Primary Care Edition Winter 2012

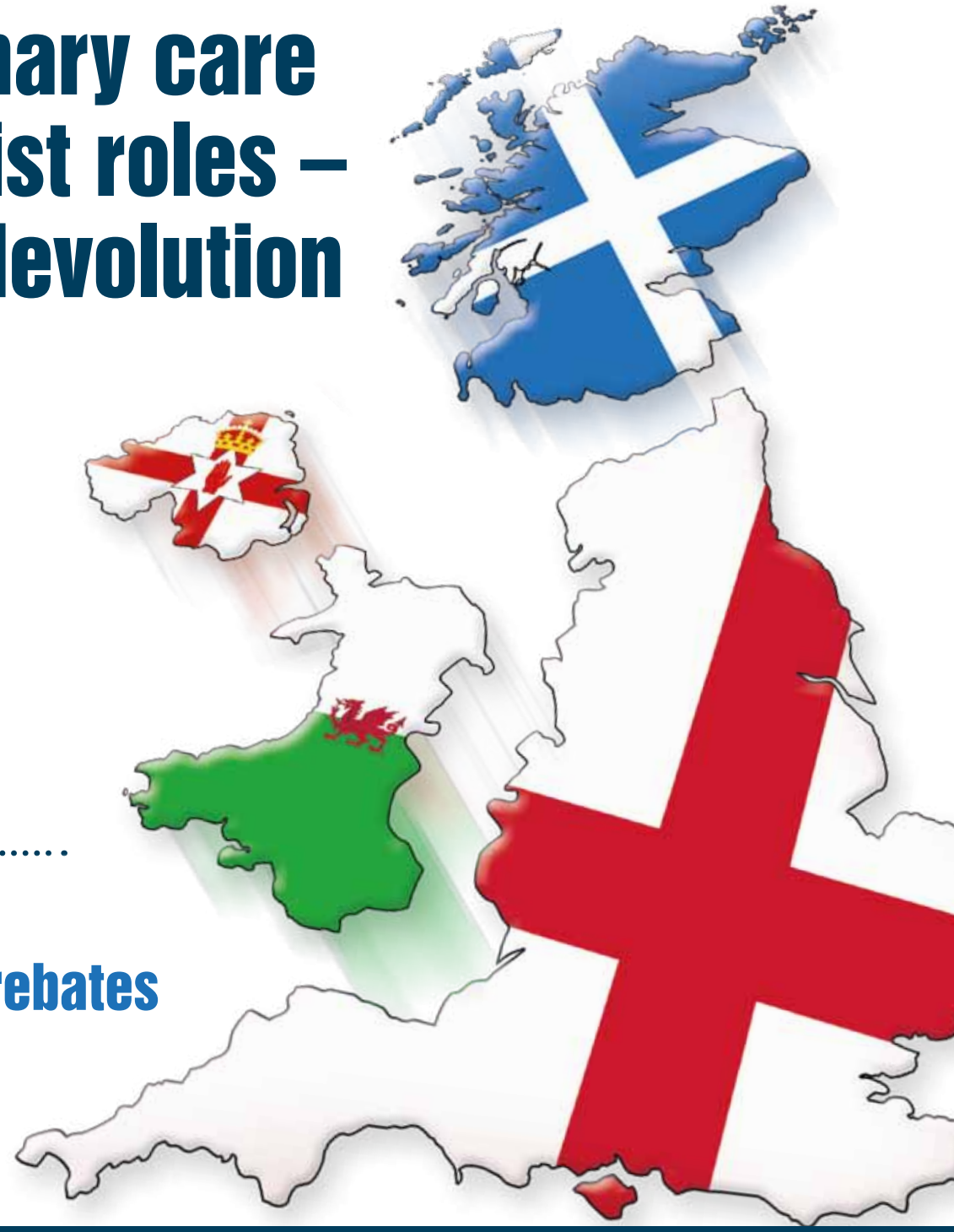
insight

pda the pharmacists' defence association

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

New primary care pharmacist roles – through devolution

Pages 2 & 7



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Carving out new roles for primary care pharmacists

Everyone knows that due to the financial pressure that the nation is under financial cuts are being imposed everywhere. The NHS is required to make £20billion of savings in just three years so it is inevitable that NHS employees will be in the firing line.

Few in the NHS are immune and primary care pharmacists are experiencing significant change. Some do not live in a part of the UK that is seeing its employer organisation disbanded. Nevertheless, they are enduring relentless pressure to deliver reductions in prescribing costs and also - added stress by way of their historic roles being handed to technicians. Many others are right in the middle of some traumatic changes leading to the creation of Clinical Commissioning Groups. Others still, have already come through it either relatively unscathed, or are currently seeking alternative employment. Many of my personal friends and also an immediate member of my family are primary care pharmacists so I am very aware of the traumas that this important sector of pharmacy is going through.

Can anything positive be found amongst all of this stress and uncertainty?

From our national information gathering exercise, a picture is emerging that suggests that despite the current financial schisms, the NHS is attaching significant value on the involvement and role of primary care pharmacists. As the article on page 4 indicates, whilst there's plenty of traumatic change afoot, generally speaking primary care pharmacy in one form or another will be remaining as a bedrock of the service going forward.

There are other signs too; recently, PDA officials were told by one of the medical defence associations that in the last decade, medical negligence claims against doctors involved in prescribing errors had significantly fallen. They put this down to one major factor – the involvement of primary care pharmacists in prescribing support.

It turns out also, that currently a significant number of prescribing pharmacists working in primary care pharmacy are not using their prescribing skills. As the feature on page 3 indicates, the government has now recognised this and thought is now being given on how to put these prescribing skills to best use.

Despite all of this, if we are to carve out some improved security and better job satisfaction for pharmacists, then we must strive to create new roles that make an even greater contribution to the public and in the way that it benefits from medicines.

Usually, major transformations come not through chance findings, but through planning and organisation and following much preparatory work at strategic level. To that end, the PDA has been busy with its strategic Road Map initiative; this is where Pharmaceutical Care is delivered to named patients by suitably qualified (prescribing) pharmacists.

The primary care pharmacy role was developed from concept in the 90's and it is therefore a relatively new role now employing thousands of pharmacists. We believe that in exactly the same way, a role that brings prescribing pharmacists much closer to patients – predominantly those with long term conditions involving poly-pharmacy is a role that may already be occurring on an ad hoc basis, but it is a role that could so easily involve many more pharmacists and one that could become the next significant new nationally recognised role for pharmacists.

Having developed our vision, we believe that the key to success will be through the devolved UK healthcare administrations. We intend to – and indeed have already started to work closely with the healthcare administrations in Scotland, England, Wales and Northern Ireland. As the article on page 7 indicates, we have already made some considerable progress on turning this vision into policy reality in Scotland (www.the-pda.org/roadmap/scotland) and work in the other countries is also underway.

I recall – because I was very close to it at the time, just how the primary care pharmacy role was initially developed and then embedded in the 90's. I strongly suspect that it will be those pharmacists who are currently primary care pharmacists – those already possessing the skills to deliver pharmaceutical care who will again be at the very forefront of developing this new and exciting patient facing role going forward.

We will continue to plan and organise and we will ask for your support.

Mark Koziol, M.R.Pharm.S.

Chairman's Letter

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NHS managers attempt to dodge redundancy payments

A trend is emerging where NHS managers are trying to avoid making redundancy payments by playing down major changes to individuals' jobs as nothing more than minor restructures.

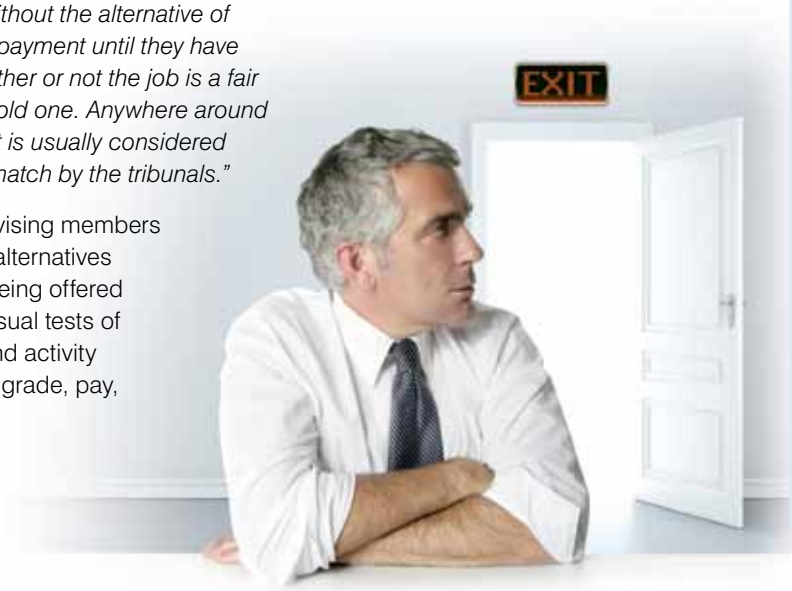
It is in the NHS interests to find a role that is a suitable for most if not all pharmacists within the changing structures to avoid the costs of redundancy. It is also the right of the individual to challenge the role that they are being offered if they do not believe that it is a 'suitable alternative'. If an employer insists that the offer is a 'suitable alternative' and it is not taken up then they can dismiss their employees without any redundancy payments. However, the employee can make a claim to the Employment Tribunal for unfair dismissal on the grounds of non payment of redundancy payments.

