these statements in the guidance is beneficial. If there are any similar cases in the near future, then we will be using this statement to explain to the Police that pharmacy prosecutions should be handled with care.

- **Clarification of what the Medicines Act was intended for**

Our research concludes that the part of the Medicines Act that has been used by the Police (Section 64.1) to deal with dispensing errors was not designed to deal with dispensing errors, but to tackle situations where dishonest medicines suppliers and manufacturers were providing adulterated or below standard medicines to the public – probably to maximise profits.

## “The guidance does not guarantee that another Elizabeth Lee situation won’t happen again.”

This ‘construction’ (as the judges would call it), would have formed an important plank of our defence argument had we had the opportunity to defend Elizabeth Lee’s Section 64.1 offence. We now find, couched in the first line of the CPS guidance the sentence **“The Medicines Act 1968 exists to protect patients from unscrupulous suppliers of medicines.”**

This statement underpins our arguments if we defend a pharmacist in the future, for it is obvious that a pharmacist who makes a human error is patently not an unscrupulous supplier of medicines.

### THE BAD NEWS

- **Responsible Pharmacist (RP) regulations**

Embellished at the heart of the guidance is the principle that it is the RP who is now required to establish, maintain and keep under review procedures to ensure that a pharmacy is operating in a safe and effective manner. The RP will need to (and we quote) **demonstrate that he or she**

**had put in place and operated written standard operating procedures, defining individual responsibilities and accountabilities, establishing procedures for identifying and remedying poor performance and ensuring that members of the dispensary team are suitably trained and competent to undertake the tasks for which they are responsible.**

The reality is far detached from this position. Many community and hospital pharmacists will recognise that employers are extremely reluctant to allow their RPs to have anything like this level of control. The pharmacy in which they work IS STILL being controlled by their employer or by someone other than the RP. The PDA is dealing with cases where RPs are either being disciplined by employers, or have been dismissed because the employer does not allow them to exercise their statutory duties under the RP regulations (see pages 6 and 7). As the guidance gives a false impression to prosecutors, it increases the exposure of RPs and it moves employers even further away from the consequences of their actions.

- **The Public interest factors**

The guidance identifies several ‘public interest factors’ that prosecutors should explore when considering pharmacist prosecutions. The questions that it asks appear to be demonstrative of only a superficial grasp of pharmacy practice. For example;

- **Is there any evidence that the pharmacist, technician or any other person has made other dispensing errors?**

With an estimated three dispensing errors per pharmacy per week in the UK, it will not be difficult to establish that a pharmacist has made previous dispensing errors, especially if error logs are being used. We are concerned that this ‘other dispensing errors’ test will result in a further reluctance to make error log entries amongst pharmacists to the detriment of the public.

The guidance asks other questions that we believe that the CPS will not be able to properly address because it does not have the expertise. Negligence must be assessed in consultation with those who know what pharmacy negligence is i.e. the pharmacy regulator. This is not a role for the Police.

These considerations include;

- **What was the seriousness of the dispensing error, were the drugs (sic) particularly dangerous or poisonous in themselves, requiring very careful handling and additional checks to be in place, or was the dosage dispensed substantially greater than that prescribed or substantially beyond the usual treatment range?**
- **What is the culpability of those involved in the dispensing error, was it simply an error or is there evidence of recklessness or intent?**

## “We need a much quicker change to the 1968 Medicines Act.”

### THE PERVERSE INCENTIVE

- **Due diligence defence**

A substantial section of the guidance deals with what it calls due diligence defence. The thrust of this is that (and we quote) **if a person can prove that he or she exercised all due diligence to secure that the (Medicines Act) would not be contravened and that the contravention was due to the act or default of another person, he or she has a defence to a criminal charge.**

The guidance makes reference to the potential liability that is faced by pharmacy technicians in the event of an error. For example if an RP establishes or operates to a robust protocol which places a registered pharmacy technician in charge of the dispensary with the pharmacist undertaking only the initial clinical assessment of a prescription. Should the pharmacist then decide to work with patients directly in the consultation room, the counter or another area of the hospital pharmacy whilst the technicians undertake the dispensing and handing out of the prescription to the patient or ward, then in this example, a straightforward dispensing

error would see the registered dispensing technicians criminally liable, but leave the pharmacist with a good defence. This position leads to the prospect (perhaps unintentionally) that pharmacists may be better off (from a criminal liability point of view) in distancing themselves from the dispensing process. We are aware that this situation is, for operational and general staff availability reasons already relatively common in hospital pharmacy, but not so in community pharmacy. We argue that for the community sector, where larger dispensary teams are few and far between, that this prospect cannot be in the public interest. If ever there was a sign that the pharmacy regulator needs to take the lead and that the Medicines Act is in desperate need of an overhaul, then surely, this is it!

### So what is the verdict?

We asked the CPS for a protocol that made clear that police led prosecutions of

pharmacists for one-off dispensing errors were not appropriate and where gross negligence manslaughter had been excluded these cases should be handed to an authority that had the expertise to deal with them. These cases should be handled by the pharmacy regulator as a professional disciplinary matter and not as a criminal prosecution.

However, what we got was not a protocol but instead some non obligatory legal guidance which does not deliver this objective. What does not appear to be understood is that once the authorities are involved in trying to prosecute a pharmacist, particularly when a death is involved, then emotive and subjective factors may drive criminal proceedings, even when gross negligence manslaughter has been excluded. At that stage, it is easy to see how there may still be a tendency to overtly argue the public interest irrespective of the non obligatory ‘general guidance’ contained in the new CPS publication.

If ever there was any doubt about the extent the CPS will pursue their ‘suspect’, one needs only to study the report of the Appeal Court hearing.

There is nothing contained in this guidance to guarantee another Elizabeth Lee situation does not arise again.

### Where to go from here?

**We need an urgent review of the 1968 Medicines Act.**

The MHRA continues to undertake the review of the 1968 Medicines Act and this is scheduled to be completed by 2012. However, the PDA will now be putting considerable pressure on the government to accelerate its efforts in this area; we need a much quicker change to the Act, even if only to the offending sections in the interim. Whilst the prosecution threat persists, pharmacists may be reluctant to participate in error log reporting, let alone be keen to undertake new pharmacy roles.

**We will seek to influence the timing of the review process and also its final outcome. With the detailed understanding of the 1968 Medicines Act acquired for this case, we are well placed to express expert opinion for the benefit of pharmacists. We are aware that other pharmacy organisations are also feeding in their views.**

**Further to that, we are set to discuss our concerns about the CPS legal guidance with the government with a view of securing some improvements.**

**Finally, we stand ready to defend any other pharmacists from prosecution in the event that the law is not changed first.**

Find the pharmacy guidance at:  
[www.the-pda.org/cpsguidance](http://www.the-pda.org/cpsguidance)

Find the Feb. 2010 CPS Prosecutor’s Code at:  
[www.the-pda.org/prosecutorscode](http://www.the-pda.org/prosecutorscode)

# PDA Union making “strong” progress

THE PDA UNION has been pleased with the progress of its development over the past year, John Murphy, General Secretary announced at the recent AGM in Birmingham on 4th June.

