

insight



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

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Get proactive!

Featured on page 22 is the continuing saga of on-call negotiations for pharmacists. This is a sorry tale which epitomises the quandary being faced by the employees of the NHS. Whilst everyone recognises that belts need tightened in the current economic climate, what we are dealing with here is the prospect not of pay freezes, but of up to 50% reductions in previous on call pay arrangements. There are a wide range of NHS employees; brain surgeons, cleaners, admin staff, nurses and everything in between and that is why the principle of equal pay for equal work has been adopted centrally. One of the reasons why the on-call problem has emerged is that the NHS still frequently relies upon local arrangements to support a range of services and these vary.

Consequently, the equal pay for equal work principle is in practice, turning out to be much more difficult to observe at local level. Some Trusts have proposed the same on-call availability rates for pharmacists as they are offering to maintenance staff and this situation is patently unacceptable.

Additionally, from the experiences of PDA members on the ground, it appears that negotiations on behalf of NHS employees are also being hampered by exactly these same factors and this is producing winners and losers. The very large Unions may well be working very hard to resolve the on-call negotiations and they may well have lots of influence, but from the reports that we are receiving from pharmacists, in some areas they appear to be hampered by their size – they have many interests to manage.

The PDA Union has provided support to hospital pharmacists in these negotiations. This may be through the provision of advice to individuals; this could be by supporting a group of pharmacists who have banded together locally to try and present their own proposals directly to their Trust; or this may be something much more detailed, like providing PDA Union representation at local meetings with Trust officials to challenge existing proposals. As described in the feature, this has required a detailed knowledge of employment legislation, pharmacy law and professional practice.

In other instances support with media handling has also been provided for members.

There are many lessons emerging from these situations, most importantly is the notion that those pharmacists who have banded together and who have proactively engaged with their Trust, notwithstanding what may have been agreed by the large healthcare Unions are tending to secure success. Those that have fared worse are those who have simply gone with the flow of the Trusts proposals.

Importantly, in our view, this work is providing some successes because PDA Union officials are only supporting the pharmacist interest. We do not concern ourselves with arrangements for any other healthcare or non-healthcare workers and we do not need to consider balancing our approach. The PDA solely concentrates on pharmacists and that is why we will doggedly fight for this interest.

In the past we have received some criticism on the grounds that we are not recognised centrally for NHS negotiations as are the very large national Unions, but how beneficial are such arrangements for NHS pharmacists when they represent such a tiny proportion of the total membership of a very large Union?

Notwithstanding what some pharmacists have been told by those perhaps concerned about the rise in PDA membership, any national agreements do not preclude local negotiation and representation of pharmacists by the PDA Union. I believe that the on-call saga demonstrates just how important the need for effective local negotiations actually is. What it also demonstrates is the benefit of a dedicated pharmacist Union as offered by the PDA for pharmacists.

Any pharmacists concerned about any outstanding issues on as yet unresolved on-call payments, should contact the PDA for support and advice.

Mark Koziol, M.R.Pharm.S.

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PDA writes to the Minister about RP regulations – again!

Every pharmacist in the land will be aware of the problems associated with the launch of the RP regulations and the deepening concerns that have emerged subsequently. The RP regulations, which were launched in October 2009 despite howls of protest from thousands of pharmacists, have been the bane of their pharmacy practice ever since. Not only has there been unnecessary increase in the red tape associated with the regulations, but the new laws also introduced brand new criminal sanctions for pharmacists and for owners of pharmacies.

From the experience of the PDA in handling many thousands of employment disciplinary, professional regulatory and civil claim defence episodes, the RP regulations are all round bad news for pharmacists, as they unnecessarily expose them to considerably more risk and have been used to discipline pharmacists.

After much protest and a letter from the PDA to the Pharmacy Minister in August 2010, he agreed for the regulations to be reviewed. An independent study was commissioned at great expense by the Royal Pharmaceutical Society in the summer of 2011.

This independent review slammed the RP regulations and concluded that they were:

- Driving behaviours that undermined public safety
- Adding professional stress and tension
- Driving RPs towards more defensive practice

It also highlighted that the regulations were not suitable for hospital pharmacy and that they should be disappplied in the hospital setting altogether or be comprehensively overhauled.

It went on to reveal that:

- Seven in ten pharmacists felt that the regulations put the RP in a difficult position by making them legally responsible for people and processes outside of their control.
- One in ten locum pharmacists had refused to work as an RP because of how a pharmacy was operated, whilst another 26 per cent had thought about doing so, but had then gone ahead and worked anyway – this increased to 34 per cent in some supermarket pharmacies.

- Only around one in three RPs felt that they had the genuine authority to make changes in the pharmacy so as to effect the safe and effective running of a pharmacy – as required by the regulations.

Far from providing the new quality framework that the Department of Health had always insisted was the driving force behind their creation, these regulations have delivered a detriment to public safety and an unnecessary burden from a pharmacy practice and liability perspective.

The PDA fully recognises that the results of this independent review of the RP regulations will be the source of more than mild embarrassment to the Department of Health. It demonstrates what the PDA has said all along – which is that the Department significantly lacks insight into the realities of pharmacy practice.

Nothing excuses the fact that despite the protests from pharmacists and increasing numbers of pharmacy organisations, and the publication of this damning independent review, the Department (as far as the PDA is aware) has done nothing to deal with these lame regulations so as to restore patient safety and to relieve the unnecessary exposure of pharmacists to stress and the risk of prosecution.

Earlier this summer, the PDA wrote again to the Pharmacy Minister setting out the concerns with reference to the independent RP review and challenging him to consider the interests of public safety and in so doing, to address the matter of the RP regulations with some urgency. The PDA has asked the Minister to explain what he intends to do now. At the time of going to press, a response is awaited.



RP Regulations - Bad news all round



PDA developments in Northern Ireland

For several years PDA membership in Northern Ireland has been gradually increasing and the association is acutely aware of some of the difficulties that pharmacists are experiencing.

As a consequence, in April 2012, the PDA appointed pharmacist Harry Harron as its Northern Ireland representative.

Based in Downpatrick Harry will be involved in developing both the reactive and proactive PDA programme in Northern Ireland.

Following his appointment, in June, PDA officials met the Chief Pharmacist for Northern Ireland Dr Norman Morrow to discuss how the PDA will seek to develop its operations.

Commenting on his appointment Harry Harron said;

"I have been a PDA member for a number of years and have often thought of the many issues that need to be addressed in Northern Ireland that the PDA could be involved in for the benefit of individual pharmacists. I am delighted that the PDA have chosen to commit to this task and I am thrilled to have been appointed to this important role."

PDA Chairman Mark Koziol said;

"We look after the interests of employee and locum pharmacists and we know that the current situation in Northern Ireland is very problematic. We are now building our infrastructure and ultimately intend to provide reactive support to our members where required and through policy initiatives like the refreshing of the

previous 'making it better' NI pharmacy strategy, we hope to be able to influence developments for the benefit of patients and pharmacists."



Harry Harron M.R.Pharm.S
PDA Northern Ireland Representative

Unions call on Trusts in SW Region to withdraw from 'pay cartel'

South West Health Trade Union Forum has called upon the 20 Hospital Trusts who are members of the South West, Pay, Terms and Conditions Consortium to withdraw from it.

The consortium which the Unions claim is no more than a pay cartel has pronounced that its purpose is to assist Trusts across the South West in modernising pay, terms and conditions to ensure that they are 'fit for purpose' going forward.

The consortium plans to develop a framework of pay terms and conditions that will have a consistency across the South West but is likely to be less beneficial than the rest of the country given that they intend to reduce the overhead costs to such an extent.

The consortium in a published document has stated that the areas of review will include:

Reduction in unsocial hour's

payments: Reviewing current unsocial hours consistent with the desire of many Trusts to extended working hours beyond the standard working day.

Increasing working hours: Exploring the potential impact of increasing working hours (currently at 37.5hrs per week).

Reducing annual leave: Specifically for those individuals that have ten or more years of service.

Reviewing pay levels: The link with Job Evaluation and the consistent application of pay bands – implying that there are too many higher banded employees.

Removal of sickness absence

enhancements: Specifically the entitlement of staff who are absent for work to receive additional enhancements relating in particular to unsocial hours.

The Unions are concerned that this local approach will not only lead to a waste of time, resources and money in local negotiations that could be deployed

elsewhere but that also this approach will be a retrograde step for patients in the region. It will lead to the loss of staff to other areas that will pay more, resulting in difficulties in employing skilled staff, driving down staff morale and productivity both of which impacting on patient care.

The Unions further argue that the imposition of reduced pay and conditions in the NHS will affect the economy of the South West, which will inevitably be exacerbated by the resultant effect it would have in the private sector. In addition, the NHS may not find itself in any better financial position should it have to resist many equal pay claims by long serving staff in particular.