"Employers are playing the whole thing as rather low key without mentioning the word 'redundancy' in the hope that pharmacists will assume that they will have to take the job that they are offered", said Orla Sheils one of the PDA employment advisors. *"Members should not feel forced to accept the offer of a new job without the alternative of a redundancy payment until they have assessed whether or not the job is a fair match to their old one. Anywhere around a 75 percent fit is usually considered to be a good match by the tribunals."*

The PDA is advising members to assess the alternatives that they are being offered by using the usual tests of job function and activity match, status, grade, pay, location, and the effect on any emotional factors such as family and caring commitments before they make a decision as to the suitability of the offer.

Some Primary Care and Hospital Trusts are insisting that a 51 percent job match is acceptable but Ms Sheils contends that this is a test that a tribunal would usually apply only if the business was close to going under and had very little choice other than to resort to these measures. *"That's not a position that the NHS finds itself in,"* said Ms Sheils *"One particular Trust has told a pharmacist that they will be able to find them a job within the restructure in a non pharmacist role and believes it does not have to make a redundancy payment to the employee. Clearly this is nonsense and any NHS employer who believes that they can support this stance in the face of an Employment Tribunal claim against them must have little understanding of the tests regarding suitability of alternative employment."*

"*Members should contact the PDA Union immediately should they feel that they are being pressurised to take on a role which is not suitable."* she said.



Prescribing pharmacists – urgent action needed

Becoming a prescribing pharmacist is a significant achievement when one considers the amount of additional training and support from a medical practitioner that is needed.

Probably, the most difficult part is securing the support of a medical practitioner so as to supervise the requisite prescribing experience for a pharmacist.

Despite this, there are now more than 2,000 pharmacists who have attained a pharmacist prescriber status – a clear sign that many pharmacists are keen to develop much deeper clinical relationships with patients.

However, recently, the government's healthcare workforce study unit – the Centre for Workforce Intelligence (CfWI) concluded that many prescribing pharmacists were not actually working in a role that required their qualifications. This is of great concern since once attained, prescribing qualifications if not used in regular practice lose their currency.

Roles for prescribing pharmacists are predominantly found in the hospital and primary care pharmacy sectors, but the PDA is calling upon the government to develop prescribing pharmacist roles in the community setting (see www.the-pda.org/roadmap/scotland). This would not only deliver greatly improved access to a prescriber for the public, but would also enable much larger numbers of prescribing pharmacists to practice.

News...

Yes minister?

The PDA has written again to the Pharmacy Minister, Earl Howe as part of the long campaign to halt the threat of remote supervision and also to resolve the vagaries of the RP regulations and their fitness for purpose.

An independent report commissioned by the Royal Pharmaceutical Society (RPS) and the Professional Forum of the Pharmaceutical Society of Northern Ireland (PFPSNI) which was published at the end of 2011 backed up the PDA's position and the union took the opportunity to remind the Minister that its original concerns appeared to have been justified.

Apart from pointing out that the RP regulations did little to achieve the Government's original objectives in all sectors, the union brought some specific conclusions from the report to his attention;

- The implementation of the regulations was driving behaviours which were felt to undermine patient safety.
- There was evidence that the Regulations were driving RPs towards more defensive practices.
- Less than one in five pharmacists (17%) felt that the Regulations had allowed them greater personal control.

In light of this, the Minister was asked in a letter to take positive action to address the recommendations of the report and not to progress the remote supervision agenda.

His response indicated that he did not feel that the report provided conclusive evidence to suggest that the RP regulations were compromising patient safety. He did confirm however, that the initial proposals for pharmacy supervision would not be progressed in the timescales originally envisaged whilst the government explored the interplay between medicines supply legislation (which currently includes the RP regulations) and GPhC regulations.

A mix of solutions for primary care pharmacy

Following on from the PDA's continuing survey work of developments in primary care pharmacy in light of significant changes with the structures of Primary Care Organisations (PCOs) especially in England it is becoming clear that new developments are emerging at an ever increasing rate.

Virtually all of the primary care pharmacists have now been through relatively stressful transitional processes and some have just begun them. However, the results are producing a wide range of conclusions.

Many of the new Clinical Commissioning Groups (and initial clusters) in England who are now reaching the end of their transitional re-organisations appear to be placing great store upon their historical primary care pharmacist teams.

In many areas of the country, the entire previous primary care pharmacy team is emerging intact (albeit with some adjustments and new surgeries to look after) from the transitional exercise.

In other areas, the pharmacy teams are being split up, with some being employed by the local authority and others remaining with the CCG in the same locality – albeit with significantly changed job descriptions.

Some CCGs are deciding to no longer employ any primary care pharmacists directly but instead to use the services of a third party specialist provider that employs primary care pharmacists. In some instances these are established specialist providers with a track record of such service provision and they have simply taken over the previous roles of erstwhile employed pharmacists. In other instances, these are new vehicles being set up by the very pharmacists who were previously employed by the PCO and who are delivering a near identical service but now through an independent structure.

The stress that this transitional process is causing is clearly traumatic, especially if the end point means that primary care pharmacists are being completely displaced from their jobs. Although the majority have already successfully relocated into their new working formats, others – a minority have still not yet entered into the change process. Some have been entirely displaced and are currently applying for alternative positions in neighbouring PCOs with no guarantee of success.

News...

Publish and be sued!

Pharmacists can be held responsible not only for the original material they produce, but also for the ongoing accuracy of material they place on the web.

The PDA recently dealt with an enquiry about a complaint concerning out of date information being available from a public website for which our member provided specialised content and advice. The website contained historic information about a drug regime that had been superseded by updates to its product licence. A complaint was made that a healthcare professional had relied upon this information when prescribing this particular drug.

"Due to the specific circumstances of this case our legal team believe that the chances of a successful civil claim for negligence are remote;" said PDA Director John Murphy. *"But to protect against such problems, pharmacists are urged to ensure that any information they publish on the internet should always contain a clear disclaimer about its use and be regularly reviewed to ensure its relevance."*

WANTED - DEAD OR ALIVE!

The PDA Union's advisory team have been left aghast at the treatment of one its members by a large pharmacy multiple.

The member was suspended from work following allegations made by his store manager that he had behaved extremely aggressively towards her and had acted in a threatening manner.

The pharmacist was not aware that he was about to be subjected to a disciplinary process when he arrived at work one day and was simply directed to another location to wait for a meeting with a senior manager. After waiting more than three hours he was called into an investigation and informed about the allegations constituting gross misconduct. By this stage he was extremely anxious and expected to be immediately dismissed from his job.

During the meeting the member explained that his only interaction with the manager on the previous day was to raise concerns over staffing levels and that, as the RP, he may have to consider closing the pharmacy unless the risk could be addressed. He had been referred to Occupational Health in the recent past due to work place stress. He emphatically denied acting in the alleged manner, but was suspended with immediate effect.

In a follow up investigatory meeting the member reported that the senior manager had behaved in an accusatory manner and that his questioning was oppressive and intimidating. The PDA member became so stressed during the meeting that he had to leave the room, he then collapsed with breathing difficulties and chest pain a paramedic was called and treated him for a severe panic attack.

It became apparent later that whilst the member was suffering his collapse, the senior manager must have been writing a letter to the member inviting him to a disciplinary meeting on the following day despite the investigation not having yet been concluded.

Even after the manager had been shown the paramedic report and treatment plan, within an hour of the PDA member's collapse the manager persuaded him to continue with the meeting, sign the notes, and then handed him the letter.

The manager let the pharmacist go home without showing any concern for his welfare or even checking whether he was safe to drive.

PDA Union advisors demanded the rescheduling of the disciplinary meeting and provided a representative. The Union representative highlighted significant contradictions and discrepancies in the witness statements that cast serious doubt on the credibility of the evidence. A grievance was then raised about the member's treatment and the complete lack of care shown towards him.

The employer wrote to our member dropping all allegations, but maintaining it had acted entirely properly. At this moment in time its position is being challenged further and the PDA will update members on the outcome.

News...

PDA plans member road-shows in 2013

Following the success of last years trial when the PDA held separate one-day conferences in four major cities in the UK, it intends to expand the initiative in 2013.

Mark Koziol the PDA Chairman explains *"Up until and including 2011 we held one major annual conference in Birmingham on a weekend, but after listening to our members feedback, many of whom felt that they would like to attend but found the travelling and timing inconvenient, we decided to try taking the conference to them in the geographic regions".*

It proved such a success that the PDA is planning to expand next years event to give even more members the opportunity of attending and having their say. Mr Koziol insisted that *"It will make it easier for members to attend a PDA event if we give them at least eight different locations up and down the UK to choose from."*

Instead of hosting a full day conference it intends to conduct evening meetings. *"Our members tell us that they are more likely to attend if we have an event limited to the topic of the day and if it is held in the evening rather than at weekends"* said Mr Koziol.