“The PDA has continued to grow in membership and in influence in the pharmacy profession. At the end of March membership stood at nearly 15,000, up considerably from the previous year” he said.



The rate of progress is best demonstrated by the willingness of union members that have put themselves forward for election to the Membership Groups at the recent by-elections in April.

“Last year I reported that we needed to get more members involved in the Membership Groups as too much work was falling on the shoulders of too few people.” Mr Murphy told the meeting but he was “delighted that the recent by-election has resulted in filling vacancies to near capacity of eligible Membership Group representatives.”

The General Secretary further reported that PDA has taken on over 1500 union related cases during the period between April 2009 and March 2010 (approx. 30 per week). Nineteen of these cases have made a claim in an employment tribunal, of which seven have settled, two have withdrawn and the rest are still in progress. The union has also acted as representative in nine cases for members negotiating compromise agreements.

## Communications Officer

Graeme Stafford was elected to the Executive Committee unopposed as Communications Officer and has been charged with ensuring that systems and processes exist to gather the ‘grass root’ views and opinions of ordinary members.

## Student/Preregistration membership.

The Assistant General Secretary (Strategy) reported that discussions were ongoing with the British Pharmaceutical Students Association (BPSA) to seek to create the student membership group of the PDA Union. To-date these have led to a position where the BPSA constitution has now been changed so as to facilitate joint membership of both the BPSA and the PDA Union.

He felt that “this initiative will deliver significant union and other benefits to pharmacy students. It will also have the effect of significantly increasing the membership numbers.”

Full minutes of the AGM are now available on [www.pda-union.org](http://www.pda-union.org)

## Membership Groups

### Locum Group

Bob Gartside - Chairman  
Catherine Armstrong - Secretary  
Lindsey Gilpin - Executive Rep.  
Stephen John Hadley  
Richard Evans  
Naina Chotai  
Andrew Jukes  
Keith Davis  
David Tyas  
Oluwaseyi Fasogbon

### Community Employee

Richard Flynn - Chairman & Executive Rep.  
Anthony Sutton  
Barry Allison  
Sushil Sharma  
Jyoti Sood  
Ihad Kamal  
Randeep Tak

### Hospital

John Farwell - Chairman & Executive Rep.  
Joanne Harding  
Asta Prajaparti  
Jamie Richardson  
Brian MacKenna

### Primary Care

Kate Hingston  
Stephen Inns - Temporary Executive Rep.  
David Akroyd  
Stephen Riley

### Student/Pre-reg

Matthew Crum - Executive Rep.  
Abbas Kanani  
James Milner

# PDA asks the GPhC to drop some old RPSGB disciplinary cases

## How can we justify this nonsense as being in the public interest?

**Dr. Harold Shipman has a lot to answer for. The ‘Shipman Enquiry’ produced new regulatory rules that now prevent registrants from resigning from their relevant professions register if they are under investigation. The RPSGB is also able to use an Interim Suspension Order (Article 54), which gives the Society the power to immediately suspend a person from practicing for up to 18 months, pending a full hearing.**

Before these new rules came into force in March 2007, we were not aware of any RPSGB powers that could stop a pharmacist from resigning from the register if they chose to do so, whether under investigation or not. But now as a result of the introduction of the Order (please forgive the irony) a proficient pharmacist who forgets to pay their fees is removed from the register; but a pharmacist who is under investigation and refuses to pay their fees will not be removed or allowed to retire from the register until the investigation has been completed (unless the Registrar agrees).

The effect of this rule, is that if the alleged misdemeanour is not sufficiently serious that it poses an imminent danger to the public and therefore avoids an interim suspension order, then a pharmacist who has not paid their registration fee can continue to practice as they remain fully registered.

**The RPSGB – it stands out as a regulator!**

It is against this backdrop that we wish to describe the lengths that the RPSGB will go to in pursuing an ordinary pharmacist who has served the profession with dignity for forty years and decided to (legitimately) retire from the profession because she was so distressed by the manner in which she was subjected to a disciplinary investigation.



RPSGB - a tough regulator

Allegations made by patients to the Society (allegedly) encouraged by surgery staff for dispensing errors made in the health centre pharmacy triggered an investigation which lasted four and a half years.

It was a messy affair involving several pharmacists, resulting in the referral of one of our past members (amongst others) to the Disciplinary Committee at a time when she believed that she had retired from the register before the Society had the powers to prevent it.

The case in question raises two very disconcerting questions; firstly how can it be justified that a referral to the disciplinary committee is in the public interest for dispensing errors which allegedly took place nearly five years ago (and by the time any hearing is conducted is likely to be more than six) and why does the regulator have the arrogance to assume that it can enact its authority over a pharmacist who removed herself from the register before the Society assumed the legal powers to prevent her from doing so?

The former issue is a subject for another day, but why is the RPSGB relentlessly pursuing a pharmacist, who retired from the Register months before it had any powers to stop her? Her resignation letter and receipt of her certificate was acknowledged by the Society, but they refused to acknowledge that they had removed her name from the Register and they continued to send a renewal and reminder notices. The PDA wrote more than one letter to the Society reminding them that the pharmacist had removed herself, asking them to confirm this.

**“what sort of unbalanced world has the RPSGB’s version of healthcare regulation given us?”**

The PDA received a letter four days after, but dated on the eve of the date on which the Society was to assume powers under the new Section 60 Order 2007 (presumably constructed in the knowledge that the letter would be received after powers were assumed) stating that;

**“Section 12 of the Pharmacy Act 1954 provides for removal from the register for non-payment of retention fee. In these circumstances Council may direct the Registrar to remove the chemist’s name from the register. To date the Council has not directed me to remove [this pharmacist’s] name from the register.**

**“I am unable to comply with your request to confirm that [this pharmacist] has been removed from the register in accordance with her requirements in her letter(s) of resignation.**

**Under the provisions of the Pharmacists and Technicians [Section 60] Order 2007**

**and the Royal Pharmaceutical Society’s (Registration) rules made under the Order, the power to retain a registrant on the register if there is an ongoing fitness to practice investigation is made explicit. The relevant rules come into force on 30th March 2007.”**

For the avoidance of doubt, the timelines for how this matter developed are detailed in the enclosed panel.