The PDA will be issuing guidance to its members through the web site www.the-pda.org and it supports the Union Forum's position in urging the consortium to dissolve and for the Trusts to return to working in partnership with the Trade Unions at a National level in order for ongoing negotiations to succeed.



P medicines on self-selection?



The GPhC recently launched its consultation on standards for registered pharmacies and in it was contained the proposal that P medicines could be sold to the public via self-selection. If this went ahead, then this would result in a move of P medicines from behind the chemist counter and onto the open shelves.

“We believe that it would result in the further reduction of public safety on the altar of profit” said Mark Koziol, PDA Chairman “as well as yet another dilution of the important safety role of the pharmacist.”

In its formal response to the GPhC consultation, the PDA argued that such a suggestion would perhaps be expected from a supermarket retailer; the fact that it comes from the regulator is incomprehensible and could be seen as a dereliction of its duty in its role as public guardian.

At a recent meeting with the GPhC, PDA officials described a practical

scenario where a patient comes to the counter and is intent on purchasing a specific P medicine. Upon questioning the patient it is apparent that this medicine is entirely inappropriate for the condition described because of safety issues: during such an interaction the pharmacist may even identify substance abuse.

The pharmacist is in a very strong position to be able to either recommend something more efficacious or stop such a sale because the item never gets into the patients hand in the first place.

Should the P medicines be on self-selection, it is less likely that such a discussion would occur and even if it did, it would be much more difficult for a pharmacist to prevent an inappropriate sale if the medicine was already in a patient’s possession.

“This valuable safety role delivered daily in many routine interactions every day across the country would be significantly compromised,” commented Mr. Koziol.

Lloydspharmacy withholds four year ‘golden handcuffs’ bonus

When a pharmacist guaranteed Lloydspharmacy four years of unbroken service in exchange for the promise of a £10,000 bonus payment, the last thing that he envisaged was that his employer would not honour the deal.

The pharmacist served his four years but his employer wouldn’t pay him because it determined the bonus

was discretionary (not contractual), and because it maintained that he had been subjected to ‘counselling’ (a pre-cursor to their performance management processes) had the right to withdraw it.

Some annual bonus schemes have disqualification clauses if the member of staff has an active disciplinary warning on file. Although this pharmacist had never been formally disciplined, because he had been subjected to a counselling session his manager decided it amounted to the same thing and was therefore enough to disqualify him from receiving the payment.

The staff handbook however stated that counselling sessions were not part of the disciplinary process. In any event it was questionable whether any disciplinary action at any time during

the four year period would have been reason to deny him.

The PDA Union has taken issue with this and its barrister will argue in the employment tribunal that this money is rightfully the pharmacist’s. Even if the bonus is ruled to be discretionary the barrister will argue that the company did not act reasonably in exercising its discretion not to pay the pharmacist the amount owed.

The practice of ‘golden handcuffs’ is probably long gone but the PDA Union is perturbed by a worrying pattern of behaviour and strongly advises members that before entering into any such agreement they seek advice to ensure that their rights are legally protected.



THE PDA  union

wins £80,000 settlement

The PDA Union has helped a member to win £80,000 in an equal pay case.

The member, who was near to retirement, became aware that for many years he had been paid considerably less than his younger colleagues and those with less service. He had managed the same small pharmacy in a large chain in an area of the country that traditionally found it difficult to recruit, and did not realise that new and more recently joined pharmacists had been retained or attracted into the same area as him at higher salaries. Market forces had moved on and because he appeared to be content and settled there for some time, he was forgotten about.

PDA Union negotiations with the company involved, failed to close the gap sufficiently to make up the shortfall in the member's salary, so an application to the employment tribunal was made on the basis of equal pay for equal work and age discrimination. Rather than go directly to a hearing, both parties agreed to judicial mediation without prejudicing our member's right to continue with formal action if there was no satisfactory outcome. A settlement figure was agreed which amounted to £80,000.

The company cannot be identified, as the compromise settlement included a confidentiality clause.



Scottish Review of Pharmaceutical Care

At the end of 2011, the Scottish Government launched a review of pharmaceutical care in the community. This large scale consultation involves numerous stakeholders to include pharmacists, other healthcare practitioners and patient groups.

The PDA attaches a significant amount of strategic importance to this initiative and has been very actively involved. A PDA policy manager for Scotland was appointed and in March the PDA organised a day conference for Scottish members in Glasgow which Hamish Wilson, the Review Lead agreed to address. Fuelled by significant member feedback and also focus group meetings, the PDA has now made its formal submission to the review process. In addition to this, the PDA was invited to make an oral presentation to the review team at the end of July in Edinburgh.

Mark Koziol Chairman of the PDA said recently; "There is no doubt that a proper pharmaceutical care service can

only be provided by pharmacists if they are able to develop meaningful clinical relationships with patients through patient registration leading to continuity of care. What we are proposing is a structured career framework for pharmacists working in the community leading to advanced practice and prescribing for those pharmacists who want to develop in this way. This would lead to the prospect of some pharmacists being able to work not as retail employees as such, but as independent and autonomous healthcare practitioners contracting directly with the NHS"

He continued;

"This exciting review of pharmaceutical care in Scotland could lead to cutting edge developments for pharmacists and benefits for patients and it is an ideal opportunity to develop the role of the pharmacist as an individual autonomous contractor."

Members wishing to see the full draft of the PDA's submission should go to www.the-pda.org/scottishroadmap

news in brief...

Extending Union Recognition

Following on from the formal union recognition made to Alliance Boots, the PDA Union has now written to the following employers requesting that it be recognised as the representative trade union for pharmacists. Superdrug, ASDA, TESCO, Sainsbury's, Morrison's, Lloyds Pharmacy and Rowlands; PDA Union is awaiting responses.



Is touching a patient's body part of pharmacy practice?

Recently a PDA member received a warning from the Chairman of the GPhC Fitness to Practise Committee because a patient had argued that she had been sexually assaulted via a physical examination during a consultation.

After months of difficult legal wrangling and representations from the PDA to prevent this pharmacist from being summarily suspended from practice through an interim order application, the PDA member was finally cleared of any sexual motivation in his contact with the patient but warned as to his future conduct. However, the non pharmacist chairman included in his reasons for his decision the following statement.

“A pharmacist is not competent to undertake a physical examination which includes the touching of a patient's body as part of a diagnostic procedure.”

The PDA disagrees strongly and has made its views regarding this statement clear to the GPhC.

“For decades pharmacists have been examining patients,” said Mark Koziol “Pharmacists are still involved in fitting trusses for instance and performing diagnostic tests, and indeed developing new roles which require the most intimate



contact with patients. The continuation of traditional and the creation of new roles must not be affected by comments such as these from a Fitness to Practise Committee chairman.”

After this verdict, PDA officials made representations to the GPhC to argue its position. It maintained that the Chairman should have considered whether or not the pharmacist in question had the competency to make a physical examination, not that pharmacists should not be involved in physical examinations at all.

The February edition of the GPhC's magazine REGULATE (page 12) provides the regulators clarification.

“Physical examinations of patients can sometimes be useful in making a diagnosis, but pharmacists should only undertake them when they have the appropriate skills and training for that type of physical examination. It is also vital to gain explicit consent from the patient for examinations.”

This case provides valuable lessons for pharmacists as to the precautions that should be taken before they physically examine a patient.

“We hope that the Fitness to Practice committees uses this episode as a valuable training experience to help it make determinations in the future” concluded Mr Koziol.

PDA writes to Tesco Superintendent about targeting of services

Following a letter to locums from TESCO which states that the existing locum hourly rates would only be paid if service targets were met, and if they were not, then a lower hourly rate would be paid, the PDA has written to the Superintendent pharmacist.

The PDA has explained that such an approach, which is effectively targeting MURs, may well conflict with the GPhC

standards which state “Make sure that your professional judgement is not affected by personal or organisational interests, targets or similar measures” and that consequently such a locum payment system represents a matter of public concern. MURs should only be performed where there is a genuine patient need and not simply to fulfil targets set by employers.

If pharmacists use their judgement to decide that there is no patient needing a MUR on any particular day, then they will be acting entirely professionally and should not be subject to a locum payment policy that penalises them.

The PDA awaits a response before it decides how to proceed with this matter.



“Who carries the can?” “Will I get the blame?” Why these are the wrong questions

By Duncan Rudkin, GPhC Chief Executive

Who carries the can for a dispensing error?

The PDA is aware that many pharmacists are concerned about delegating certain aspects of the dispensing process to pharmacy technicians. With the fear of potential civil litigation, criminal prosecution and professional disciplinary action being taken, who would blame them?

PDA officials meet regularly with the GPhC Chief Executive to articulate these and other concerns and he has agreed to set out how the pharmacy regulator sees it.