PDA members are urged to look out for details of the conference with the most convenient location for them when this is published in the New Year.

GPhC must revisit its policy on risk of retailing in pharmacy

The GPhC has been a regulator for two years and during that time it has established itself as largely a credible regulator.

However, whilst maintaining the integrity of the register is one measure of its success, if it is to be successful in the long term its development of regulatory standards must have a beneficial impact upon both the public and the profession. To accomplish this, it will need to build both credibility and respect in depth at policy level and that will largely be determined by the extent to which it can come to know and understand the way in which pharmacy operates.

The GPhC recently submitted a response to a Law Commission Consultation on the regulation of Healthcare professions which has given the PDA considerable cause for concern.

The GPhC's response to the section on business regulation states;

"We understand that many pharmacies are businesses and how they operate may differ as a result, but we think there is the potential to over-estimate the impact that has for us as a regulator when compared to other regulators who solely or predominantly regulate professions or provision of services within an NHS managed environment."

Far from the risk of retailing in pharmacy being over-estimated, the PDA believes that one of the main justifications for having a pharmacy specific regulator at all (as opposed to a combined one like the Health Professions Council), is that it is best placed to understand the unique risks delivered by retailing and non-pharmacist ownership in community pharmacy. All pharmacists in community pharmacy practice will know that the pressures placed upon them to drive sales, particularly by the large non-pharmacist owned corporate organisations are immense and often they impact upon patient care.

The GPhC goes on to say;

"Although different, NHS organisations also have many pressures not directly related to patient care; GP practices are in effect private businesses; NHS providers in England are increasingly required to compete for income…."

This policy platform is at variance with a view that is not only held by a very significant proportion of the profession but also the view of the European Court of Justice. This gives the PDA significant cause for concern and as a consequence it will be raising this matter at a meeting with senior GPhC officials in December 2012.

The review of pharmaceutical care in the community in Scotland

If pharmacy is to optimise its contribution to the NHS, then pharmacists must be enabled to develop clinical relationships with patients on a one to one basis. The delivery of pharmaceutical care in this way is already seen in some hospitals and especially in primary care pharmacy, but rarely in the community pharmacy setting. Currently in England, through what the PDA calls 'the commoditisation of services', pharmacists have been pressurised into hitting (often unrealistic) MUR and NMS targets. Under such unsatisfactory arrangements, the PDA believes that the patient simply becomes a means to a financial end and the pharmacist an expensive overhead. To this end, the PDA has lobbied hard this last two years and to support a much more 'pharmacist/patient' centred concept, has developed its 'Road Map' strategy. Recently, this was submitted to a team appointed by Scottish government who were tasked with the review of Pharmaceutical Care in the Community in Scotland. (www.the-pda.org/roadmap/scotland).

Whilst the review was community based, the PDA believes that it has significant implications for all pharmacists who are willing to develop pharmaceutical care and some that will already be qualified to do so. The review is now concluded and it is largely supportive of the PDA's Road Map.

Review lead Dr Hamish Wilson explained that the government would now consider what to do with its findings and whilst he could not publish it, he could offer a number of observations: *"Many review participants told us that community pharmacy today is still seen as a money making retail business and not really a member of the healthcare team so community pharmacy will need to up its game if it wants to become a key player in the NHS."*

And Dr Wilson asked: *"Why is it that patients could not recall the name of their pharmacist in a way that they could the name of their GP? 'Named pharmacist' was a phrase that was mentioned many times – patients wanted it – they wanted to be able to develop a relationship with the individual pharmacist. This made sense as empowering the individual pharmacist would lead to responsibility and accountability for direct care. The current arrangements in community pharmacy however leave the individual pharmacist outside of the clinical governance arena."*

> 'Named pharmacist' was a phrase that was mentioned many times

He also intimated that new governance arrangements would need to be established to tackle this: *"Design influences behaviour and a better service design will lead to an improved public perception of pharmacy. Pharmacists are good risk managers, whilst doctors by the nature of their work take risks, the two are a perfect blend but only if they can work in a more integrated way. Developing collaboration and networks would be important and all healthcare professionals must be allowed to use their unique skills to best effect."*

He explained that pharmacists, doctors and nurses should be trained together both at undergraduate and postgraduate levels: *"Pharmacists will still need to be involved in the safety of dispensing, in the promotion of safety and the reduction of risk. Consequently, protected time will need to be found to enable them to develop pharmaceutical care."* And he explained that under new arrangements, the pharmacy team will be expected to do a lot more to facilitate this.

This brief description cannot hope to cover the whole presentation. However, it could hardly be more supportive of the PDA's strategic position and it represents a very powerful opportunity to develop the professional agenda in a way that will be highly beneficial for both patients and individual pharmacists alike. The PDA is already engaging with the Scottish government and has offered its support to assist with the turning of this vision into reality.

Too many pharmacists? What's being done?

With pharmacy undergraduate numbers more than doubling over the past ten years PDA members recently took part in a series of meetings to discuss how best to handle the issue. This feature considers the progress made.

PDA policy regarding pharmacist numbers takes a two track approach: to control undergraduate numbers and to balance additional supply by creating additional demand. This can be achieved through a seven point plan.
(see panel)

❶ Develop a workforce plan

Without a workforce plan there is no way of telling (in the medium to long term) whether reducing graduate numbers would be beneficial or not. Since the PDA held a series of events on the topic of over supply several organisations have made strong representations to government via the Modernising Pharmacy Careers Board, on which the PDA has a seat. These include the Council of University Heads of Schools and the British Pharmaceutical Students Association. The Pharmacy Minister is now aware of the problems.

Consequently the government's Centre for Workforce Intelligence (CfWI) published a Pharmacy Workforce report in August 2012. This concluded that there is likely to be a shortage of pre-registration training placements, and it also raised concerns about the increasing numbers of pharmacist prescribers who are not using their prescribing skills due to a lack of central planning. It called on the government to lead further research into the future supply and demand for pharmacists and to involve stakeholders in finding a balance. Clearly, the recently developed PDA policy will be pushing at an open door and although this alone will not resolve the problems immediately it does mean that decision makers are now on board with the programme.

❷ Control the numbers entering schools of pharmacy

It is unlikely that schools of pharmacy will rush to cut their intake because popular courses create easy income. And because of pharmacy's historically good employment prospects many more courses have been established. If, due to over supply, pharmacy becomes less popular some universities may review their policies, but this will take time.

The PDA is also looking carefully at what the universities are telling their incoming undergraduates. If they are selling themselves on the basis of good employment prospects on graduation, then they could be exposing themselves to significant liability if their graduates are not able to secure work as pharmacists.

The PDA has written to the deans of all universities with schools of pharmacy warning them about the current problems. Despite the mounting pressure on pharmacy schools, urgent action is unlikely due to the pharmacy student 'lead' times. If over production of pharmacists is to be tackled, it must be done in a more sophisticated way.

❸ Drive new roles to increase the demand for pharmacists

Pharmacists are already seeing a fundamental transformation of their roles, but much more needs to be done. New role development for pharmacists is very much the direction of travel for the NHS and the PDA expects this to accelerate markedly over the next two or three years.

The PDA is actively promoting the idea that the future of pharmacy service provision is through the recognition of the pharmacist as an individual autonomous professional practitioner (see point 7).

4 Drive new roles in the community but not at the expense of the supply function

The good news is that government sees pharmacists in increasingly clinical roles. The bad news is that some within government also believe that pharmacist involvement in the supply function is a waste of valuable resources, preferring that technicians take over this role and leave pharmacists free to develop new roles. This is significantly at odds with the PDA's position.

The PDA agrees that pharmacists should not spend a vast amount of time and energy on licking and sticking and that technicians should take on far more dispensing activity. However, patients will only continue to receive their medicines correctly and safely if pharmacists stay closely involved in the supply process at the clinical check, counselling and counter prescribing stage. New roles should be developed by pharmacists, but not at the expense of the supply function.

The PDA has instigated a PhD research project that seeks to establish the value of the pharmacist in the supply function from a patient safety point of view. Plus, the Company Chemists' Association recently published a survey result showing how pharmacist involvement in the supply function prevents large numbers of harmful errors reaching the public. This will continue to be an important PDA policy position and the Association will be encouraging its adoption by other bodies in pharmacy.

5 Focus on roles that deliver improved safety for patients through the unique skills of pharmacists

There is little point lobbying government about protecting pharmacists' livelihoods, nor in seeking to develop roles that can be done more cost effectively by other healthcare professionals. Instead the PDA is talking to government, patient groups and other healthcare professions about ways in which pharmacists can support patients' needs and particularly ensure the safe use of medicines. The PDA is also discussing how the patient journey can be improved with greater support from pharmacists, involving other pharmacy organisations in these discussions wherever possible.

6 Develop a supervision policy that makes the pharmacist more accessible to the public in the pharmacy, and not less so

The government believes that the public would benefit from pharmacies operating without a pharmacist on the premises using remote supervision, but the PDA strongly disagrees.
For the best part of five years, the PDA has been tirelessly campaigning to prevent remote supervision. And despite many false starts the government has still not deployed its policy – long may that continue. The PDA continues to engage the government on this anachronistic proposal and is keen to ensure that any new supervision regime will make the pharmacist more accessible to members of the public in a community pharmacy and not less so.