Timeline	Action taken
Zero minus five months:	Initial letter of resignation sent to RPSGB with certificate.
Zero minus four months:	PDA sought acknowledgement of receipt and removal from register - no response.
Zero minus three months:	Pharmacist received renewal reminder
Zero minus two months:	Pharmacist, through the PDA, sent another resignation letter requesting confirmation that she was now removed from the register - no response.
Zero minus one month:	PDA sought proof of receipt and asked for confirmation that her name had been removed - no response.
Zero minus one week:	PDA again demanded confirmation
Zero minus twenty four hours:	Letter written by the Registrar to PDA legal representative in which it states for the first time that she cannot be removed and that they will assume powers to retain her under the Rules of the Order which come into force the following day
Zero plus four days	PDA receives the letter dated March 30th from the Registrar

We believe that the Society deliberately procrastinated until (in its belief) it was too

late for our member to do anything about it thus then claiming to assume the powers to investigate and possibly discipline her. We feel that this was an appalling abuse of its powers. The PDA expressed its exasperation to the Registrar (zero minus one week);

**“Quite apart from the above (the legal points), can you or the Society say what on earth is to be gained by seeking to drag (this pharmacist) through the sheer hell of the Society’s regulatory machine at the end of her fine career (of which she herself no longer wants to be a member of the profession or practice pharmacy? Are the interests of the public and [this pharmacist] not simply best served by accepting that she ceased to be a member upon her resignation and closing this matter?”**

**This cannot be light touch regulation** Surely, this cannot be the ‘regulation with a lighter touch’ that the government

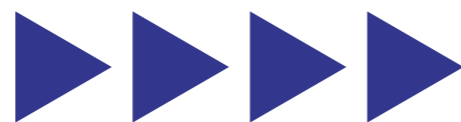
architects of the Section 60 Order intended.

When will the RPSGB realise that it is not dealing with war criminals and in this case, a frightened elderly individual (now near a nervous breakdown due to all this) and now no longer dealing with the public, who simply wants to retire. She has dedicated most of her life to fulfilling patients’ needs.

There are numerous other cases that the PDA has been involved in that prompt the question as to what sort of an unbalanced world has the RPSGB’s version of ‘healthcare regulation’ given us in the hallowed name of ‘public interest’? And what of the cost implications this all has for the rest of the profession as it ends up footing the bill for such regulatory largesse?

**PDA asks the GPhC to drop some of these cases**

In September, pharmacy regulation will be taken over by the GPhC; their approach surely cannot be worse than that of the RPSGB. Initial meetings with senior officials of the new regulator indicate that they will be more proportionate in their dealings with pharmacists than the RPSGB regime which we have been used to. There are special provisions set out for transitional arrangements in the Pharmacy (Section 60) Order 2010 to allow the GPhC to deal with overlapping cases “in such other manner as it considers just”. We have urged them to look into long outstanding and outrageous cases with a view to closing them. We hope that they will be predisposed to consider them humanely and without damaging the public interest agenda.



The revenue generated by MURs has become a very important and substantial source of revenue for some large organisations especially with Category M income falling.

Whilst many pharmacists agree that MURs are a good development for the profession, sadly, the obsession of some large organisations to treat MURs as a vital income generator has led to many pharmacists being harassed to deliver rigid targets regardless of their achievability.

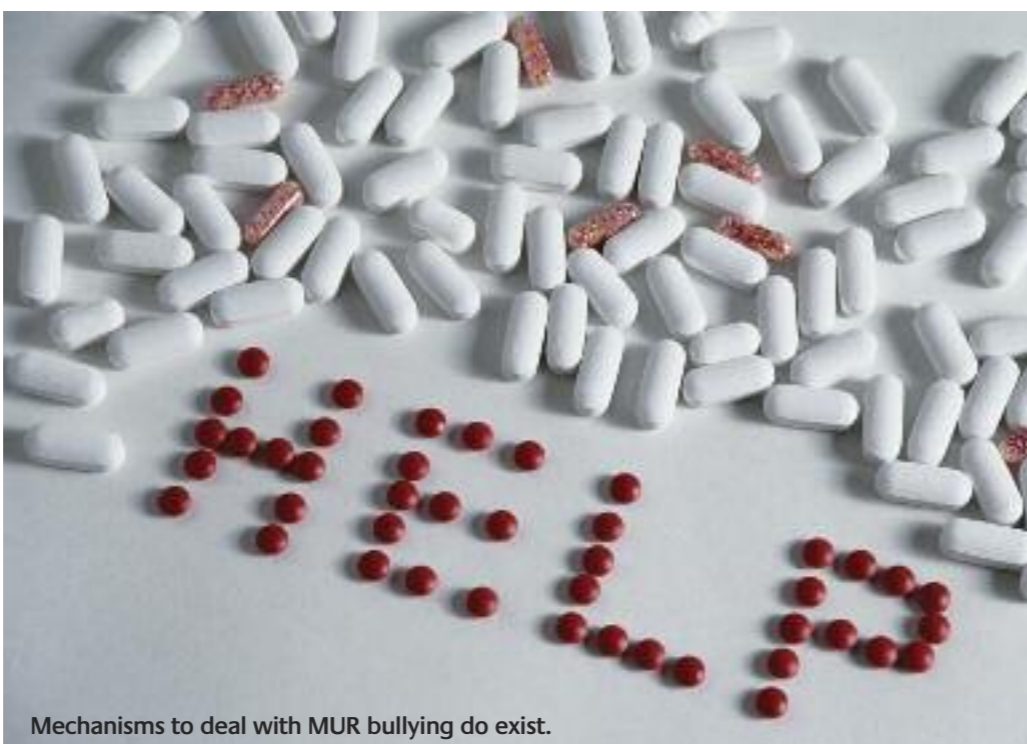
Since the last article on MURs in the Winter 2009 edition of Insight, the PDA has helped hundreds of its members to deal with unreasonable pressure from managers to perform MURs.

The PDA is aware of some tragic cases where pharmacists have buckled under relentless pressure from managers to meet targets and have even gone as far as resorting to falsifying company records to keep disciplinary action at bay. Such activity cannot be condoned and is soon exposed through company audits, which ironically have been tightened due to a rise in such cases. It is the view of the PDA that some companies may believe that the financial rewards generated from their pharmacist workforce being “encouraged” to produce large numbers of MURs are probably deemed by them to outweigh the “collateral damage” caused by some of their more vulnerable employees being disciplined and dismissed when they succumb to the pressures they are under and resort to ‘out of character’ behaviour.

**“The PDA has helped hundreds of members to deal with unreasonable pressure to perform MURs.”**

However, pharmacists should be encouraged by a number of successful experiences that PDA members have had in tackling undue pressure from company managers. Employment legislation and company policies can give significant protection from bullying behaviour and this coupled with robust PDA Union representation has dealt a wakeup call to arrogant and bullying managers.

In order to help other pharmacists realise they have the power to stand up to their employer, we have detailed how some of our members have made their working lives a lot easier.



Mechanisms to deal with MUR bullying do exist.

## Area manager receives a gross misconduct verdict for aggressive behaviour

John was subjected to increasingly threatening emails about his MUR performance over a period of six months. John’s area manager refused to believe that he was doing all he could to deliver the MUR target; visits and communications from the area manager became increasingly aggressive.

After contacting the PDA for advice, John was advised to keep a diary about his treatment and archive the emails he was sent. John was determined to try and deal with the pressure he was facing with as little fuss as possible and forwarded some of the worst emails to a senior pharmacist in his employer’s organisation in the hope that this would mean the area manager would stop bullying him. Unfortunately this inflamed the situation and the area manager angrily remonstrated with John at his next visit for going over his head. The bullying got worse after this and John agreed with his PDA case manager that the only option was to submit a formal grievance direct to the pharmacy superintendent.