You're a conscientious hard-working pharmacist. You are feeling the pressure. You want to do a good job for your patients. And lurking in your mind is that horrible question “If anything goes wrong am I going to be blamed, even if it's not my fault?” Fear of reprisal must be a very unpromising place to start if you want to achieve the high standards of professionalism to which the majority of pharmacists and pharmacy technicians I meet are committed.

Being a professional with professional responsibilities should be a source of pride rather than anxiety and fear. If this is news to you, or you sometimes find it hard to believe, you might find these five facts useful:

Fact: The GPhC Council has made a high-level commitment to regulating in a way which promotes and encourages professionalism – the polar opposite of a regulatory culture based on enforcement and blame – the evidence is there to read in the GPhC strategic plan, which you can easily find on our website.

Fact: GPhC staff and committees live up to this commitment in practice on a daily basis in their approach to dealing with cases they are working on – the evidence is there to read in the “learning points” section at the back of every edition of Regula+e.

Fact: Punishment, retribution and blame have no part to play in GPhC Fitness to Practise procedures. This is how we want it to be and also happens to be what the law requires of us. The issue is whether a person continues to be suitable to remain on the pharmacy register without restrictions.

Fact: In some areas of law, such as negligence, it's possible to be held “vicariously liable” for the actions of another person. In professional regulation, there's no such thing as fitness to practise being “vicariously impaired”. For example, if you make a responsible decision to allocate a task to

another registrant, whether that's another pharmacist or a registered pharmacy technician, and that person misconducts themselves or performs poorly in carrying out that task, if it's serious it may raise a question about their fitness to practise. But not yours. By the same token, if you do have a management or supervisory role and you behave or perform badly yourself in that role, that's about your conduct and performance, not anyone else's.

Fact: When you join a profession like pharmacy you sign up to a commitment to be “accountable”. This is about being willing and able to give an account of what you've done and why. Accountability is at the heart of the GPhC Standards of Conduct, Ethics and Performance. This accountability – to the public, through the regulator – goes beyond your duty to your employer and is what makes being a registered pharmacist, or a registered pharmacy technician, much more than a “job”. It's the necessary flipside of the authority and, yes, the prestige, which comes with being a registered professional in your own right. Being accountable for your professional practice is therefore something to cherish, not to fear.

So next time you catch yourself wondering if you'll be blamed unfairly, why not try asking instead what kind of account you'd want to be able to give of yourself in that situation, and how you can be ready to do that, professionally and with confidence.



PDA submits premises regulation proposals to GPhC



Since the introduction of the new approach to healthcare regulation following on from the Shipman enquiry post 2007, the emphasis of pharmacy specific regulation has moved away from pharmacy owners and has gravitated towards the individual. In contrast with the position 12 years ago, these days, the vast majority of regulatory proceedings are being taken against individual pharmacists.

PDA believes that this has been a disproportionate development. In 2011 alone the PDA was involved in nearly a thousand cases where it supported pharmacists in their interaction with the regulator. Consequently, as a defence association, the PDA finds itself ideally placed to understand what leads to professional regulatory action and is able to analyse the causes.

Space here, does not allow a full analysis, suffice it to say, that a focus on the individual is in many instances not the answer. Pharmacists can often find themselves working in unacceptable circumstances created by their employer, and being held accountable for situations and circumstances for which they are not responsible. The PDA believes that the GPhC should focus on the causes of these episodes, rather than create a process that focuses on and ultimately punishes individuals unlucky enough to have worked at a pharmacy on the day when something went wrong.

Some of these situations are caused by staff shortages leading to increasing workplace pressure and the causation of errors, unrealistic targets set by employers for MURs and other services,

and sometimes just the generally unacceptable standards found in the pharmacy due to a failure in proper establishment investment. This is by no means an exhaustive list.

We therefore welcome the GPhC's decision in early 2012 to finally put the spotlight on owners and premises by launching a consultation on the standards for registered pharmacies. The PDA has submitted a comprehensive list of proposals to this consultation (see panel adjacent for a selection of these).

Introducing corporate accountability; the accountable manager

One idea submitted by the PDA was the creation of an 'accountable manager', this idea emanates from the Airline Industry.

In pharmacy, services are increasingly being provided by companies who do not have pharmacy as a core part of their business and there is a danger that the regulator could easily lose regulatory traction in such a situation.

If a requirement for an 'accountable manager' were to be established by the regulator – a senior individual with authority, probably a director and possibly a non pharmacist, then this would be someone that the GPhC could hold to account during their annual inspection cycle. The creation of such a position would also assist in situations where a relatively inexperienced and expendable superintendent may be appointed by a large multiple operator, so as to ensure that their commercial trajectory is unlikely to be deflected by such a token post holder.

The PDA's full and comprehensive submission can be found at: www.the-pda.org/standards

Some PDA recommendations on premises regulation

- Strengthen provisions that ensure the professional independence of the pharmacist.
- Ensure that commercial pressures do not take precedence over professional ethics
- Use powers available under the Pharmacy Order to regulate non-pharmacist area managers or non-pharmacist owners
- Clearly separate those elements of the pharmacy that are the responsibility of the owner from those which can be legitimately be said to be under the control of the RP
- Publish outcomes of premises inspection visits
- Protect the public by ensuring that P medicines are not sold/ supplied by self-selection
- Create a senior 'accountable manager' within all large pharmacy businesses
- Minimise the prevalence of the SOPs culture that now pervades pharmacy.



Patient Safety; Common Errors

Thankfully medicines supply errors do not happen that frequently when one compares the proportion of mistakes to the amount of prescriptions dispensed (0.025 per cent), but regrettably mistakes do happen and when they do it can cause harm or anxiety to the patient and distress to the pharmacist responsible.

Even if the errors are statistically acceptable, the effect on an individual is not and it is indisputable that the number of claims emerging as a result of dispensing errors is rising. This may be a reflection of the litigious society that we live in, or the emergence of a particular breed of easily accessible, highly advertised, no win no fee solicitors.

In this article, Harminder Lall, one of the PDA's pharmacist advisors, explores the lessons learned from some of the most frequently seen errors.

An error occurs

One of the most common errors the PDA encounters is switching amitriptyline and atenolol; the following case study is an example of the sequence of events that occur after an error is made.

The prescription called for 28 amitriptyline 25mg tablets, one to be taken at night, but atenolol 25mg tablets were supplied in error by the locum. The patient failed to notice that this was not the usual medication, and proceeded to take it for the whole month.

It was two months later before the locum learned of the error but she promptly notified the PDA. Many pharmacists

make the mistake of believing that there is no need to inform us, since either early signs of a claim progressing are absent, or they are lulled into a false sense of security by the assumption that the owner's insurers will deal with the matter.

Top Tip number 1:

Promptly advising the PDA will mean that we can get to the heart of the incident quickly with the intention of stopping it escalating. Prompt notification means that there will be no argument from underwriters about the possibility of policy invalidation.

The patient, now a claimant, had engaged solicitors in pursuing compensation. The pharmacy then passed on the claim to the business insurers who established a locum was responsible for the error and contacted us. Upon our advice, the locum had undertaken her own investigations, and was able to view the label and confirm that she recognised the signature as being hers. It is always worth investing in an unusually coloured pen and having a signature that can make for easy recognition - far better to ensure that you have a distinguishable audit trail and be able to establish liability one way or the other rather than having to take responsibility for an error by default or by virtue of being signed in as the RP on a given day.

Top Tip number 2:

Never rely on being informed you have made an error, seek to satisfy yourself and see the evidence.

The locum was also able to establish that the GP had been informed by the pharmacy of the error, and had satisfied himself that the patient hadn't suffered any major ill-effects. The diligent pharmacist was able to reflect upon the incident and concluded that there were several factors in play that had probably contributed to the error, including:

- A new and inexperienced technician who had recently made a number of mistakes
- A large number of opioid dependency patients requiring attention
- Staff constantly interrupting her whilst she was undertaking the final check
- Attending to patients requiring assistance in being sold OTC remedies.

These are all very commonly cited reasons for errors, but from the perspective of the regulator, we are all responsible for our own working practices. So it would be reasonable to expect to manage expectations of customers, train staff not to interrupt and advise the public that it may be a while before you are free to speak to them.

An early admission of liability for the error was made, with the intention of curbing any spiralling solicitor's costs.

Top Tip number 3:

A lawyer employed by the claimant charges by the minute, the letter and the email, so it's in their interests to send as many as possible – be warned.

The case was reviewed by our panel of pharmacists and lawyers and the PDA sought to make an offer of compensation to the claimant, which was initially rejected. The solicitors then commissioned an "expert opinion" and the matter of damages was resolved some 12 months later. Unfortunately, it took a few more months to resolve the issue of costs incurred by the

solicitors representing the claimant, which amounted to three times what the claimant received. Unfair? Maybe, but that's how it works.

The matter was put to bed eventually, but importantly the patient was okay, the pharmacist did not get embroiled in any complaint subject to investigation by the regulator, and the superintendent can sleep easily.