7 Halt the commoditisation of pharmacy services and enable pharmacists to develop clinical relationships with patients

As an alternative to the MUR and NMS approach favoured by the government in England, the PDA advocates that individual pharmacists should be able to develop clinical relationships with patients through the delivery of pharmaceutical care. In such a way medicines can be:

- Taken more safely through a reduction in adverse drug reactions
- Optimised, with much improved effect
- Cheaper, through reduced waste.

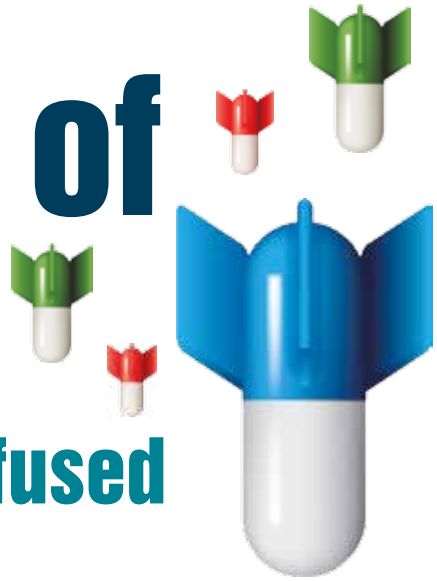
A consequently much improved patient journey would result in fewer hospital admissions.

These are the concepts embedded within the PDA's strategic Road Map proposal and it is investing considerable resources in promoting its proposal. Already, there are some positive signs of success (see report on page seven). Balancing the supply of pharmacists with increased demand requires significant activity and the PDA will continue to develop the program described – sometimes alone and sometimes working with others.

The synopsis of the PDA conferences on this subject and the policy developed is described in the autumn edition of Insight (www.the-pda.org/toomanypharmacists)

Self-selection of P medicines

a bombshell that must be defused



The General Pharmaceutical Council has enjoyed something of a honeymoon period during its first two years of existence and the PDA welcomed the news that it was going to develop new standards for pharmacies. Whilst the PDA was engaged in the various communication exercises, it was greatly concerned to learn that the final policy contained the bombshell proposal to allow Pharmacy medicines to be available via self-selection.

The GPhC's consultation on premises standards tried to move away from fixed rules and towards outcome based regulation. Here, the final outcomes would be set and the profession would be allowed to find its own way(s) of achieving them. This was intended to allow for innovation and professional empowerment. The new approach carried some risks, but also some benefits through a much more targeted form of inspection, which if operated as intended would keep errant employers in check – something that on balance the PDA supported.

The PDA submitted its response in July 2012 (www.the-pda.org/premisesstandards) and whilst appreciating outcome based regulation, it argued that the GPhC should avoid 'throwing the baby out with the bathwater'. Pharmacy is now largely an employee profession overtly influenced by large retail and not primarily healthcare organisations. If all the old rules were lost, then this could give the large retailers carte blanche to drive for profits in a way that destroyed the professional empowerment and welfare of pharmacists.

The hidden bombshell

The consultation was mainly about premises regulation, but one page contained an incidental reference to how medicines could be available on self-selection. Few respondents read deeply into this but those that did, concluded that P medicines on self-selection was up for debate and submitted a very robust defence of the P category.

"The suggestion that P medicines should be sold on self-selection is an argument that we would expect to see coming from a large retailing lobby group and not from a health profession regulator which should have a better understanding of medicines," said the PDA's submission. *"We urge the GPhC to think again about this intention as it will be met with significant resistance from the wider profession."*

However, by far the vast majority of respondents probably did not spot this bombshell as they made no reference to it. Following the consultation the GPhC confirmed the move to outcome based regulation. It then argued that as a consequence, the prohibition of the sale of P medicines from open display should no longer apply. Instead, a decision on whether or not P medicines should be on self-selection should be made locally by owners or superintendents.

The GPhC stated that there were to be three pre-conditions:

1. Pharmacies would need to notify the GPhC of their intention to allow P medicines on self-selection.
2. Guidance on compliance for pharmacies would need to be developed and communicated in advance.
3. The current prohibition on self-selection of medicines would remain in place until new enforcement rules came into effect in October 2013.

The PDA's concerns

Almost immediately the PDA heard from alarmed members, with some reporting that their employers had already moved P medicines onto the open shelves. The PDA promptly raised its concerns with the GPhC. It is difficult to understand how a regulator whose main role was to protect the interests of the public could have made such a decision. The PDA requested copies of minutes of meetings and any policy papers that its Council had been considering and issued an urgent press release (www.thepda.org/pressrelease/pmeds) registering serious concerns.

There are many concerns about this proposal, including:-

- Allowing P medicines on self-selection in one pharmacy and not another would create more confusion among the public in an area where too much confusion already exists, and would undermine the standing of the profession.
- The P medicine is a special category of medicines which enables de-regulation of products from POM to P. It ensures that newly deregulated medicines can be sold under a restricted and controlled format.

If P medicines went on self-selection this assurance would be diluted and the de-regulation programme harmed.

- The proposal to allow owners and their business managers to decide whether P medicines should be sold on self-selection undermines the pharmacists who are responsible for sales of medicines and for securing the safe and effective running of the pharmacy.
- Currently, a pharmacist can choose to temporarily suspend P medicine sales (perhaps due to temporary absence, or because of severe staff shortages), but not if these medicines go on self-selection.
- Self-selection reduces the opportunity for prevention of improper sales, placing pharmacists and staff at greater risk.
- Many PDA members face disciplinary action by employers because they have refused to sell patients the P medicine of their choice even though this is the right clinical decision. Self-selection would cause even greater tension between commercial and professional considerations.
- Extreme pressure already exists encouraging the public to buy as many medicines as possible – such as three for the price of two promotions. Self-selection would exacerbate the tendency for medicines to be treated like normal items of commerce.

What is going to be done?

The GPhC has ended up at odds with many in the profession on a matter which is core to the profession's identity – that of guardian of the nation's medicines. The PDA has asked it to revisit this policy, but the GPhC believes that, since a Council decision has already been made, the best way forward is for the PDA and other concerned organisations to work with the GPhC to create guidance on compliance. This guidance may end up being so stringent that few, if any pharmacy owners would be motivated to go down that route. Alternatively, it might show that self-selection was simply not feasible. If that were the case then the GPhC would be duty bound to ask its Council to consider the matter.

The PDA is uncomfortable with such an approach, believing it better to treat the causes of the problem rather than its symptoms.
The PDA view is that there are several causes of the current impasse and these need to be urgently addressed:

Transparency

The consultation was about standards for registered pharmacies – not about P medicines on self-selection. It is not acceptable for the GPhC to reach conclusions on a matter of such fundamental importance through a consultation on a different matter.
The PDA has urged the GPhC to hold a specific and separate consultation on the self-selection issue.

The impact of retailing in community pharmacy

The PDA is telling the GPhC that it believes one of the primary reasons for the existence of a pharmacy regulator (as opposed to a general healthcare regulator) is that it should have a deep appreciation of the greater risks associated with the supply of medicines in an aggressive, largely non-pharmacist owned retailing environment.

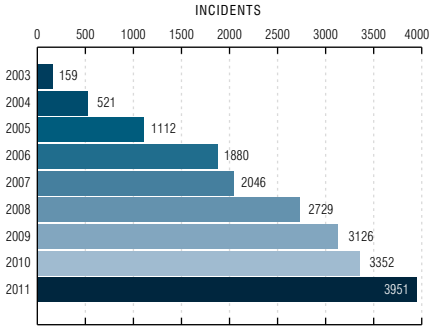
The GPhC's official policy currently is that it thinks that there is a potential to over-estimate the impact for the GPhC of the fact that community pharmacy is operated as a business as compared to other regulators who regulate professions operating within a managed NHS environment (see News page 6).

The PDA believes that this policy is fundamentally flawed. All community pharmacists know that the pressure upon them to increase sales – often at the expense of professional decision making and patient experience – is relentless. The PDA believes that this policy is not only flawed but is a significant contributor to the GPhC's current self-selection predicament – it must be urgently re-visited.

The PDA is seeking a reversal of the current GPhC policy, even though policy guidance work may make P meds on self-selection unfeasible.
A policy that actively prohibits self-selection (as is currently the case) is much better than a policy that allows it theoretically, even though it rarely appears because it is a little difficult to deliver.
PDA members will be kept in touch with any developments and may be asked to participate in surveys or petitions if necessary.

Defence episodes top 4,000

The PDA provided more than 4,000 defence episodes during 2012, or the equivalent of 15 new requests for support every working day of the year. This article highlights some of the learning points to take from these cases.



While some defence episodes require relatively simple handling, others – such as the Elizabeth Lee case – need a complex series of measures often resulting in months of legal management. Being a highly regulated and predominantly employed or self-employed profession, pharmacists face the risk of unwelcome action in four key areas:

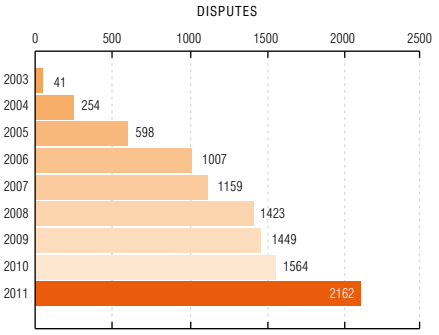
- Employment disputes
- Professional/regulatory investigation
- Criminal prosecution
- Civil claims for compensation in the event that an error harms a patient.