As part of the support provided to members, John was helped to construct and articulate his grievance by an experienced advisor who also provided personal representation at the meetings.

The pharmacy superintendent was provided with an extensive dossier of information and John gave a full account of what had been happening. John had followed the PDA’s advice very closely, the evidence that was presented was overwhelming and after a number of witnesses were interviewed, the pharmacy superintendent upheld every point of John’s grievance and agreed that the behaviour of the area manager was unacceptable and the emails he sent were threatening and aggressive.

John was then asked what he wanted as an outcome to his grievance and decided that due to the behaviour of the area manager which appeared incapable of being rectified, he no longer wished to work for him. As a result of the grievance, the area manager was disciplined for gross misconduct and issued with a severe sanction, including having John’s store being removed from his area.

## Non-Pharmacist store manager is demoted

Another pharmacist had severe problems with her store manager pressuring her to complete MURs. This non-pharmacist store manager even waited outside the consultation room and harassed the pharmacist in front of patients to see if an MUR had been completed so that he could enter better figures onto his area managers report. The manager’s behaviour gradually got worse and culminated in some very offensive comments being made to the pharmacist after the manager lost his temper with the pharmacist for not meeting the MUR target.

Like in John’s case the pharmacist was given extensive support to raise a grievance and was represented by a PDA union official at the meeting to discuss her concerns.

As a direct result of the PDA’s intervention, the non-pharmacist store manager was disciplined for gross misconduct and removed from his managerial position. Both of these examples show that by using established employment processes along with support from the PDA, pharmacists can protect themselves from the bullying behaviour that seems prevalent in some organisations.



The law does not permit bullying in the workplace.

**“As a result of PDA intervention, the non-pharmacist store manager was disciplined for gross misconduct and removed from his managerial position.”**

## Developments at Co-op

Some pharmacists employed by the Co-operative pharmacy have found themselves invited to disciplinary meetings for failing to meet the company target of two MURs per day. Some documents seen by the PDA confirm that any shortfall in the MUR target on one day has to be made up on subsequent days. This approach clearly has the potential to place enormous pressure on pharmacists when workload or lack of suitable patients makes two MURs per day an impossible goal to reach, let alone three or more on subsequent days. As part of its support to members, experienced PDA representatives have been supporting members

## ADVICE ON HOW TO HANDLE PRESSURE ON MUR DELIVERY

Pharmacists can help protect themselves from being disciplined for MUR performance by following some simple steps and by seeking advice from the PDA at an early stage.

- Don’t agree to a target that you know to be unachievable. Target setting should be a two way process and the objectives agreed should be realistic and attainable within the resources you have.
- Always contemplate the professional and patient interest considerations, you should only be undertaking an MUR when it is in the patient’s interest to undertake one, this, and not employer business driven targets, should define whether an MUR is to be undertaken or not.
- Never agree to a rolling target where the next days target increases if the current days target for whatever reason cannot be met.
- If you are unable to reach a target without extra support, resources or training being provided by the company, it is essential that this is documented at an early stage and that this is communicated to your line manager.
- When circumstances outside your control prevent you from reaching a target, make a note of these for discussion at review time.
- If you experience bullying, harassment or generally unacceptable behaviour at work from your line manager, then keep a diary of events and retain copies of emails or other correspondence that will help you prove this if needed at a later stage.
- If matters start to get out of hand then make contact with the PDA for advice as soon as possible.

who have been called to disciplinary meetings established by Co-op. Ahead of these meetings, they made contact with the HR advisors supporting the disciplining managers in order to request information needed for the members to defend themselves.

**The PDA is pleased to note that in every case where members have come to us for advice about being disciplined by the Co-op for failing to meet MUR targets, the meetings have subsequently been cancelled and the allegations dropped after our intervention.**

The PDA set up PDA Plus, our PDA member exclusive benefits package, so as to find a range of services that would save our members money and others that would be highly valued because they are complementary to pharmacists' professional and work related needs. John Murphy, PDA Director, reviews some of the services.

An important threshold that the providers of these services had to reach before becoming part of The PDA Plus portfolio is that they would work in partnership with us. In other words, if we were to put services under the PDA umbrella, then the organisations that provide them must have similar values and motivations for success to the PDA. In short they must have the individual and their needs at the heart of what they offer.

We now provide ways and means for members to make significant savings on car hire, holidays, eating out, etc (which is dealt with in more detail on the opposite page) and we have a number of organisations that provide services which we see as vital if an individual is going to practice with total peace of mind.

## Our partnership with PG



Caring for members since 1928

One benefit we are particularly proud to be associated with is the Income Protection Plan from PG (Pharmaceutical & General Provident Society).

The consumer magazine Which? opens an article on its website on **"Income Protection; how does it work"** very pointedly;

**Millions of us have policies like critical illness, private medical insurance and payment protection, sold to us over the years by salespeople who convinced us we needed protecting. However, whilst they were right about the protection, they were wrong about the policies. The one protection policy every working adult in the UK does need is the very one most of us don't have - income protection (IP).**

Do you believe that illness, accident or disability will, of course, never happen to you?

Currently 2.2 million people of working age will be off work for at least six months because of sickness and disability, and more than 2.6 million people are claiming incapacity benefit (source: www.dwp.gov.uk); so clearly it does happen and it can happen very unexpectedly.

I was struck by a posting that I saw on Locum Voice - an electronic community for pharmacy locums. The posting was made just after we had launched The PDA Plus brochure in which we brought our members attention to the PG Income Protection Plan. The 'poster' was a young healthy woman who



Will my employer pay me if I am sick indefinitely?

had a particularly nasty tobogganing accident and shared her dilemma with her 'virtual' colleagues.

*"It was nearly a good start of the year for me, apart from a sledging accident I've had on the 9th of Jan. My leg was practically crushed from the knee down, I've about 5-6 fractures plus a broken ankle. I've been in hospital ever since, I've had two operations, nearly missed some other ones...but now I'm home. And wondering, how many of you people are insured for income protection?"*

*When I became a locum I took out PDA membership, and felt covered enough. Being fairly young and able, nothing could happen to me to prevent me from working...so I never even thought about taking additional insurance.*

*When I came back from hospital I was looking through my unopened mail and I found a brochure from PDA where they asked: "In case of an accident, can you manage on government Employment and Support Allowance?..." Well, I can answer that question now, and the answer is no, I can't manage on 60 quid a week, but how was I to know? See that destroyed woman with long hair in the picture who holds her head in her hands while the husband looks at her from a distance? I could model for that, I've even got pain and true feelings.*

*And since I have time, I wonder just how many locums are actually insured. Was I a fool not to get insured, or is it normal?"*

There was an interesting range of responses to her question, some admitting that they didn't have cover but acknowledging that they were running a 'risk'. Others told heart-warming stories about how they came to use their IP plan to a very useful effect.

There is still the myth however that such plans will not pay out to self-employed people however, this is not the case with PG who already work with many self-employed pharmacists. For those of you who think that your employer will give you sufficient sick pay the Which? article gave advice as to how to assess whether or not Income Protection insurance is a requirement and suggested that you ask these questions of yourself;

- Will your employer pay you a percentage of your salary indefinitely if you are off sick?
- If not, and you are part of a couple, could you pay all the bills and live on your partner's income indefinitely?
- If not (or you are single) do you have savings you could live off indefinitely?