Common Errors

The most common errors that we see; the compensation for which is growing include:

- Mistaking chloramphenicol ear drops for eye drops. This often happens because somebody in the pharmacy has put stock away incorrectly, thereby contributing to a picking error going unnoticed at the final check.
- Confusing ropinirole tablets with risperidone tablets.
- Dispensing trazodone instead of tramadol.
- Mistaking Xalacom and Xalatan eye drops.

From careless to catastrophic

Apart from the wrong medicine being supplied, another frequent mistake is the wrong formulation being supplied. Examples include standard release carbamazepine being confused with controlled release carbamazepine. The release status of the medication may affect the stability of a patient's epilepsy, resulting in problems of a transient though distressing nature.

Often there is no relationship between the clinical significance of an error and the likelihood of a claim. From the claimant's perspective, either their medicine was the right thing or it wasn't. Sometimes it does not make good sense for us to argue the finer points of pharmacology, as we want to avoid a further series of complaints, however much we may want to. If negligence is clearly apparent, then we will seek to agree the amount of compensation as quickly as possible.

Sadly, sometimes it is quite clear that a dispensing error has caused severe harm. These are the classic cases we learn about at undergraduate level, such as making sure that diabetics receive the correct insulin or tablets. Our statistics seem to suggest that the number of insulin errors has declined over the last five years; most SOPs now require that patients are shown their insulin to confirm it is the correct one prior to leaving the pharmacy.

It would be wise to be extra vigilant with every prednisolone tablet prescription, given the nature of the dosing. Six or eight tablets of most drugs which are not prednisolone have the potential to cause severe harm. Most pharmacists will not need to be reminded of the very well documented case of Elizabeth Lee, involving the supply of propranolol instead of prednisolone tablets.

The PDA has handled some high value claims that have arisen from oral contraceptives either having the wrong dosing directions or progesterone only contraceptives being supplied instead of combined formulations. Whilst it may be a blessing for one woman to fall pregnant, it may be catastrophic for the next.

This feature has highlighted some of the most common errors we encounter; why they happen can be more complex, but often the same reasons are cited: similar packaging, insufficient staff, pressure from other activities and human error.

Some of these things are within our control and some are not. It would be unreasonable to expect a pharmacist to make no errors, but over the next few Insight editions, we will be sharing our experiences of the common errors we deal with and share our learning to help you to minimise the risk of committing them.



PDA Conference reports

This year, in response to member requests, the PDA took its conference offering out to the members and organised a series of conferences around the country. The Conference in Scotland considered the Scottish government's review of pharmaceutical care and the Birmingham, London and Cardiff events explored what should be done about the large increases in pharmacist numbers

The Scottish review of Pharmaceutical Care

Glasgow March 25th



In October 2011, the Scottish Government announced that it was undertaking a comprehensive review of how pharmaceutical care was going to be delivered in community pharmacy in Scotland. The PDA has been busy developing its proposals to include a day conference in Glasgow in March. The review concludes its work towards the end of 2012.

According to Dr Hamish Wilson, leader of the Review; "Pharmaceutical care that is person-centred, safe and clinically effective for every patient, every time, is the best way that pharmacy can contribute to the Scottish Government's ambitions under its Healthcare Quality Strategy." Speaking at the PDA's Conference, Dr Wilson explained the Review's work to date and how good pharmaceutical care needed to be integrated with the wider national health strategy, empower patients, improve safety and make best use of pharmacists'

skills. "Pharmaceutical care that supports people to live longer, healthier lives at home or in the community can help shape the Scottish government's '20:20 vision' of sustainable, high quality healthcare", said Dr Wilson.

The Review of Pharmaceutical Care in Scotland is focusing on four key areas:

- The pharmaceutical care needs of patients and the NHS
- Future arrangements for NHS Pharmaceutical Care in Scotland
- Their fitness for purpose
- Their sustainability.

Mark Koziol explained how the creation of a 'clinic pharmacist' role, based either in a pharmacy or in the wider community, could deliver detailed pharmaceutical care to patients on a named and registered basis. This would develop much deeper clinical relationships with patients and carers, optimise medicines use and support patients on complex medicines regimens to take more responsibility for their own health.

This model, which would also underpin and support those pharmacists responsible for the supply function, would vastly improve the patient journey, increase efficiency, flexibility and capacity for the NHS, and improve job satisfaction and security for pharmacists.

"This model, which forms the basis of the PDA's Road Map proposals, would allow the pharmaceutical care pendulum to settle in the most appropriate place, allow the supply role to be delivered safely, and allow a more specialist pharmaceutical care role to be developed within structures that support professional autonomy," said Mr Koziol. "It would also provide a solid foundation upon which pharmaceutical care could meaningfully support the '20:20 vision' healthcare strategy for Scotland."

The meeting in Scotland allowed PDA members to participate in focus groups and their views have been embellished within the production of the PDA's formal submission to the review process.

Are we producing too many pharmacists?

Conferences held in
Birmingham April, London
May and Cardiff June 2012

In 1999, the pharmacy undergraduate population was 5,534; in 2009 it stands at 13,026 and the number of pharmacy schools is set to increase still further. The PDA's Conferences in England and Wales considered this subject and explored possible solutions

Pharmacist supply and demand disconnected

"Pharmacist supply and demand has become disconnected, with potentially dramatic consequences for the future of the profession," warned PDA Chairman Mark Koziol. "If pharmacy is to flourish then it is important to ensure that the forces of supply and demand are linked with an intelligent plan, but currently no such plan for pharmacy exists," he continued. "There will be trouble ahead if these issues are not addressed, and the PDA wants to work together with other pharmacy bodies to develop solutions."

There are now 26 schools of pharmacy in the UK, around 63 per cent more than ten years ago, with three more due to open. There is no central control on pharmacy numbers and no limit to the number of additional courses set up. This also raises the question of whether there are sufficient numbers of suitably experienced teaching staff to run

these new courses. A lack of workforce planning therefore threatens to affect both the quality and career prospects of newly qualified pharmacists.

According to PDA Director John Murphy: "We have studied similar situations emerging in other parts of the world and it is rare to find a subject that could affect so many pharmacists in such a significant way. It is vital that action is taken to minimise the disruption."

The academic view

Professor John Smart, Chair of the Council of the University Heads of Pharmacy (CUHOP) and a speaker at the conferences, argued that undergraduate numbers must be capped and that UK schools of pharmacy are nearing capacity as the number of new entrants has more than doubled over the past decade. Increasing numbers of trainee pharmacists could force the government to introduce a cap to limit the cost of preregistration training. Insufficient preregistration places would then detract from the popularity of the course, with knock on effects in term of status and ultimately upon government funding, said Prof Smart.

The Government's 'Modernising Pharmacy Careers' programme has proposed that the pre-registration year be split into two six month placements, with universities and employers jointly responsible for the delivery of a five year integrated training programme. This would mean that in future, the number of new entrants should never exceed the number of work-based placements.

However, these plans are unlikely to be enacted for at least four years and CUHOP wants student numbers managed now. It also wants to be, "closely involved in this discussion, with the aim of managing the transition to ensure the best outcome for students, schools of pharmacy, the profession, government and ultimately patients".

The view from the GPhC

According to its Chief Executive, Duncan Rudkin, The General Pharmaceutical Council has no direct role in controlling student numbers - these are matters considered by a number of other bodies to include:

- The Scottish and Welsh governments



- Health Education England (which will be responsible for the strategic planning of NHS education and training in England with a budget of £5bn)
- Local Education and Training Boards – regional bodies responsible for commissioning and overseeing NHS education and training
- The Centre for Workforce Intelligence.

As far as pharmacy education is concerned, the GPhC is responsible for approving qualifications for pharmacists and pharmacy technicians and accrediting education and training providers.

Mr Rudkin added that it was important to understand that the growth in numbers is not only driven by new schools, but also by existing schools. In the eight years between 1998/99 and 2006/07 there was an 80 per cent increase in the number of students within the existing schools, from 5,534 to just over 10,000. Furthermore, he was at pains to point out that there was no correlation with the premise that established schools of pharmacy provided superior courses to the new ones.

Developments from the Society

Martin Astbury, President of the Royal Pharmaceutical Society, discussed factors affecting supply and demand of pharmacists, such as pharmacy openings, increasing script numbers, and changing models of practice. Mr Astbury announced that the English Pharmacy Board is launching a review of pharmacy that will seek to set out 'New Models of Care Through Pharmacy' that pharmacists can provide in the reformed NHS. The RPS will be inviting all pharmacy organisations to submit their ideas for this important piece of strategic work.

Recently, a number of pharmacy organisations have been putting forward their ideas, but these have not been connected in any meaningful way and as such they lack traction. The PDA too has been awaiting the proper pre-text to submit its Road Map proposal for

It is important to be able to control the supply of pharmacists otherwise it will be very difficult to be able to plan the development of the profession going forward.