Added to this is the 'special' risk faced by self-employed locums who are often roughly handled by those who have contracted their services and then don't pay the locum fee because an unrealistic MUR target had not been met. Increasingly pharmacists are finding themselves simultaneously facing more than one form of action.

Learning points

1. Trying to avoid situations which result in some form of action against a pharmacist is by far the best form of defence.
2. The PDA invests significantly in risk management activity; where the bad experiences of the few can provide useful lessons on how to avoid similar problems for the many. Members are urged to study some of the features in Insight magazines where such experiences are shared.
3. Learn how to handle a patient in a dispensing error situation before such a situation actually occurs.
4. Once something untoward has occurred it is really important to contact the PDA as soon as possible. Calling your family lawyer, or a well-meaning volunteer pharmacist friend (even if they are some kind of a committee member) is unlikely to bring about the best results. Pharmacists are also urged not to rely on an organisation that is in any way connected to an employer or an employer's insurer.

Employment disputes

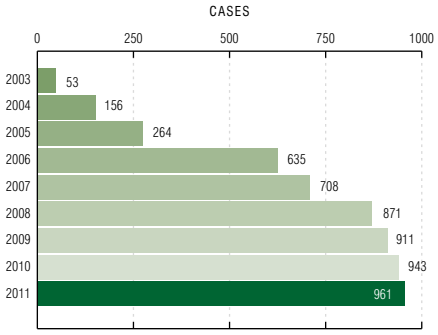


More than half of all defence activity is expended in the area of employer/employee disputes. When members' rights or professional standpoints are ridden roughshod over the PDA is often effective in securing a remedy in favour of the member. The recent joint action employment tribunal that the PDA took on behalf of its members against Alliance Boots is a case in point where many pharmacists enjoyed significant sums in back pay as a result of the successful outcome.

The majority of disputes between employers and employees occur when pharmacists are keen to act in a way that represents best professional practice and employers act in a way that seeks to maximise profit. This conflict of interests causes significant tension within the profession and often it manifests itself in a way that directly impacts on patient care. As yet, the regulator and the government appear not to consider that commercialism is a major risk factor within pharmacy worthy of any special attention, but this is an area of lobbying activity that the PDA is increasingly focussing on (see news page six).

Since it attained union status, the PDA Union has been involved in a far greater volume of cases. The PDA continues to develop its union activity and has numerous requests in progress for formal union recognition with various pharmacist employers.

Professional/regulatory investigations

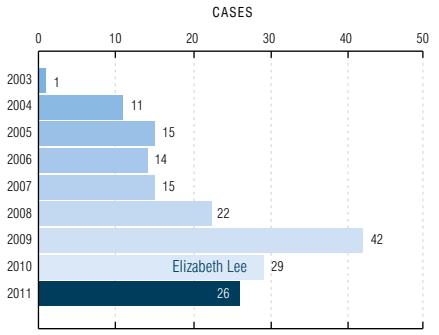


Since the Shipman disaster healthcare regulation has been dramatically and perhaps excessively overhauled. As the graph shows, pharmacists are now facing many more regulatory procedures. Pharmacists are not behaving any worse than they were a few years ago, but rather the bar that qualifies for a fitness to practise investigation has been lowered. Additionally, the right to be able to practice pharmacy is now being scrutinised – pharmacists must now demonstrate their participation in CPD and the issue of regular revalidation is emerging.

Pharmacy students too are now falling under the fitness to practice regime and it is now expected that 18 year olds entering schools of pharmacy are to observe standards of behaviour that reflect the status of a healthcare professional. In situations which up until quite recently may have been handled under the banner of 'exuberance of youth', the PDA is now increasingly called upon to provide representation in front of formal student fitness to practice procedures.

The number of professional regulatory cases handled by the PDA continues to generate high levels of activity. The GPhC has stated that it is keen to ensure that generally a proportionate approach to regulation can be taken, and the PDA continues to lobby it so that unnecessary action against pharmacists is avoided. Additionally, a considerable amount of work remains to be done to ensure that the policy creation work of the GPhC is properly connected to its inspectorate and to its judiciary (its disciplinary committees).

Criminal prosecution

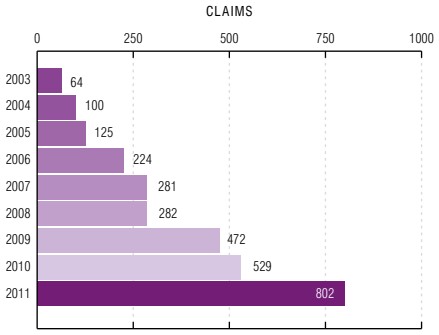


As the graph shows, criminal prosecutions of pharmacists are the least likely of all of the perils that face pharmacists, but when they do occur they are extraordinarily problematic. The consequences of a criminal prosecution can be serious – a suspended prison sentence in the case of Elizabeth Lee for making a single dispensing error, for example. Efforts are currently underway to seek to remove criminal sanctions for pharmacists who commit a dispensing error.

Once a police investigation into a potentially criminal act is underway, the consequences for pharmacists are usually complex and far reaching. Often this will have repercussions in their employment relationship and also may alert the pharmacy regulator to a fitness to practice investigation. The key to successfully defending pharmacists in these situations is to persuade the police not to prosecute in the first place and to this end the PDA has met with some success.

PDA members are urged to contact the PDA if they are unfortunate enough to be interviewed by the police. One important word of warning is that pharmacists are urged never to accept the 'on the spot' sanction of a caution because they are told (or think) that the incident won't escalate any further if they 'nip it in the bud'. Accepting a caution in a situation where a prosecution is unlikely is never in pharmacists' best interests, nor is it in the interests of justice. Accepting cautions will be seen as an acceptance of guilt and will always cause difficulties with an employer, and will almost certainly lead to an investigation and usually a sanction by the pharmacy regulator.

Civil action (claims for compensation)



Pharmacists are now practicing in an increasingly litigious society with claims against them on the increase. The most worrying trend of all is the cost of third party 'ambulance chasing' lawyers. In one recent case a non-contentious simple compensation claim was settled for £1,000 with the patient, but his lawyers have demanded fees of £40,000 – despite having done very little to deserve such an exorbitant fee. Discussion about these fees is now heading in the direction of the court as the PDA is keen to allow a judge to ascertain the probity and ethics of this type of conduct by legally qualified professionals. Furthermore, the PDA is also seeking to engage the government to try and outlaw such practices, as the 'ambulance chasing' issue is also one that significantly harms the NHS.

In the second of a series of articles investigating dispensing errors, Harminder Lall, one of the PDA's pharmacist advisors, explains the lessons to be learned from errors made around repeat prescriptions, opioid dependent patients and delivered medicines.

Patient safety: systems failures

A study conducted by Manchester University in 2005 evaluated the dispensing error rate and found that at that time it was equivalent to around 4.4 errors per pharmacy per week[1]. Since then, the number of items dispensed in England has risen from 720 million to 961 million in 2011[2] and it might be expected that the rate of incidence of errors has increased proportionately. With that in mind, this article reviews some of the systems failures that PDA members have reported as contributing to dispensing errors.

Repeat prescriptions

Recent analysis of errors reported to the PDA shows that one third of errors involved items that were part of a repeat service. This statistic may surprise some, especially policy makers who believe that pharmacist involvement in repeat prescriptions is a wasteful use of their time and that repeats can easily be delegated as they are relatively risk free. The PDA has been warning about the inherent dangers of repeat prescriptions for some time. Additionally, it has also expressed concern about downgrading the checking of repeat prescriptions to a low priority task deferred until more urgent tasks have been completed.

Typically, labels are generated on one day, assembly takes place the next and a final check is not undertaken until another day. It appears that repeat prescriptions often exacerbate the pressures that such a system should in theory, alleviate. Where an error is made it can be very difficult to pinpoint where the system has broken down. This usually puts the pharmacist who has the misfortune to be the RP on the day the label was created (as the PMR may be the only point of reference) in the frame for civil, criminal (if death results) and/or regulatory action.

The PDA advises locums to ensure they are quite clear about what the process is in each pharmacy prior to undertaking a clinical and accuracy check, and ideally before commencing work at a new pharmacy. Pharmacists who work regularly at the same location should be in a position to exert their authority to ensure regular safe practices. A well managed repeat prescription system, with the appropriate level of staffing, ought to be one that allows for good risk management.

Whilst the activity of separating out each stage of the assembly and checking process seems to be common practice, experience gained by the PDA in handling errors shows that it can only serve to increase risk. However, if a relief pharmacist or locum decides to follow the custom and practice, they should at the very least ensure that their audit trail is not compromised and that they can pinpoint their involvement in the process.

Boots in particular has developed a good audit trail mechanism, involving the use of a circular stamp, with four quadrants, each quadrant requiring a signature upon completion of each stage.