It further went on to state that in its investigations it found that the vast majority of IP plans give only 50 or 60% of income back to the insured and that (all) policies pay out after you have been off work for a period of time known as the 'deferred period'. The good news is that there are options for you to take out a plan with PG which will replace as much as 70% of lost income and they offer 'Day One Cover' – especially useful for locums.

In the early days of the PDA, one of our members found himself in a difficult situation. He had had a brain haemorrhage which had kept him off work for some months.

Although the consultant signed him off as fit to do 'work' he did not want to work as a pharmacist until he was convinced that he

could trust all his cognitive skills. It was sensible for him to 'work-shadow' another pharmacist (in a non-earning capacity of course) until he, and the other pharmacist were both satisfied that he was not a danger to the public. I am happy to say that the member made a full recovery.

His then insurers however, once he was pronounced fit to do any kind of work (e.g. stacking shelves in a supermarket or delivering newspapers) no longer continued to pay out. PG, on the other hand, can cover a pharmacist until they are able to resume their pharmacy career - one of the benefits of joining a society which specialises in your profession.

The reason why the relationship between PG and the PDA works is because we have two 'like-minded' organisations, both not-for-profit, dedicated to the needs of pharmacists. What works for us and our members, works for PG.

In addition to this, all PG's policy holders gain a rare financial advantage in the form of an investment element designed to provide a cash lump sum for their retirement. As a mutual organisation, any surplus is returned to the membership - irrespective of any claims that an individual may have made.

Finally, as a PDA member, we have arranged for you to enjoy a 15% discount off the first three years' contributions.

**A friend in need is a friend indeed!**

To find out more about income protection go to: <http://www.the-pda.org/pdaplus>

## Food for thought?

Over the next few Insights we will be looking at different ways that you can save the cost of your membership by using the services we offer through The PDA Plus scheme. In this article, we feature the **Gourmet Society scheme**, which is heavily discounted to members.

*"Eating out is one of those luxuries that we are prepared to sacrifice when a recession bites. A survey conducted by market analysts 'Buckingham Research' found that three-quarters of British families will stay at home during the recession rather than eat out at restaurants. Couples and single people are also less likely to go out over the coming year.*

*One of the ways you can maintain your normal 'eating out lifestyle' with the added benefit of saving the cost of your PDA membership is by trying out the Gourmet Society scheme, which encourages you to eat out at least as much, if not more often for less.*

*Being a fee paying member of the Gourmet Society entitles you to two meals for the price of one or 25% off a meal including drinks (depending on the establishment).*

*I was rather sceptical so I tried it out for myself and the scheme, claiming that it has over 3,500 restaurants or eateries, threw up nearly 140 establishments within a 25 kilometre radius of my postcode in Nottingham. I was very impressed; not only were there so many but there were a good quarter of them that I recognised and I had eaten out at a variety of those locations on at least twelve occasions over the last eighteen months or so.*

*I won't need any encouragement to get enrolled on the Gourmet Society scheme because I could have saved at least £350 on what I had been billed in those restaurants over that period of time if I had known about it."*

**Annual subscription usually costs £53.50, but you can join for just £24.95 and get two months extra FREE.**

There are many offers available through PDA Plus which members will be well advised to research before making buying decisions; it could save a lot of money. We have searched for the best companies to partner with and negotiated for the best price.

Where you see this symbol (national price promise) the benefits we offer will be as good as or better than you will find anywhere else (conditions apply).



Go to [www.the-pda.org](http://www.the-pda.org) to find out more about **THE PDA PLUS**  
additional member benefits



I could have saved £350.  
John Murphy, PDA Director

# Workplace Pressures Campaign - Is the RPSGB the solution or part of the problem?

The PDA recalls numerous meetings going back over several years with senior RPSGB officials, prior to spring 2009, where it tried to push the Society into acting on workplace pressures faced by pharmacists. The Society wasted several years as it continued to deny its very existence due to what it claimed was a lack of evidence.

So although it came out of the blue, the PDA cautiously welcomed the U-turn in the spring of 2009, when the Society announced that it was now to launch its Workplace Pressures Campaign.

This RPSGB initiative was launched in a high profile PR campaign which at times almost appeared to indicate that the Society had discovered a shocking (and hitherto unknown to anyone else) problem within the profession - that thousands of pharmacists are suffering from unacceptable levels of stress in the workplace. The campaign was to be personally spearheaded by no less than the Society's President Mr Steve Churton.



Question mark over RPSGB commitment

Perhaps it is cynical of us to suggest that this new initiative had its route cause in the fact that within months the Society knew it would be a voluntary body and needed to show some (albeit belated) member friendly initiatives. It mattered not to the PDA what the motives were, what mattered was that the Society had finally opened its eyes to this problem and we resolved in our members' interests to join the campaign. However, working with the Society on this matter has proved very frustrating. Twelve months later, we are concerned that despite the hype, the Society's words have not been matched by meaningful deeds having had plenty of opportunities to do so.

C&D – PDA survey results	employed pharmacists	self-employed locums
Had experienced suicidal thoughts in the past year	4%	
Had experienced stress in the past year	85%	62%
Had experienced pressure from management in the past year	71%	52%
Had experienced intimidation from customers in the past year	44%	
Had experienced trouble sleeping in the past year	51%	26%
Said their employers did not provide support for the above issues	84%	93%
Approximately a third of those who raised such issues said it had affected the service they provided to patients. Several took the trouble to tell us that this effect included increased dispensing errors and near misses, and poor quality MURs.		

The results from the recent Chemist and Druggist and PDA annual salary survey show that the stress levels endured by pharmacists at the coalface have significantly increased in this last twelve months, it is clear that the RPSGB's workplace pressure campaign has not delivered.

## Forget the spin and stick to the substance

The annual review brochure of the RPSGB describes the work now being done by the Society to recognise that work place pressure is one of the biggest concerns in pharmacy. Page 6 describes the organisation of a major workplace pressure conference, it states that the RPSGB Council has called for support within the profession for adequate rest breaks and finally it describes a 'major report' called 'professional workload' which the Society has now published.

Whilst we welcome this work, it is just not enough. None of these developments have resulted in improving the life of many, if any pharmacists at all. The PDA is still receiving hundreds of calls for help each year primarily because of excessive workload, and this is a growing trend also at the pharmacist support charity.

Judging by the smiling faces that populate this year's RPSGB annual review, it seems that some of our current leadership are content with progress. Perhaps they truly believe that their workplace pressures campaign is the jewel in the crown of their improved member friendly credentials.

We believe that if the RPSGB is not part of the solution, then it is actually part of the problem. The RPSGB must recognise its failings of the last twelve months and it must learn the hard lessons from them.