England and thus far such a pre-text has been missing.

"We will be inviting views from all pharmacists and pharmacy organisations," said Mr Astbury.

"We know that various organisations like some of the contractor bodies and the PDA have been busy developing some good ideas and we will be keen to consider them in detail during this important project."

"I am delighted that the Society is going to have a strategic review of pharmacy as such a review is already underway in Scotland, Wales and Northern Ireland at the behest of the various governments" said Mr Koziol. "We all now have an ideal opportunity to submit our views on the future of the pharmacy practice and we will be submitting ours into this useful exercise on behalf of PDA members."

Can threat be turned into opportunity?

It is necessary to ensure that the over-supply of pharmacists did not just become a subject of an interesting conference and that a plan of activity could be agreed. During the conference and the plenary and focus group

presentations the following principles were developed and will now form the basis of PDA policy:

Policy principles

1. A workforce plan must be developed.

It is important to be able to control the supply of pharmacists otherwise it will be very difficult to be able to plan the development of the profession going forward.

Pressure will need to be brought to bear upon the universities so that they become part of the solution rather than (as currently) part of the problem.

2. Use new roles to increase the demand for pharmacists – especially in the community/primary care setting.

This can be most effectively achieved through aligning the interests of the patient, the NHS, the healthcare team, the community pharmacy contractor and the pharmacist. An absolute necessity however, is that the profession reaches agreement on the models of pharmacy practice and then that it could unite behind that single vision.

3. Drive new roles in the community – but not at the expense of the supply function.

A worrying narrative was emerging where pharmacist involvement in the medicines supply function was being talked down, the idea being that this was a role that could simply be undertaken by registered technicians. Whilst the role of technicians and technology was important, nothing was going to replace the vital safety role played by the pharmacist in undertaking the clinical checks upon prescriptions and in delivering the reactive and proactive patient facing role within the community pharmacy. Whatever new roles were to be designed, these must be built upon the premise that pharmacist involvement in the safety of the supply function was not to be diminished.

4. Major upon the improved safety for patients.

New roles for pharmacists need to have as their main objective the delivery of enhanced safety and an improved healthcare journey for patients. Consequently, it would be highly beneficial to create a quality multi-layered service level provided by pharmacy, which would be built upon a structured career framework in the community setting that would consist of four levels, thus

- Practitioner
- Advanced practitioner
- Specialist
- Consultant.

In this way, any new roles for pharmacists could become an attractive proposition for those pharmacists delivering them, enabling those so inclined to specialise and those who prefer to remain as generalists to do so.

5. Develop a supervision policy that sees the community pharmacist being more accessible to the public in the pharmacy and not less so.

The thrust behind the Government's proposed policy on supervision is to enable remote supervision – the plan to operate a pharmacy in the absence of a pharmacist. As PDA members will know, the PDA has actively campaigned against this idea since it was first proposed by the Department of Health. It is recognised that the policy on pharmacy supervision needs to be updated, but currently the Government appears to think that it would be beneficial for the pharmacy to be able to operate with no pharmacist on the premises. The PDA's position on this matter is that any change to the supervision regime, especially in the community setting, must result in the pharmacist being more accessible to the public and not less so. The Government appears determined to launch its consultation on supervision in the near future and the PDA's position will be steadfast.

6. Pursue and develop new roles that major upon the unique skills of pharmacists.

There is little point in developing roles for pharmacists that could be easily delivered by nurses or others for less cost. It is important therefore to develop new roles that focus upon the delivery of pharmaceutical care, which is defined as:

“A patient centred practice in which the practitioner assumes responsibility for a patient's medicines related needs and is held accountable for this commitment.”

This is not a role that can be undertaken lightly, or as a service delivered incidentally over the counter. During the conferences, the PDA was able to present elements of its Pharmacy Road Map proposal. Significant new areas of pharmacist involvement which delivered benefits to patients were described, which led to the creation of new roles and responsibilities for pharmacists based upon the delivery of pharmaceutical care, both in the community pharmacy and the residential home setting.

7. Halt the commoditisation of pharmacy services and enable professional autonomy.

In recent years there has been a trend towards the commoditisation of pharmacy services, which is perceived as damaging to the patient and the professional agenda. The delivery of MURs and the financial targeting thereof is a classic example of a service that is now largely commoditised and as a result is not popular with many pharmacists, patients and GPs. Such commoditisation was brought about by coercive and target setting policies of some employers, and it is also attracting considerable scorn and ridicule from the wider healthcare community.

Any new pharmacist roles have to enable pharmacists to work as autonomous healthcare practitioners as per the definition of pharmaceutical care, and not be subject to coercion and aggressive target setting in the corporate retailing setting. The PDA is calling for pharmacists providing pharmaceutical care to be recognised by the NHS as independent autonomous contractors in their own right.

Conclusion

The thrust of what was explored and agreed at these events is simple: if it is possible to balance the increasing supply of pharmacists with the development of significant new roles, then it is still entirely feasible to turn the threat of increasing numbers into a valuable opportunity.

These conferences represent the first time that the PDA has travelled around the country and considered one particular issue in a concerted way. The result is that these events enabled the production of a significant policy platform which the PDA will now actively pursue. Furthermore, the involvement of the other pharmacy organisations in these events, especially the RPS and CUHOP, means that certain aspects of this policy platform will enjoy the agreement and the active support of others, making it much easier to generate momentum for change.

How the Boots tribunal was won...



The background

Between April and June 2011, the PDA Union was approached by a number of members who were seeking advice on whether or not their employer, Boots, could reduce their Sunday premium payments from twice the hourly rate to one and a half times. Boots had already changed the premium rates for new pharmacist recruits to time and a half in 2000, thus the group affected by this change were longer serving with at least twelve years' service – and all of them, by definition, over a certain age.

Broadly speaking the reasons given for the change was so that the company could redistribute the money that it saved from this initiative into a wider remuneration package, paying non-pharmacist 'colleagues' who were yet to be recruited a higher basic rate of pay to match some competitors.

Not surprisingly, the pharmacists affected were dismayed; as one person who only worked Sundays so graphically put it, "The Company are now asking me to work one Sunday in four for nothing".

The initial announcement was delivered to staff as a 'fait accompli' giving them the impression that these premiums were and always had been discretionary and that it was in the company's gift to remove or reduce them when it wished.

The advice

The PDA Union was of the opinion that the premiums were contractual for these members, and that because the changes to their terms and conditions were so fundamental, that what the company was doing in not consulting with them, combined with an unreasonable business rationale for doing so, was unlawful.

The PDA Union requested that Boots hold a group grievance allowing the PDA to simultaneously represent numerous pharmacists, as at that time there were 70 individuals who had expressed a desire for the PDA Union to represent them. But this approach was rebuffed – a tactic, the PDA Union believed, which was intended to isolate objectors. Boots treated any formal objection as a grievance and set about holding individual meetings with our members and their PDA Union representatives.

The PDA Union believed that this was tantamount to a divide and conquer approach being taken by the employer and it worked to some extent. A number of those that were originally advised to put the company on notice that they would not accept the new terms if imposed and would be working to them under protest, dropped out of any further action when they were exposed to a one-on-one meeting.

The Grievance Process

PDA Union representatives considered the grievances and appeals to be a sham as it was obvious that the local managers were holding the grievances in the knowledge that they had no authority to uphold any objections. In the tribunal, which took place over a year later, the judge expressed great concern at the way the grievances were conducted.

They could only have been set up to satisfy procedure, they failed to give the manager the autonomy or authority to do anything about the grievance, and the judge commented on the fact that those conducting the meetings were ill-prepared. The hearing of the appeals was no different.

Launching the claim

With all options explored, the PDA Union issued claims against Boots on behalf of 19 of its members who decided to stay within the tribunal process for making unlawful deductions of pay and, in addition, on the grounds of age and sex discrimination. The claim for age discrimination arises from the fact that the changes to the employees' contracts only affected a group of people over a certain age. Sex discrimination is a little more complex; many of those affected are carers and work as part of a pattern that fits in with sharing their caring responsibilities with their partners.

Statistically most carers work part-time and at weekends and are female, and therefore a case could be made that the contractual changes are indirectly discriminating against women. In a 'case management conference' at which a judge and representatives of all parties were present, it was decided that the substantive hearing would only consider the case for the 'unlawful deductions of pay' and that the discrimination cases would be held in abeyance for a separate hearing to be held in the autumn of 2012. The PDA Union will report on these hearings more fully in the next edition.

The Employment Tribunal

The hearing took place in Nottingham, starting on 10th April 2012, the day after Easter Monday, scheduled for three days to finish on 12th April. As there was more than one claimant, it is normal to agree a lead case with the judge so that a similar case does not need to be heard 19 times. The PDA's barrister was present as was USDAW's who was advising a number of shop staff.