Some dispensing errors involve patients who receive their medication in dosette trays, or some form of monitored dosage system. Often, these patients belong to a more vulnerable patient group and have carers responsible for collecting medicines and even the administration of these medicines. In one notable case, a locum pharmacist was signed in as the responsible pharmacist when a bag of medicines previously assembled and checked but with an incorrect bag label was handed out to the carer of a patient, Tragically, the carer went on to administer the incorrect medicines to the patient, not realising the error. The elderly patient died and the pharmacist was required to attend a coroner's inquest.

Ultimately, it was found that the death was unrelated to the ingestion of the wrong medicines, but for the pharmacist it was a time of a great anxiety. Whilst this case involved a locum pharmacist, the PDA has often seen similar cases resulting in employees being disciplined by their employer for being in breach of the SOPs relating to the checks that should have been undertaken when medicines have been handed out. In an intensely busy pharmacy, with multiple tasks requiring the attention of the pharmacist, it can be quite easy to delegate the apparently uncomplicated task of the bagging and handing out medicines to the least qualified members of staff. Whilst the argument for defence in such a situation might be that it was perfectly reasonable to expect a registered pharmacy technician to ensure medicines are given to the correct patient, this argument could not apply in the case of a member of staff whose level of qualification or competence had never been established.

Opioid dependent patients

One factor contributing to dispensing errors often cited by PDA members is the pressure to check large volumes of prescriptions for opioid dependent patients. This can result in errors for such patients directly, or being distracted when conducting final checks for other patients' prescriptions. The bar for criticism is raised for dispensing errors involving controlled drugs. It is important to ensure that the process for the assembly for such items is clear, appropriate and to your standard, prior to conducting the final check

The most frequent type of errors in this category are mistakes made at the handing out stage, with the patient receiving someone else's methadone. Most SOPs will clearly state that when handing out medicines, patients are asked to confirm their identity. Time and time again, it is the case that such patients are very well known regulars with whom a rapport has been built and pharmacy staff, including pharmacist. are almost embarrassed to ask for an address. What can be done? Develop a clear policy about who in the pharmacy team can hand out medicines, ensure that everyone is familiar with the SOPs, explain to patients that their identity will be checked on every occasion, and then make sure this happens.

Delivered medicines

Where medicines are delivered to patients, some pharmacies have better procedures than others. The patients involved are often the elderly or the infirm, who are more susceptible to the risks of adverse events. It can be easy to fall into the trap of thinking that once an item has been checked off, that it will safely reach the patient. Points to consider include checking:

- Is the label on the bag the correct one and does it have the correct address on it?
- How does the driver check which bag is being delivered where?
- Is a signature obtained from the patient upon receipt?
- What happens with CDs?
- What happens if the patient is not at home?
- What process does your pharmacy have for delivering new medicines?

Increasingly, large chains are engaging in a cost driven exercise of mass collection of repeat prescriptions from doctors' surgeries, assembling them in one location, and then shipping them out to pharmacies from where they are distributed. In such a case each pharmacist involved in the chain of supply would be implicated in the event of an error. There ought to be in existence, as a minimum, a clearly defined SOP with accountability laid out. Pharmacists should be aware that patients will expect a duty of care to be exercised by the pharmacist who directly provides them with their medicines.

Painful as they can be, when used as a stick to beat pharmacists with, SOPs can provide useful guidelines on risk management strategies within the pharmacy. When in doubt consult the superintendent pharmacist, when in difficulty call the PDA.

References

1. Prospective study of the incidence, nature and causes of dispensing errors in community pharmacies. Ashcroft DM, Quinlan P, Blenkinsopp A. Pharmacoepidemiol Drug Safety. 2005 May;14(5): 327-32
2. NHS. The Information Centre. Prescriptions dispensed in the community: England, Statistics for 2001 to 2011.

Time for the PDA Union's five yearly elections

It's hard to believe that five years have passed since we elected members to the Executive and membership groups. Those members who had the vision to come forward and make the Union work could not have contemplated how far the Union has come over the past five years.

Obtaining a Certificate of Independence from the Certification Officer of Trade Unions was the most difficult hurdle we had to overcome. But this indicated to the pharmacy world that the Union had come of age and meant that we had met the same criteria as the Unisons and Unites of this world. Since then we have fought and won class actions in Employment Tribunals, represented thousands of pharmacists either individually or collectively, and obtained recognition rights predominantly amongst hospital trusts.

We are seeking recognition rights from all the major pharmacy chains and have met with several companies in an endeavour to obtain voluntary agreements. Plus of course the well publicised application for recognition rights in Boots will shortly go to the Central Arbitration Committee. We have also opened discussions with the Union Learning Fund, with the intention of providing a Life Long Learning Scheme for our members.

Ask any of the officers and they will probably tell you that taking an active part in looking after the interests of their colleagues has been one of the most rewarding experiences in their professional career. If you feel that working in support of your colleagues is for you, then you will have the opportunity of becoming part of this team in the 2013 elections.

How the Union is structured

6 x National Executive Officers

1. General Secretary
2. Treasurer
3. 6 Assistant General Secretaries
4. Communications Officer
5. Other Officer

The officers will ensure the day to day running of the PDA Union

5 x Membership Group Representatives

1 2 3 4 5

Each Membership Group committee selects its group representative and deputy.

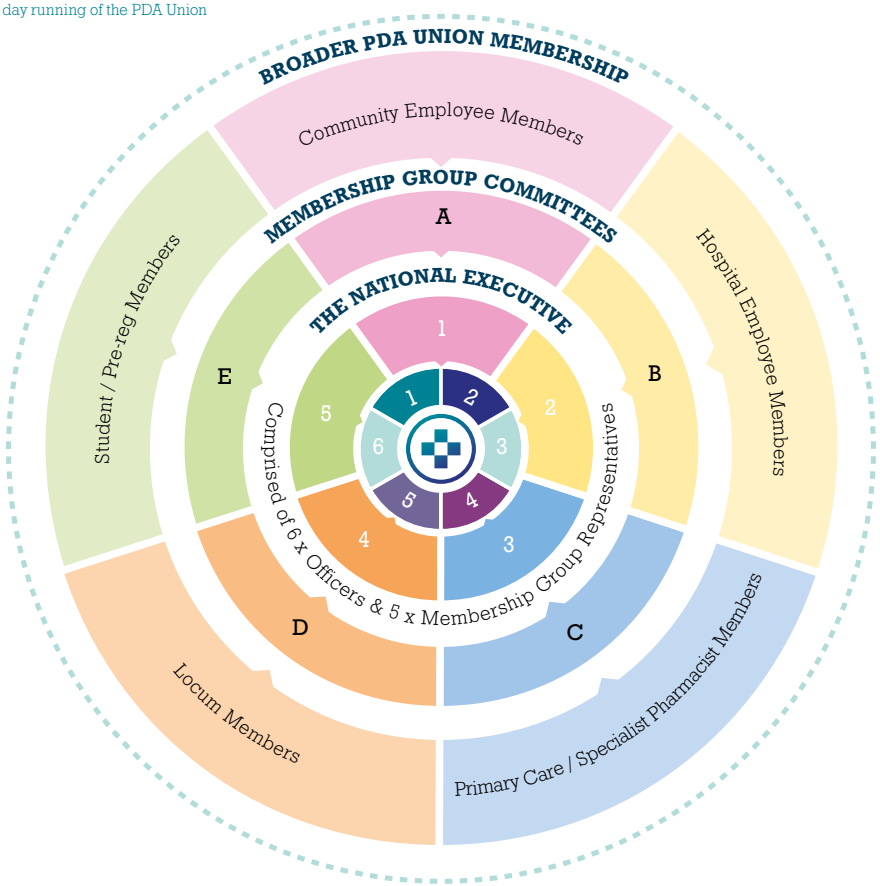
Each representative ensures that issues important to their membership group are brought forward to the national executive

Membership Group Committees

A B C D E

These are responsible for developing policy relevant to their Membership Group and also participating / organising membership activity

One committee member per 500 members in PDA Union membership



The membership is subdivided into five sectors based on the type of work they perform and/or their employment status. Each subdivision is democratically represented by its corresponding membership group.

Union rules state that no more than one per 500 (or part thereof) of the population of pharmacist members from that sector can be elected to the membership group posts to represent their cohort to the Executive Committee.

The membership group will nominate their representative for the Executive Committee.

The term of office in the membership groups is five years. Nomination papers for the vacancies will be made available in January/February next year to those who wish to put themselves forward.

The governing body of the Union is the Executive Committee, which comprises of 11 members, one each from the five membership groups, and six members who are directly elected by the membership. These six people make up the officers of the Union.

Elections will also be held for the Union Executive posts that have been held by the same incumbents for the full five year period since the Union was inaugurated. There is no limitation on the number of times any such incumbent can be returned by the electorate at five yearly elections.

John Murphy, General Secretary comments: *"I would like to go on record to publicly thank all of those officers and membership group representatives who have contributed so effectively to the consolidation of one of the youngest organisations to emerge in the modern Union movement. Whether those that have already served five years decide to stand again or not, they can be truly proud of their contribution".* In looking to the future he adds: *"The next round of elections offers all our members an opportunity to take an active part in the workings of the Union and I urge them to grasp it".*

More information as to what the roles entail, is available on the PDA Union website: www.pda-union.org

What happens next?