**What would help the situation is a more practical course of action taken by the RPSGB. Let us not forget that it is still the pharmacy regulator (until at least September 2010), so it could flex its regulatory muscles, however, it appears reluctant so to do.**

## Failure to investigate an employer that did not allow proper rest breaks

In September of 2009, the PDA submitted to the RPSGB a formal complaint calling for disciplinary action to be taken against a large multiple employer for, amongst other things, not allowing any proper rest breaks. However, the RPSGB refused to act, instead it stated that;

*"You anticipate that our investigation will resolve a number of broad professional issues regarding employer's responsibilities and good working practices. We do not deny that such issues are a concern and do need resolving, but we do not believe that the inspectorate and the RPSGB's fitness to practice processes are the right and appropriate instruments in achieving the outcome that you are hoping for."*

Had the RPSGB taken disciplinary action, or even instigated a disciplinary investigation against this large multiple, then this would have sent a message to all those employers who deny rest breaks to pharmacists. This would have done far more to reduce workplace pressure and introduce rest breaks than what the Society did – publishing a Council discussion paper that called all employers to recognise rest breaks.

## Failure to investigate a superintendent over RP memo to pharmacists

In October 2009, when the RP regulations were freshly launched, some employers where quite wrongly urging their pharmacists to sign on as RPs from 8.00am, when they started work at 9.00am. This retrospective signing on was a source of much concern and stress for pharmacists with many complaints received by the PDA from members.

The PDA applied considerable pressure and the RPSGB sent out advice to all pharmacists stating that Responsible Pharmacists (RPs) may not retrospectively sign on to allow the pharmacy to operate from 8.00am if they only arrived and commenced their duties at 9.00am as this was not a lawful practice.

However, the superintendent of a large pharmacy multiple decided to send out an internal memo to employee pharmacists which had the effect of telling them to disregard this advice because the employer did not agree with the position of the regulator.

**"If the Society talks like a duck, but walks like a large pharmacy multiple, then it will fail to secure the trust of the membership."**

Imagine the intolerable stress caused to pharmacists by being told one thing by the regulator and another by the employer. The PDA brought this to the attention of the RPSGB straight away, however, we are not aware of any disciplinary measures being taken against the superintendent pharmacist involved in this conduct, nor are we even aware of any disciplinary investigation being instigated.

Imagine if the RPSGB had indeed convened a disciplinary investigation into this matter, this would have sent a forceful message out to all pharmacists in positions of authority. The net effect of this would have produced far more impact upon reducing workplace pressure than what the Society did in fact do – which was to publish what the RPSGB calls a major report entitled "Professional Workload".

## Failure to act on the RP regulations

In the summer of 2009, large numbers of pharmacists were expressing serious concerns about the impending RP regulations. Many aspects of these regulations had very obviously not been thought out properly and consequently, they were not ready to be launched. This was a source of much stress amongst the pharmacy workforce and more than 5,000 pharmacists signed a petition calling for a delay to the launch of the regulations. Sadly, the RPSGB held a Council debate and decided not to support this call for a delay. The Society decided that it would instead seek clarification from the Department of Health so as to alleviate concerns. Clarification was to be sought about rest breaks, the legal position of which clashed with the RP regulations.

However, far from securing clarification from the department around rest breaks – the RPSGB instead secured clarification that allowed pharmacies (mainly the large multiples) to operate their pharmacies before the arrival of the RP. These moves, whilst good news for the employers, would have further increased the levels of stress and anxiety for RPs.

The PDA is already handling the first of a new breed of RP based civil, criminal and employment sanctions against pharmacists (see feature on pages 6 and 7) simply because of the fact that the RP regulations had not been properly thought through and were implemented too early. All of this could have been avoided had the profession stood united and the RPSGB had backed the calls of the PDA and many pharmacists for the delay to the implementation of the RP regulations.

## So where to from here?

It is the view of the PDA that if the Society wants to be a member facing body and that it is genuinely concerned about work place pressures, then its actions should match its stated intentions.

**The Society's current reluctance to flex its regulatory muscles and to take affirmative action against employers gives the distinct impression that it is an organisation that prefers to support the agenda of the large pharmacy multiple.**

There's an old adage that says; **"If you want to be a duck, then you have to talk like a duck and walk like a duck."**

However, we believe that in the Society's case, if it talks like a duck, but walks like a large pharmacy multiple, then it will fail to secure the trust and support of the membership that it so desperately desires.

There is now very little time left for the current RPSGB leadership to use its regulatory powers to bring some of the large multiples to account, in just a few short months, when regulation is handed to the GPhC, the RPSGB will lose this opportunity forever. We have no doubt that the newly elected board representatives that many PDA members voted for are alive to these issues and would be desperate to act decisively. However, by the time they take the reigns of the RPSGB, the regulatory role of the RPSGB will have gone forever.

These next few months will therefore represent the last historic opportunity for the Society to act decisively as a regulator.

**We appealed to the RPSGB and its president at the recent AGM not to squander what is left of this regulatory opportunity, for if it were to act, then it may yet persuade pharmacists that it is serious about truly trying to resolve their workplace pressures.**

**There is still time left - let us see if they deliver.**



# Pharmacist settles for £30,000 in unfair dismissal case

Many of the enquiries that we deal with involve members alleging that they have been unfairly dismissed, however proving this is difficult as the system is very much stacked in the employer's favour.

There are six potentially fair reasons that employers can use to dismiss employees, one of which is 'conduct' and generally speaking, an unfair dismissal claim can only be brought if the employee has a minimum of one year's continuous service.

In one recent case the employer relied on conduct as its reason for dismissing a pharmacist. They alleged that he failed to ensure adherence to the Standard Operating Procedures (SOPs) by staff. It was therefore not the conduct of our member that was being called into question (something that he had done) but the actions of others that he had failed to supervise.

Two dispensers complained that our member did not carry out a clinical assessment of some prescriptions and they believed that they were handing out medication to patients contrary to the SOPs.

Our member was adamant that he had carried out a clinical assessment of every prescription and that there should never have been any occasions where the dispensers would have given medication to a patient without this being done. He was certain that the staff must have been mistaken and in the absence of any other explanation must have had a more sinister motive in raising such a complaint.

During the disciplinary hearings, at which we represented the member, we were appalled at the quality of investigation and asked for examples. No such evidence was forthcoming (not even a single example) and the employer justified their action by saying it was 'common occurrence'. We pressed the employer to ask the complainants whose instructions they had been working under when handing out medication that had not been checked if this was indeed the

case; the employer chose not to establish this information.

Our member was summarily dismissed and the decision was upheld on appeal. Having exhausted the internal process he brought a claim for unfair dismissal in the Employment Tribunal (ET). The pleadings were the lack of a reasonable investigation by his employer into the matter; the difficulties encountered with being away from the dispensary (on the employer's insistence) in the consultation room conducting MURs for example; and the fact that the staff had been trained how to dispense properly and had worked as dispensers for a number of years. If they who had knowingly breached the SOPs were not disciplined, our member, who had no knowledge of the breach, should not have been disciplined either. He made it clear that he was always in control of the pharmacy and had an understanding with trained staff that all medication should be checked by him with regards to the clinical and accuracy check.