Boots secured the services of a very experienced barrister who had been involved in some high profile cases and was well known for her robust cross-examination technique. As it happened, the claimants stood up magnificently to her questioning and gave a very good account of themselves.

In essence Boots defence to the claim which the judge eventually allowed to run, following an eleventh hour change to its barrister's pleadings (which caused considerable delay to the proceedings), was that:

- The premium payments were not contractual but discretionary and that they formed part of an overall wider benefits package, including a higher basic pay for new employee shop staff not yet recruited, and therefore they had the right to change it
- Even if the payments were judged not to be discretionary and were contractual, Boots has the right to vary the contract in any event
- That as the claimants had worked to the terms of the new variation had benefited from the 'top-up' payment they had therefore implicitly accepted the new terms.

As a result of the first day being lost to last-minute legal argument put forward by Boots, the judge concluded the hearing but had no time to deliver his judgement so deferred it. He did give a strong indication there and then that he would not be accepting the third point as a reason to deny the claim, as all claimants had made their objections clear throughout by issuing a grievance and had further demonstrated their non-acceptance by lodging the claim.

The conclusion

When the judgement arrived its open paragraph stated succinctly.....

"All claims of unlawful deduction of wages relating to the ending of premium rate pay at double time succeed."

Boots has since stated that it believes that it lost the action on a technicality and because of some ambiguity in its staff handbooks. It is true that the judge did cite the ambiguity of the communications in his deliberations, but he came down against all points of Boots' response in its defence and in judging as to whether or not the payments were discretionary, as Boots had claimed, he stated:

"...from the inception of Sunday working, there was a clear practice, never departed from in relation to these employees and which ran all the way through to the decision to unilaterally change in April 2011. It follows that

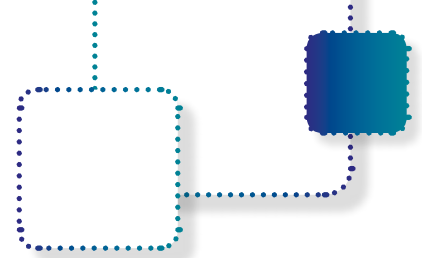
I am wholly persuaded that it was not discretionary; it had become a term and condition of employment."

In conclusion, the judge pronounced: *"I am persuaded that Boots did not have the contractual entitlement to unilaterally vary the contracts of the employment of the Claimants so as to reduce their entitlement to rates of premium pay for Sundays and Bank Holidays!"*

It was a conclusive victory and one that Boots did not appeal against. However since the judgement, the PDA Union has been inundated with pharmacists who maintain that they were misled and their reliance misplaced when they were told by their managers and the Boots Pharmacists Association that the company was entitled to make these changes. The PDA is currently trying to join them in the claim.

Subsequent claims that the PDA Union has added on would definitely have been successful had they been lodged with the original 19. A decision as to whether the judge will accept these additional claims is awaited.





Protecting your terms and conditions of employment

Many enquiries into the PDA Union office relate to employment contracts and a frequently asked question is how to resist an unwelcome change that an employer wants to impose. The PDA Union legal team has considerable expertise in this area and has successfully advised many pharmacists facing such problems.

The employment contract sets out the binding framework of a working relationship. This article explores the steps a pharmacist can take to help protect their employment rights and minimise the impact a change has. Terms and conditions of employment can be varied in a number of ways by an employer. Recently, we have seen changes being made by a variety of employers, which have caused our members to feel anxious. We have not only been concerned about the changes proposed but also about how poorly meetings have been conducted, with many members complaining that employers have been heavy handed, seemingly presenting matters as a done deal.

Consultation

Whether your employer wants to change a discretionary benefit, exercise an existing term in the contract or introduce an entirely new term, the first step should be consultation. This can be on a group basis when the change involves a number of employees, or on a collective basis through a recognised trade union when there is an agreement in force between the union and the employer.

Ideally, consultation should then move to a one-to-one basis involving a series of meetings at which union representation should be offered. The employer's proposals should be put to you so you are aware of exactly what your employer is seeking to do, when it wants to do it and why it wants to do it.

Minutes of meetings should be taken and provided to you to sign to confirm they are an accurate reflection of the meeting. Employers will obviously want to make changes to suit themselves, however they should bear in mind that the consultation process should be genuine and meaningful with alternatives considered at every stage.

The change

Employers will attempt to introduce changes to your terms and conditions usually in one of four ways:

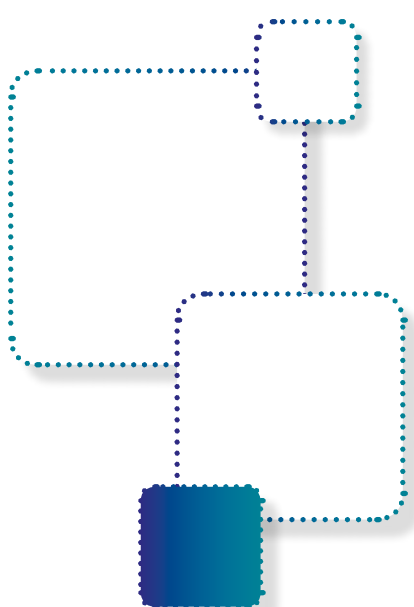
1. Obtaining your consent

This is where you and your employer both agree on the issue at stake, usually because the change mutually benefits both parties or the issue at stake is relatively minor and has little or no impact. An example might be where your employer seeks to extend the opening hours of the pharmacy by 15/30 minutes and you are able to cover this period happy with the opportunity to be paid for this.

It is important to note that an employer can argue a change has been accepted and you are bound by the change if you continue to work under the new arrangement without raising an objection. Therefore, unless you are entirely happy with any proposals, you should ensure your objection is noted and seek legal advice on the matter.

2. Exercising an existing term in the contract

Employment contracts usually give some flexibility to employers to alter certain elements of it. A common example is your place of work. Whilst you may generally work in one location, a mobility clause is usually found in contracts which allows employers to transfer your employment to another location temporarily or even permanently. However an employer must exercise this right in a fair and reasonable manner and it does not give carte blanche to act with impunity. Reasonableness includes taking into account your personal and domestic circumstances, extending to caring responsibilities and health, and limiting a move to as small a radius as possible.



3. Altering a discretionary benefit

Some employee benefits are defined as discretionary, which therefore means an employer has control over whether or not they can change. Your contract or company handbook should clearly identify which benefits you have a contractual entitlement to and which ones are discretionary. Typically, discretionary benefits will include bonus payments or company sick pay.

Employers tend to believe that when it comes to exercising their discretion they can act as they choose to without challenge, however discretion is not absolute and should be exercised reasonably and rationally. This means that an employer has to act fairly and consistently ensuring the rules of the scheme are applied to everyone company wide. An example of changing a discretionary benefit might be to apply conditions to your bonus so that if you have a live disciplinary warning you will not receive a bonus. Provided an employer can show it has acted reasonably and rationally any changes will be considered fair.

4. Introducing an entirely new term

Employers are responsible for drafting contracts of employment, and employees have no input. Whilst many contracts are now considered to be watertight with every clause necessary to protect the interests of the business included, the quality of contracts varies across businesses and employers regularly seek to introduce new terms. In the current climate employers are increasingly conscious of profit margins and changes to existing contractual benefits or established working patterns are emerging. Those of you that are employed by Boots Management Services Limited, for example, will be familiar with the concepts of Customer Driven Profiling and seven day mindsets, which basically translate into employees being very flexible and making themselves available to work at a number of stores over a seven day period. It is these changes which present employers with a headache, as they have

less control over them and a meaningful consultation should take place with a view to securing your agreement before the changes are imposed.

Acceptance of the changes

If you accept the changes proposed by your employer a new contract or a letter that incorporates the changes into the existing contract is signed. These terms then supersede previous terms and you are bound by these.