The PDA Union will make an announcement as to the posts that are up for election via the website and email in early January 2013, inviting members to stand for the vacancies.

Pharmacists may join the PDA Union at any time. However, those wanting to either stand in, or vote in, the forthcoming elections (to be held early in the New Year) will have until Friday 11th January 2013 to become PDA union members. Any member joining after that date will not be eligible to stand for office.

Those PDA union members who are interested in putting themselves forward for any of the posts described can do so by requesting an election pack, which is available from the election scrutineers (name and address to be confirmed) upon request from noon on Friday 1st February. This will contain a nomination paper and details on how to become nominated.

Completed nomination documents should be returned to the scrutineers by noon, Friday 1st March, 2013.

For contested posts, all PDA union members will receive a biography of all candidates and election ballots from Friday 8th March, 2013 and the arrangements for the elections will be disclosed at that time.

The rules for the election will also be available on www.the-pda.org.

The election process will last four weeks and the results will be announced by the independent scrutineers by Wednesday 3rd April 2013 at the latest.

Step One

11th January 2013 – Deadline for membership eligibility to stand in forthcoming elections

Step Two

1st February 2013 – election process opens and nomination documents available

Step Three

1st March 2013 – closure date for nominations

Step Four

8th March 2013 – ballot arrangements announced

THE PDA union
strength in numbers

Know your maternity rights

As part of a series of articles on employment rights, Ruth Williams, PDA Legal Adviser explains that there are a number of things to consider whilst pregnant and post pregnancy relating to your employment.

Pregnant employees have four key rights:

1. **Paid time off for antenatal appointments**
2. **Maternity leave**
3. **Maternity pay**
4. **Protection against unfair treatment or dismissal.**

1. Paid time off for antenatal appointments

All pregnant employees, however long they have been in their jobs, are entitled to reasonable time off work for antenatal care. Any time off must be paid at your normal rate of pay.

You must tell your employer that you are pregnant at least 15 weeks before the beginning of the week when your baby is due. If this is not possible, for example because you did not realise you were pregnant, you must tell your employer as soon as possible. However, the earlier the better because it will then be able to plan around your maternity leave and carry out its legal obligations to you.

Employers also have certain obligations to ensure the health and safety of pregnant employees, and your employer should give serious thought to conducting a risk assessment as soon as it learns you are pregnant. Your employer should involve you in the process and continue to review the assessment as your pregnancy progresses to see if any adjustments are necessary.

The most common risks posed to pregnant employees are heavy lifting, bending, overreaching, and standing for prolonged periods of time. If an environment is considered to be unsuitable for you then you can be offered alternative duties, or if no alternative exists you may be suspended on full pay. In the case of a pharmacist it may be difficult to make adjustments to your workplace as the role is one that is not known for being sedentary.

Where women become ill during their pregnancy they will be entitled to whatever sick pay arrangements the company has agreed to pay them. These will normally be found in your contract or staff handbook. Another alternative is that you begin your maternity period sooner than expected. Employers can insist that this happens if you are off work for a pregnancy-related illness during the four weeks before your baby is due. In this instance your maternity leave and Statutory Maternity Pay will start automatically, regardless of what you had agreed with your employer.

2. Maternity leave

You have the right to take up to 52 weeks maternity leave.

Ordinary Maternity Leave (OML)

OML is the right to 26 weeks leave from work with the right to return to the same job at the end of it. Please see below, or refer to your contract of employment for confirmation as to whether you are entitled to have this as paid leave. All female employees are entitled to OML from day one of their employment. It does not matter how many hours you work or how long you have worked for your employer.

The earliest you can start your ordinary maternity leave is 11 weeks before the expected week of childbirth. You can change the date on which you wish to start the maternity leave with 28 days' notice to your employer.

Additional Maternity Leave (AML)

This is an "extra" period of 26 weeks of maternity leave to which an employee is entitled on top of the 26 weeks of ordinary maternity leave. It starts the day after the OML ends and expires by 52 weeks after the birth at the latest. Depending on your contractual rights and/or service, you may be entitled to up to 13 weeks maternity pay during this period.

An employee who returns to work during or at the end of her AML period is entitled to return to the same job on the same terms and conditions of employment as if she had not been absent. However, if it is not reasonably practicable for an employer to do so it should offer a position that is suitable and on terms that are no less favourable.

3. Maternity pay

To help you to take time off work before and after your baby is born, you may be able to claim Statutory Maternity Pay (SMP). This is a weekly payment from your employer. You may also be entitled to contractual maternity pay in addition to this and you should check your contract for details.

To qualify for SMP, you must have been:

- Employed by the same employer continuously for at least 26 weeks into the 15th week before the week your baby is due
- Earning an average of at least £107 a week (tax year 2012-2013).

If you qualify for SMP, it is paid:

- For the first six weeks at 90 per cent of your average gross weekly earnings with no upper limit
- For the remaining 33 weeks at the lower of either the standard rate of £135.45, or 90 per cent of your average gross weekly earnings.

4. Protection against unfair treatment or dismissal

Under the Equality Act 2010 it is unlawful for an employer to treat you less favourably because of your pregnancy or because you take maternity leave.

You will continue to accrue your statutory and/or contractual annual leave entitlement throughout your maternity leave and you should not feel obliged to take it as part of that leave. You can take any accrued holiday you have earned for the holiday year in which your maternity leave commences before you start that leave. On your return you will be entitled to the full amount of holiday pay you have accrued through the remaining part of that year, in the year in which you return.

You are also entitled to receive a pay rise or other improvements to your terms and conditions given to other employees in your grade or class of work. Your employer should also consult with you during your maternity leave about any proposed changes to your job in preparation for your return.

If your role is made redundant because you are pregnant or have taken maternity leave you can make a claim for unfair dismissal and sex discrimination.

Other considerations

'Keeping in Touch' days

Once on maternity leave you can work up to ten days during your Statutory Maternity Leave without losing your Statutory Maternity Pay or ending your leave.

These are called Keeping in Touch days and may only be worked if both you and your employer agree. They should make it easier for you to return to work after your leave and you will need to agree with your employer what work is to be done on Keeping in Touch days and how much pay you will receive.

KIT days do not have to be consecutive, and days of work will not extend your maternity leave period. You are also protected from dismissal and detriment for refusing to work during maternity leave.

Giving notice of your return to work

If you wish to return earlier than your expected date of return you must give at least eight weeks' notice. If you do not, your employer can insist that you do not return until your previously agreed date.

If you decide not to return to work at all, you must give your employer notice as per your contract of employment.

Flexible working

To help you balance caring for your child and work you can make an application to your employer for flexible working, stating your case. The employer is not obliged to provide you with such a working pattern but must give sound business reasons for denying you the request. If on appeal your request is still denied you cannot make another application for at least one year. Parents of any children aged 16 and under, or of disabled children aged 18 and under, are entitled to request a flexible working pattern.

Look out for the follow-up articles in this series on paternity rights, shared parental leave and flexible working.

PDA survey highlights potential income gap

With the economy emerging from a significant double dip recession it is no surprise that the purse strings of the treasury are much tighter than they have been in the past regarding state benefits. Statutory Sick Pay is no exception to this rule... but how many of us now know the current level of this benefit?

Add to this that the days of 6 months' full pay and 6 months' half pay are long gone for most employees, as more and more employers cut back on staff benefits such as levels of sick pay and the issue of receiving an income that you can live on if unable to work due to ill health or accident becomes more of a priority.

In conjunction with Not for Profit Insurer PG Mutual, the PDA has recently conducted a survey of our members to examine levels of awareness regarding this issue.

In essence at least 83% of respondent's income is crucial to their household budget.

PDA Member Surveys 2011/12

The findings of our survey confirmed that over 68% of respondents earn in excess of £30k per annum however of significance is that 65% of respondents also represent the main income earner within their household and a further 18% are equal contributors. In essence at least 83% of respondent's income is crucial to their household budget. The question for people to consider therefore is what would be the impact on their family if this income were to be taken away?

The results from our survey highlight a significant issue with 42% of respondents confirming that at present they would receive only state benefits if they were unable to work, although 76% of respondents confirmed that they are unaware of how much they would receive. More worryingly a number of respondents indicated that at present they would consider working through any period of illness to ensure their income did not suffer, a potentially serious issue considering the critical nature of Pharmacy.

Let's remove some of the uncertainty for you: If you are employed, after 3 days of absence from work you would be entitled to receive Statutory Sick Pay^(SSP), through your employer. The current level of SSP is set at £85.85 per week and lasts for a maximum of 28 weeks. If you are still absent from work beyond this time then you will now be at the mercy of the benefits system to ascertain what, if anything, you are entitled to moving forward. The level of SSP therefore, and this needs to be made clear, is not in any way related to your normal earnings. If we take a salary of £30,000 which represents a take home salary of approximately £2,000 per month after tax, this would mean that during a period of ill health and absence from work your income would drop by 81% down to just £372 per month.