Our member had also submitted a grievance to his employer prior to the termination of his employment which had not been dealt with until his dismissal. It was during the grievance investigation meetings that the company eventually sought to question the claims made by the

As this case did not proceed to a hearing we cannot be certain that if a similar situation occurred the case would be successful at trial. Had the case come before a judge he/she would have had to consider;

1. Did the employer have a fair reason for dismissal? (on conduct grounds)
2. Was a fair procedure used? (investigations, disciplinary and appeal meetings etc)
3. Was the decision to dismiss within the range of reasonable responses open to a reasonable employer?

The latter point is perhaps the most important of these and essentially relates to the concept of fairness. This is where we consider what the actions of a reasonable employer would have been in the circumstances. Put simply, the question asked will be: **Is it possible that a reasonable employer, faced with these facts would have dismissed?** It is important to bear in mind that where an employee has already been subject to various stages of the disciplinary process such as warnings etc, it is not difficult to make a case to dismiss.

**“In a game of brinksmanship, the employer's representatives contacted us with an offer of £30,000 to settle the case one hour before close of play.”**

staff. Those staff who had earlier claimed to believe that they were handing out medication which had not been checked by a pharmacist now said that they “did not know” if checks were carried out. Unfortunately this was too late for our member.

In a game of brinksmanship, the employer's representatives contacted us with an offer of £30,000 to settle the case one hour before the close of play the day before the tribunal.

This was not an issue in this particular case as the pharmacist had an exemplary record.

The action by the employer has significant implications for those of you working as Responsible Pharmacists believing that you can trust all your staff to follow the SOPs. The case also highlights the very real problems that can stem from an employer's failure to conduct a reasonable investigation should staff make allegations about you and the low standard of proof that dismissal requires.

To comment on this article please go to [www.the-pda.org/is/109](http://www.the-pda.org/is/109)

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# Contesting the new Alliance Boots staff pension scheme

In January 2010, Alliance Boots announced that it proposed to cease accrual of benefits under the defined benefits (final salary) pension scheme with benefits from that scheme (reflecting salaries and length of service at the date of closure of the scheme) being transferred to a new employer.

In its place the company introduced a 'defined contribution scheme' the final benefits of which will depend on the contributions made by the employee (supplemented by the employer).

There are more than 1000 PDA members working at Alliance Boots and on their behalf we took issue with the following matters;

## The current scheme was not in deficit

The final salary scheme had already been closed to new staff and as it was in surplus, there seemed to us to be no main reason for the company to change the scheme for current members other than to take advantage of the current downturn in the economy to reduce its contributions to the pension fund and transfer greater risk from the employer on to the individual.

## Financial implications

Our members who were currently in the defined benefits scheme could be disadvantaged financially by being moved to the new scheme. Although the company state that pharmacists will receive a contribution of employee to employer of 1:2, this may not compensate for the losses they would have accrued through staying in the original scheme.

## The method used to close the scheme

Having made a proposal to cease accrual of benefits under the scheme the method used by the company to achieve this was in our opinion and that of our expert advisors not illegal, but not within the spirit of the law.

The vehicle used by the company to move employees from one scheme to another was TUPE -Transfer of Undertakings (Protection of Employees) legislation. The original purpose of this was to protect employees' rights when they have been taken over by another employer; however

pensions are exempt from transfer under this legislation and by setting up a new company (a vehicle still owned by Alliance Boots) and transferring all employees into it, Boots had no obligation to transfer the original, more preferential pension scheme with the employee. If the employee had refused to transfer to the new company then potentially they could have been dismissed. We believed that this was using the TUPE legislation for purposes for which it was not intended. And frankly what option did the employee have but to accept it?

## The consultation

We wrote to the Chief Executive of Alliance Boots setting out our concerns and they have set out to justify their consultation process. We have pointed out in reply that:

- Although the company was obviously happy to consult with the 'in house' Boots Pharmacists' Association (BPA), it did not appear to wish to do so with the PDA even though PDA has more pharmacist members than does the BPA.
- The company argued that it would have been prepared to stop the reform of the scheme based on the results of the consultation process, but we find this difficult to accept given the time taken within which such a major decision was made. This massive logistical exercise involved consulting with 45,000 employees, amending the proposals, getting applications made to the new scheme and transferring everyone to the new management services company. This could not have been done without many months of preparation yet executed in three to four months (however, this timescale did comply with the legal requirements for consulting with employees).
- We have asked why the TUPE regulations were used for purposes for which they were not intended, but have received no response.

To comment on this article please go to [www.the-pda.org/is/110](http://www.the-pda.org/is/110)

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Who is trying to protect your pension nest egg?

## Members' rights to reserve their position

Within the process, there appeared to be no space for contingency; this was a company with a mission! Many of our affected members were concerned and wanted to know how they could resist the momentum and how to protect their rights. We recommended that they should enter into the new pension arrangement so as they would not be disadvantaged but should "reserve their rights" to challenge the clause which made it conditional that they waive their rights to any accrued benefits from the 'old' scheme. This would create a true test of the company's flexibility.

However, Alliance Boots informed the PDA that they would not accept any 'reserving of rights' and would deem such applications to be invalid thus making members ineligible for entry into the new scheme from 1st July and that as a consequence their death in service benefit would be affected.

The PDA had taken expert, independent legal advice at every step of the process and passed it on to our members. We believe that our advice was appropriate and reasonable.

The PDA has reverted to the Pensions Ombudsman in the hope that they will make a challenge. However, we have been warned that the likelihood of success is limited. Through our parliamentary connections, our hope is that in future, at least the loophole in TUPE legislation can be closed to prevent large employers using TUPE in such a way.

The PDA awaits a response from the Pensions Ombudsman.

To comment on this article please go to [www.the-pda.org/is/110](http://www.the-pda.org/is/110)

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# A focus on Hospital RP issues – why hospitals should be exempted from these regulations.

**It is well known that the RP regulations were primarily designed for application in the community setting. However, as the RP regulations came nearer, it became clear that the RP regulations would impact upon hospital pharmacy practice to a much greater extent than anyone had previously imagined.**

The RP regulations create a number of new operational requirements that must be met by RPs and create new criminal offences for those who fail to observe these; such as for not making a record and for not keeping the record for five years. It is obvious that these regulations were all about being able to hold individual pharmacists to account in the event of a problem. Bearing in mind that the profession has just about had its fill of needless exposure to criminal convictions and the fact that our research showed that the profession was just not ready for these new regulations, the PDA called for a delay to the implementation of the regulations in July 2009. This call for a delay was backed by a petition, which attracted more than 5,000 pharmacist signatures. A delay would have given a period where the profession could try and bed in the regulations away from the threat of professional and criminal sanction.

When the RPSGB council came to consider this, they asked whether the Guild of Healthcare Pharmacists felt that hospital pharmacy was ready to implement the regulations. Surprisingly, the Guild position was that it was quite content for the regulations to go forward on October 1st. Sadly, the Guild chose not to support a call for the delay, notwithstanding the exposure of hospital pharmacists to criminal sanctions that the regulations would produce. The RPSGB Council then voted not to support the PDA's call for a delay and the RP regulations went live on October 1st 2009.