Rejection of the changes

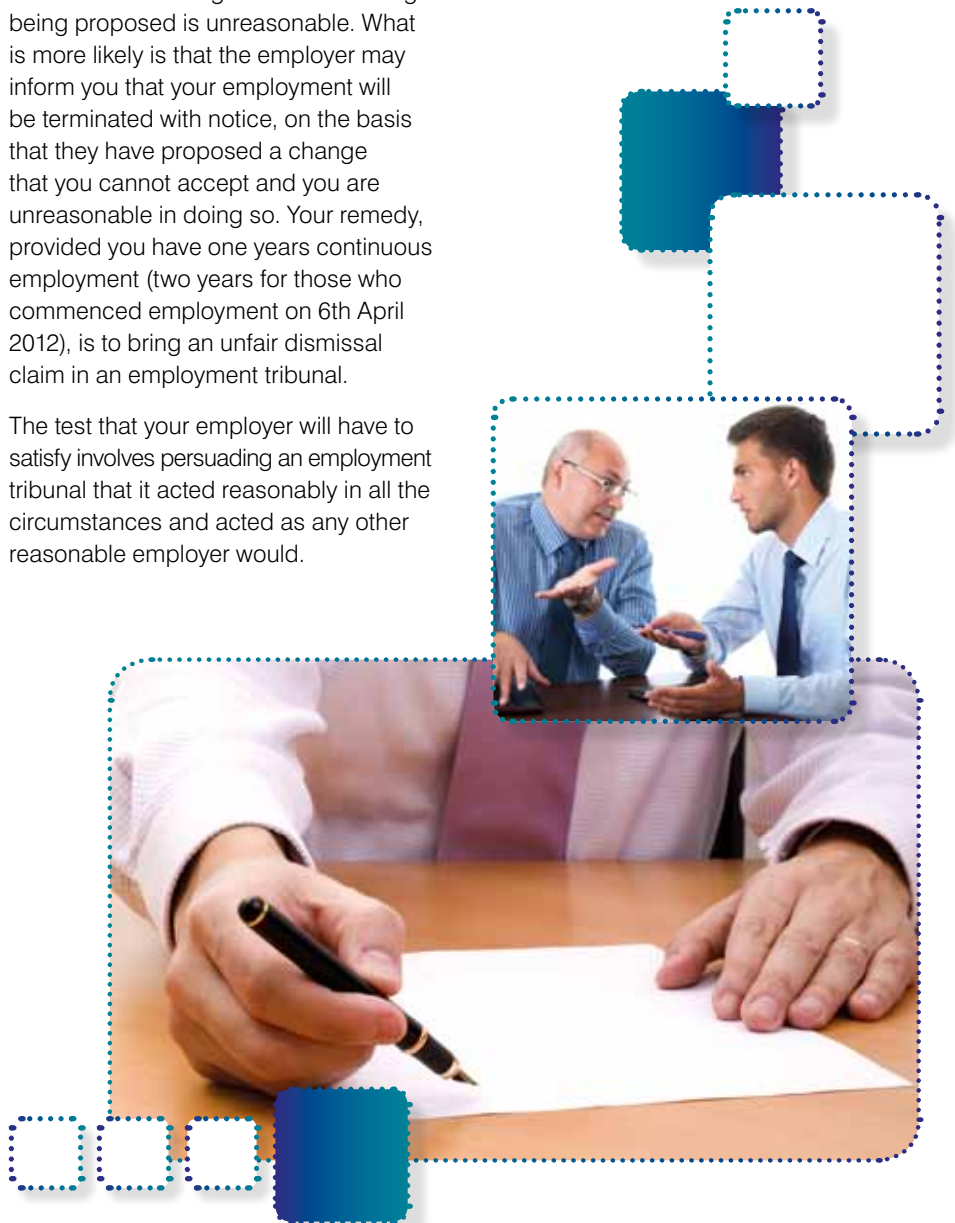
If you reject a change your employer can accept this and forget about making the change altogether. This rarely happens although we do have a lot of success representing our members in meetings where the change being proposed is unreasonable. What is more likely is that the employer may inform you that your employment will be terminated with notice, on the basis that they have proposed a change that you cannot accept and you are unreasonable in doing so. Your remedy, provided you have one years continuous employment (two years for those who commenced employment on 6th April 2012), is to bring an unfair dismissal claim in an employment tribunal.

The test that your employer will have to satisfy involves persuading an employment tribunal that it acted reasonably in all the circumstances and acted as any other reasonable employer would.

Employers need to show that there was a good business rationale for making the change, so that when you rejected the change they were left with no option than to terminate your employment.

One example of where an employer might convince an employment tribunal that a dismissal was fair might be if the business was about to go into administration and the changes proposed, although detrimental to you, were vital to the existence of the business and consequently justified.

If we could ask you to take one thing from this article it would be that you must raise any concerns you have regarding proposed changes with your employer immediately and follow the advice we give, otherwise it will be assumed by your employer and an employment tribunal that you agreed to the change.





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PDA Plus has been put together by the PDA as a member benefit scheme to save members and their families time and money, whether at work or in their own leisure time. There is a wide array of preferential discounts available, and we are confident that there is something for everyone.

One area that may be of particular interest to members is the 'eight ways to save the cost of membership'. At a time when every penny counts, we hope that you can at least recoup the cost of your membership, if not much more.

Cinema discounts

Access to fantastic cinema admissions discounts, giving average savings of 38 per cent* on cinema tickets. This offer enables you to purchase vouchers to be used at your nearest participating cinema (including Cineworld Cinemas Empire, Apollo Cinemas and Showcase) at discounted prices. For example, a family with two adults and two children attending Cineworld in Wandsworth, six times a year would save £146.40* per year.

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Cashback Giftcards is a simple way to earn cash back on everyday purchases. The giftcards offer a wide range of retailers, and you can earn cashback of between 5-15 per cent at Sainsburys, ASDA, M&S and H Samuel, to name just a few! For example, if you do your grocery shopping at ASDA, you would select an ASDA giftcard. Let's say that you typically spend £250 per month, you would earn cashback of £130.50* net per year!

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Member Energy

PDA members have access to Member Energy's free, 100 per cent impartial energy price comparison service. This can help you or your business find the cheapest gas and electricity suppliers in your area. The service includes every tariff available on the switching market, and average member savings are currently £228.56*.

Gym membership

Looking to get into shape? Let PDA Plus help. Get access to an exclusive network of over 2,000 gyms and leisure centres, such as Fitness First, Nuffield Health and LA Fitness, with an Incorpore membership. With access to the lowest corporate rates, you could save between £50 and £250*.

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PDA members have access to an additional 10% discount (6.5% when booking over the telephone) on last minute deals offered by Thomson, Thomas Cook, First Choice and more! What's more, there are no credit card, handling or administration fees! Book a package holiday to Tenerife through Travellers Advantage and you could save £250.40*

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Through Travellers Advantage, PDA members have access to a 12% discount on over 60,000 hotels, cottages, villas and apartments in the UK and worldwide. Choose from a vast range of accommodation, from big city hotels and theatre breaks to all inclusive beach hotels, villas and self-catering apartments. Book a Paris break for you, your partner and child and you could save £127.78*

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Vehicle Servicing Manager uses the UK's largest network of independent garages to deliver average savings of 30%*, on all your car servicing and repair requirements, compared to the prices charged by main dealers and franchised garages. With VSM you can also save 20% on the cost of your next MOT. Your vehicle can be collected from your home or place of work and delivered back to you washed and vacuumed. You could save £95* on your next service!

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*Terms and conditions apply to all benefits. See website for further details. Examples used are illustrative.

On-Call Update

Background

On-call arrangements were the only part of the national NHS pay system not reformed as part of the Agenda for Change (AfC) programme. The NHS Staff Council agreed to review on-call as part of the AfC agreement and use interim arrangements until 31 March 2011.

As part of the national review, the NHS Staff Council analysed information on current on-call arrangements in 25 organisations across the UK, which totalled over 300 separate on-call schemes. It recommended that negotiations be devolved to a local level and the NHS Staff Council published national principles to support local negotiations on new arrangements for on-call in November 2010. Employers needed to have these new arrangements in place from 1 April 2011.

The PDA Union has been called by hospital pharmacist members throughout the UK and has supported them through this process since this issue first emerged; unfortunately there are still a number of Trusts that have yet to finalise arrangements.

Slow progress

During August and September 2011, the NHS Employers organisation carried out a survey to check progress on the discussions, which according to its own guidance should have been completed by April 2011. The results showed that progress was slow to say the least! Of those Trusts who responded only 21% said that new arrangements had been agreed in partnership and implemented. A further 10.5% of respondents had

agreed new arrangements in partnership and set a future date for implementation. 64% of respondents said that discussions were still continuing with a further 4.5% stating that discussions had broken down and interim arrangements remained in place. In summary close to 70% of NHS organisations had yet to reach agreement 6 months after the target date.

Current reality

NHS Employers have repeated the survey during August 2012 and based on the operational experience of the PDA and feedback from members it is likely that there are still a significant number of Trusts who have yet to reach agreement when the survey is published later in 2012. Considering that 18 months have elapsed since the deadline for implementation, such a delay leaves many pharmacists with great uncertainty about their level of income.

A number of Trusts have taken the opportunity to cut the cost of providing on-call services by insisting on a flat rate payment scheme for being available for on-call that applies across all staff regardless of their grade and rejecting schemes that would properly recognise the skills and responsibilities of higher grades of staff such as pharmacists. Under a flat rate scheme a manual worker would receive the same payment as a pharmacist for being available on-call. We believe that this is grossly unfair and against the principles of equal pay for equal work, as pharmacists have greater restrictions on their private life when on call and a much greater level of responsibility. For example pharmacists often receive telephone calls for specialised advice whilst on-call and need to remain close to reference

sources and internet access, in addition to being prepared to attend their place of work in an emergency. Added to this is the fact that pharmacists are required to take professional responsibility with wide ranging personal accountability and consequences for patients in a way that manual workers do not. This means they can be restricted to remaining at home and often subject to frequent disturbances by telephone. Under a flat rate scheme a pharmacist would receive the same payment as a maintenance worker whose role does not involve providing telephone advice from home and typically would be disturbed much less frequently. Members are reporting that flat rate payments as low as £12 to £15 for a 12 hour period of on-call availability have been discussed and accepted during negotiations. These equate to a massive cut in the level of payment made to pharmacists for being on call.

Negotiations around payment for work done whilst on call (which is separate to any availability payment) have generally been less contentious with the exception of payment for telephone advice. National guidance states that telephone calls should attract payment for work done; at least one Trust tried to argue that such work was included within the availability payment and pharmacists would not be paid for providing telephone advice. Even more remarkable, in the PDA Union's opinion was that the Trust reached this position with the knowledge of the major Unions, including that which the Guild of Healthcare Pharmacists (GHP) is part of. It took the direct intervention of the PDA Union with the HR director of the Trust to force it to reverse its position and agree to pay for telephone work when pharmacists are contacted at home for advice. In the PDA Union's view the same Trust also displayed an assertive approach to the negotiations and when



agreement could not be reached with its pharmacists, it put them on notice that unless they accepted the changes to on-call it would dismiss them and offer reengagement on the less favourable terms. At the time of writing pharmacists at this Trust are considering whether to accept the imposed terms and at least one pharmacist intends to seek redress through an employment tribunal for unfair dismissal supported by the PDA Union.

Some Trusts have decided to widen the pool of pharmacists who provide on-call services and a number of members have required PDA Union representation at formal meetings when their personal circumstances preclude them from being required to participate in on-call services.

Lessons learned

Based on our experiences and reflecting on progress there are a number of common themes that have emerged over the past 18 months that should help pharmacists decide how to approach similar issues in the future.

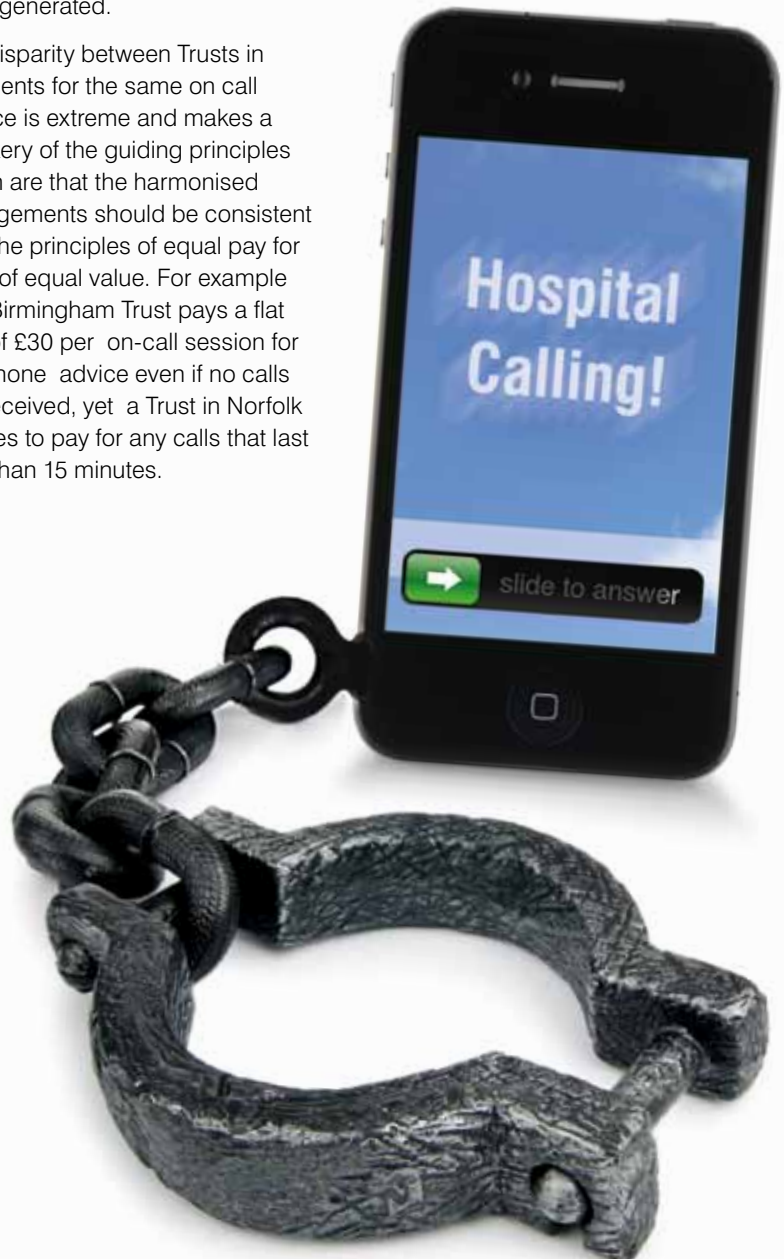
- Pharmacists who took an active interest and were pro-active during the consultation process were more likely to secure a better deal. Those who followed PDA Union advice and prepared their case were able to argue for a better deal and were more successful than colleagues who left negotiations to staff side representatives, who often lacked the requisite knowledge of pharmacy.
- Some PDA members rejected finalised on-call proposals that had the support of Unite/GHP and threatened to withdraw from the provision of on-call services. The Trust subsequently revised

their position and recommenced negotiations which resulted in a more favourable outcome.

- Pharmacists have reported that the major Unions, such as Unite and Unison appear to have agreed on-call arrangements which, whilst they may be satisfactory for the average NHS employee are not satisfactory for pharmacists despite protest from the pharmacists.
- Although the review of on-call was not intended to be a cost saving exercise, many organisations were opportunistic and chose schemes which dramatically cut the payments to pharmacists providing on-call services. Due to the extreme financial pressure that the NHS is currently under, any awareness of poor on call settlements being imposed have been drowned out by the outcry that other cuts to staff and services have generated.
- The disparity between Trusts in payments for the same on call service is extreme and makes a mockery of the guiding principles which are that the harmonised arrangements should be consistent with the principles of equal pay for work of equal value. For example one Birmingham Trust pays a flat rate of £30 per on-call session for telephone advice even if no calls are received, yet a Trust in Norfolk refuses to pay for any calls that last less than 15 minutes.

Summary

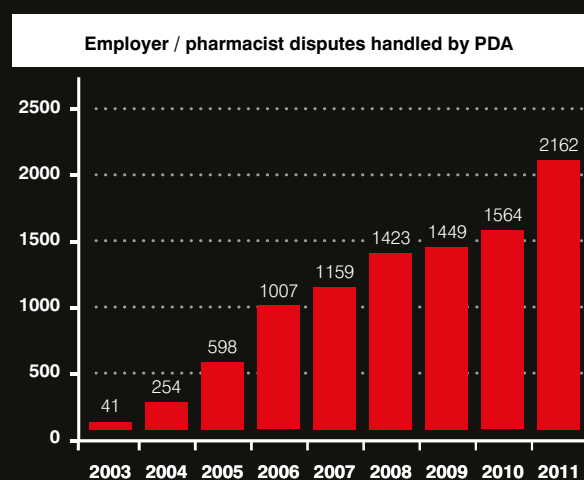
The devolvement of the on-call consultation process to a local level has resulted in protracted negotiations and widely differing levels of remuneration for the same service. What pharmacists receive for providing an on-call service is more a combination of luck and proactivity rather than a function of national consistency. Against the background of attempts by some NHS employers to agree local arrangements for on-call services, the recent moves by an NHS consortium to negotiate pay at a local level (see News page 4) should be a salutary warning about the dangers of local negotiations on terms and conditions.



Think your chances of falling out with your employer are small?

THINK AGAIN!

The NHS is trying to save more than £20 billion in operational costs and this is a source of conflict.



The relationship between a pharmacist and hospital management must be based on understanding and respect as sometimes, there needs to be a robust discussion to ensure that financial interests do not overwhelm professional considerations and patient safety.

These days, with the financial pressures upon the NHS, such a discussion is becoming increasingly difficult to have.

Perhaps unsurprisingly, the number of disputes between pharmacists and their employers has dramatically increased and this problem continues to grow.

The PDA has supported many thousands of members with advice and support in various pharmacy employment disputes across all sectors. In many cases we resolve these through mediation, but in others we pursue employers who have treated our members harshly or unlawfully. Already we have secured more than £1million of compensation for our members in this way.

If ever there was a time for pharmacists to have their rights protected by the PDA – then that time is now!

- ✓ More than £1,000,000 compensation already secured from employers who have treated pharmacists unfairly or illegally
- ✓ £500,000 worth of Legal Defence Costs Insurance
- ✓ £5,000,000 worth of Professional Indemnity Insurance
- ✓ Union membership option available

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