**“Surprisingly, the Guild position was that it was quite content for the regulations to go forward on October 1st.”**

Since then, there have been growing concerns being expressed by hospital pharmacists about these regulations and we decided to establish whether this is a localised problem or something much broader. Members will have seen that we have undertaken various surveys and member feedback initiatives. This feature takes a snapshot view of how the RP regulations are currently perceived by hospital pharmacists. The results of our findings are worrying and they bring us to conclude that the RP regulations serve no useful purpose in hospital pharmacy. The capacity of hospital pharmacy to be able to observe the RP regulations to the letter of the law is limited and as a consequence, some hospital pharmacy departments are not at all able to meet the requirements. This exposes pharmacists to the prospect of criminal and professional sanction. Worse still, where attempts to comply with the regulations are being observed they significantly hinder hospital pharmacy operations and in some cases even lead to the closure of some patient services. We examine specific aspects of our findings;

## **Insufficient preparation leads to a lack of clarity and perception.**

The various government departments commenced some additional RP work to focus on hospital practice in the summer of



2009. The hospital RP toolkit was not released until the end of August, leaving just a few weeks before the implementation date. This meant that many senior managers were not ready to induct their departments in time for the initial start date. Surveys have shown that many hospital pharmacists did not receive a briefing about the RP regulations before October 1st, what is worse is that nine months later, a significant number (in excess of 40% of respondents) claim that they have still not had an RP induction.

Whilst the absence of an induction is obviously problematic, it is becoming apparent that some senior managers are still not at all clear about the regulations.

Comments from some senior managers which have been received by the PDA include;

**“This is all about one pharmacist signing other pharmacists in and out on a rota system.”**

**“The RP regulations do not change anyone's culpability, I would still be made answerable for any errors.”**

**“These regulations make no difference to those signing on as RPs.”**

The fact that this is a wider problem is confirmed by responses that we are receiving from many more junior pharmacists when they confirm that their concerns are not being addressed by management;

**“When we organise meetings to try and get some answers about RP, there is clearly a great deal of confusion.”**

**“We are just not being offered the full legal implications of the role of the RP.”**

**“The Chief Pharmacist told us that it didn't really make any difference to us, we raised some objections, but they did not listen.”**

**“The dispensary manager is a technician and could not answer all the issues that we raised.”**

**“I have been lulled into a false sense of security as I have never been told what I am signing up to do.”**

Clearly, there is also evidence to show that many pharmacists do not fully understand the regulations, however, in those cases, they are frequently able to offer powerful testimony as to their operational unworkability.

A general review of the many responses that we have received show that many hospital pharmacists just don't know what they don't know. This has led to many of them acquiescing to being RPs because it is the 'done thing' and because it is expected of them – they do not want to be seen by management as being awkward.

Even the most basic examination of the regulations will confirm that the RP regulations are anything but “business as usual”, requiring RPs to take new statutory responsibility for significant aspects of the pharmacy operation and for them to comply with specific operational activities. We are not supportive of the application of the RP regulations in the hospital setting, but we nevertheless advise pharmacists who have not had an RP induction, or where there is a lack of clarity about the regulations, that they are facing unacceptable risks and may find themselves the focus of both criminal and professional investigations, which some prior planning could have otherwise mitigated.

We urge all senior pharmacists to establish what their hospital's 'RP' policy actually is and to ensure that it is fully compliant with the regulations. Once that is established, then this should be communicated to all those affected by it in an unambiguous way. Any departments that have not yet provided a formal induction of the RP regulations should seek to urgently address this.

## **What about insurance arrangements?**

Some pharmacists, when they complain about the lack of information from senior management about RP regulations, are simply being told “Don't worry, the trust's vicarious liability will cover you all.”

What they are saying is that if a pharmacist falls foul of the RP regulations and ends up with a criminal, professional or employment sanction, then the Trust will stand up to defend the pharmacist. This advice is seriously misinformed. That this suggestion could even be contemplated, demonstrates that those who make it have no idea of what an employment, criminal or professional investigation can look like. From the many thousands of cases handled annually by the PDA, we can confirm that no hospital pharmacist should be satisfied with such a response as in reality, employers will be much more interested in making sure that their reputations remain intact. Indeed, if a hospital pharmacist is the subject of sanctions due to falling foul of the RP regulations, judging by the results of surveys that we are receiving, it is very likely that we will be seeking to draw Trusts into the firing line for a lack of proper preparation for these regulations.



## **The unworkability of the regulations.**

It is now obvious that aspects of the regulations do not fit easily in the hospital pharmacy setting. This 'misfit' situation manifests itself in numerous ways.

- Junior staff are left to sign on as RPs simply because they spend more time in the dispensary. However, because they tend to have a hierarchy of more senior staff in managerial positions above them, they cannot exercise the professional control that the regulations would require them to. It is therefore inappropriate to expect them to deliver and review departmental protocols and to hold them responsible for securing the safe and effective running of the pharmacy. However, this is what the RP regulations are holding them to account for.

**“The dispensary is managed by technicians who are in positions of authority, they tell me what to do even if I as RP disagree, they are also in charge of all of the other dispensary staff.”**

- RPs are often not in a position to make any clinical interventions on prescriptions as the clinical pharmacy input is being made remotely (usually on the wards). Consequently, many pharmacists are very reluctant to sign on as RPs as the regular functioning of the hospital pharmacy service mitigates against the intended application of the regulations.

- Our surveys are showing that routinely, RP registers are not being maintained, as is required by the RP regulations, resulting in many departments operating unlawfully. In some hospitals, certain individuals are even given a specific mop up role where they sit down to fill in the gaps by entering lists of pharmacist names into the RP register. Whilst this may be a pragmatic approach, it makes a complete mockery of the regulations.

**“I have been given the job of RP monitor, it is my job to fill in the names.”**

- Because of the regulations, some patient services such as out of hours supplies to other hospitals have been reduced. Others, such as specialist satellites or even satellite pharmacies in community hospitals have been closed down making life more difficult for patients. It would appear that these regulations are of no benefit to hospital pharmacists and that they are also impacting in ways which were not anticipated on patients.

The RP situation in hospitals is a subject that could fill an entire magazine. However, we feel that the words expressed to us by one member sum up the position when she says that;

**“The RP regulations have significantly hindered hospital pharmacy by adding unnecessary work and affecting certain operations like supplying external organisations. I believe that they have added no benefit at all to the public. As a junior pharmacist in the organisation, I seriously think that this regulation needs to be reviewed as a situation where I sign on as being responsible for safe and effective operations which are outside of my control and beyond my competency is unlikely to be beneficial to the patient, the profession or the organisation.”**

Once all of the data has been analysed, the PDA intends to make contact with the Pharmacy Minister asking that he exempts hospital pharmacy from the regulations. In the meantime, we ask that all hospital pharmacist members participate in our ongoing surveys, as the more information that we can gather, the greater will be our chance of securing some positive outcomes.

# IS IT WORTH A CANDLE?

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