There is more confusion surrounding our self employed respondents, a number of which are under the impression that they would not receive any state support. In reality, if you are self employed, and provided your N.I contributions are up to date, then you do not qualify for SSP but instead would have to apply for Employment Support Allowance (ESA^). The level of ESA is currently set at £71 per week resulting in a drop in income, from the example above, of 85% down to just £307 per month. With ESA comes a degree of qualification that the state can use to ascertain if an individual really isn't fit enough to work. This would potentially require a claimant being checked out by an independent doctor who will check to see if the individual is fit for work and this may be judged against any form of work not necessarily a complex and professional role as seen in Pharmacy.

With little or no help from the state and so many people now in a position of little assistance from their employer (42% no cover, 10% up to 1 month maximum and 27% unsure to what extent their employer will help them), why is it that Income Protection is still only utilised by the minority to protect their own and their family's lifestyle?

"The one protection policy every working adult needs in the UK is the very one most of us don't have – Income Protection."

Which? magazine 2012

Which? magazine in January 2012 stated "The one protection policy every working adult needs in the UK is the very one most of us don't have – Income Protection." After all, the simple premise is that without an income how could you pay for the essentials of life let alone items such as insurance policies and pensions etc?

Almost a fifth (19%) of respondents do not see the need for income protection or consider that as they have never been ill that they never will be, however data suggests those who are never going to be ill are actually few and far between.

- More than 1 in 3 people will develop some form of cancer during their lifetime.*
- It is estimated that the total number of road casualties in Great Britain is around 730,000. This includes an estimated 80,000 people who are seriously injured.**

Almost a quarter (23%) of respondents highlighted the cost of cover as an issue and it may well be the case if you are looking to take out the maximum levels of cover available to you (normally between 60 – 70% of Gross Income), that the cost appears to outweigh the potential benefits.

Even those who take out such protection often automatically look to put as much cover in place as possible without first considering the actual cover they would need. Although minimal state benefits can be received – and bearing in mind that if you can't work your lifestyle will change to accommodate this – it is unlikely that many of us would need the maximum level of cover available; so you might want to consider a budget based approach? Work out the level of monthly contribution you could afford to protect your income and find out how much cover you could get for your budget, there are many ways to alter the premiums in line with your budget and providers are more than happy to discuss options with you to tailor a suitable level of cover around your budget. Most creditors would be more responsive to a borrower that is able to make proportional payments to one that makes none at all.

Many of us work and study hard in order to gain employment status that gives us an income which provides a comfortable lifestyle. Becoming ill or having a serious accident through no fault of your own can put all that effort in jeopardy – which is why it is so important to have the right cover in place.

The PDA has reached the conclusion that Income Protection is a serious consideration for any pharmacist in the modern world, especially when considering how some employers treat illness. That is why it has approached PG Mutual and has negotiated a significant premium discount for PDA members which lasts for 3 years. Visit www.pgmutual.co.uk (using discount code PDA2011) for more information to obtain the detail you need to make an informed judgement.

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Key Indicators:

- 68% of respondents earn in excess of £30k
- 65% of respondents are the main income earner in their household
- 42% of respondents rely solely on state benefits for sick pay
- 76% of respondents are not aware what the level of state support is
- 23% of respondents state that the cost of cover is a barrier

Sources

1. PDA member surveys 2011 and 2012
2. ^ DWP website, November 2012
3. * CancerStats Briefing (May 2012)- Cancer Research UK web site, November 2012
4. ** RoSPA web site, November 2012

Primary care rebates on medicines – some common sense principles

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Financial challenges

With unprecedented financial challenges, NHS organisations will continue to be under pressure to work differently to improve productivity and this is where the prescribing budget will be under pressure. However, efforts of primary care pharmacists over the last 15 years or so mean that most of the low hanging fruit has already been picked. Technology in the form of decision support and integrated information systems can enhance effectiveness and efficiency, but with patient choice and access to new high cost medicines a political imperative, it is unlikely that these alone will be enough to meet the challenges ahead. Many primary care organisations (PCOs) are turning to commercial deals with pharmaceutical companies and other suppliers to add a new dimension to their cost-saving activities. The PDA is aware that some approaches to the management of rebate schemes have attracted problems for both pharmacists and the PCOs involved; consequently this feature explores the governance requirements that should be considered.

Are rebate schemes ethical and legal?

Rebating in its simplest form can be seen as a means of providing a discount to PCOs. The concept relies on the PCO claiming money back from the supplier based on how much of a product has been dispensed at a pre-agreed value per pack. The Department of Health has advised caution, citing the Pharmaceutical Price Regulation Scheme agreement which states that UK Health Departments do not support schemes outside of the PPRS in primary care, but at the same time they acknowledge some of the potential benefits urging PCOs to seek a local legal opinion. The practice of rebating is relatively widespread, however, whilst many such rebating schemes are undertaken in an ethical and transparent manner, some, on paper at least are not. Additionally, since there is a flow of money from manufacturer to PCO, the practice of rebating brings with it a new set of risks for both primary care pharmacists and ultimately for the PCO and these risks need to be managed. Getting it wrong could result in accusations of accepting or requesting bribes or inducements, offering illegal inducements to prescribers or making decisions without due process. Pharmacists involved in rebating schemes are urged to consider the common sense principles enclosed.

Guiding principles for managing rebates

1. **Do not link commercial deals with decision making** – Anecdotal evidence exists which shows that either NHS organisations ask for, or suppliers offer rebates in return for preferential place on formularies. Any decisions relating to formularies, guidelines, competitor products or responses made to rebate offers while discussing or negotiating commercial arrangements with suppliers or their agents should be avoided.

2. **Consider keeping commercial and clinical advisory functions separate** – Many pharmaceutical companies keep commercial, medical and promotional functions separate and there are some very powerful (ABPI code) 'compliance' reasons behind this. Medical departments provide non-promotional clinical information as well as overseeing many sales and marketing activities from a governance perspective. Commercial teams are experts in commercial law and practice. A similar differentiation in NHS organisations is advisable, with a separation of those individuals managing rebates from those preparing, discussing and managing formulary submissions. Even if this were not feasible, as a very minimum a pharmacist involved in formulary or guideline decisions should transparently declare their involvement in any rebate negotiations.

3. **Maintain robust decision making** – The NHS constitution requires organisations to make decisions regarding funding of medicines and other technologies in a robust and transparent fashion. Rebate deals could be viewed simply as a price adjustment mechanism; that seems reasonable and would allow for rebate adjusted prices to be considered alongside established factors such clinical effectiveness, safety and tolerability, and patient choice and convenience. However, organisations are urged to consider the risks and benefits specific to rebate schemes such as longevity, deal structure and any risk sharing parameters. It is also imperative that rebate scheme discussions do not place a disproportionate influence on the overall decision making process, or worse, allow it to be bypassed altogether.

4. **Maintain a level playing field with suppliers** – When rebates may have a strong influence on formulary positioning, it is important that other suppliers do not perceive that they have been blocked from seeing decision makers. There are examples of manufacturers taking NHS bodies to judicial review over decision making in relation to medicines use. Furthermore, a legal precedent could be seen by suppliers as a solution to the on-going problems that some of them perceive as not being able to access primary care decision makers. However, it is also advisable to avoid setting up a quasi tendering approach whereby all suppliers of a particular class of medicine are invited to submit rebate offers. A tendering process is something altogether different and is subject to a very specific and well defined process.

5. **Maintain commercial confidentiality** – Most manufacturers will demand that their rebates are kept confidential, as they are commercially sensitive Consideration needs to be given to how this will be achieved in practice, including how requests for disclosure under the Freedom of Information Act will be managed.

6. **Adopt the DH guidelines for switching** – Where a rebate scheme might prompt a switch programme, it is important that this is managed in accordance with DH guidance contained in 'Strategies to achieve cost effective prescribing.'

7. Adopt robust organisational policy and oversight – With large sums of money and additional risks involved, adopting an oversight policy specific to rebates is recommended. This should include governance arrangements and an oversight mechanism. Of particular importance is how the organisation ensures that perverse dynamics are not introduced into the decision making process at either policy (formulary and guideline) level or clinical level. Rebates should not benefit those in control of them without robust oversight. Performance management of individuals involved in rebates should be carefully considered and prescribers should not be able to benefit directly from their clinical decisions. For example, when medicines management teams or GP services are funded or expanded through rebates - oversight at Finance Director level, with input from others not involved with prescribing, e.g. lay stakeholders would be appropriate. Recognising the potential risks involved has led some PCOs to consider the use of specialist third party organisations to either undertake the rebating scheme in its entirety on their behalf or simply to provide certain specific functions such as data management. As well as providing expertise and delivering an economy of scale, such a third party arrangement can also deliver the proper separation of clinical and commercial considerations.

As more experience is gained with rebates, it is expected that good practice will further evolve. In the meantime we recommend a carefully considered and common sense approach. These principles provide a starting point only and are not a substitute for a local legal opinion.

Two scenarios are provided. One is good practice, the other is not so good. Can you spot the difference?

Scenario 1	Scenario 2
Pharmacist A meets with manufacturer X to discuss product P.	Pharmacist A meets with manufacturer X to discuss product P.
Pharmacist A asks manufacturer X for a 20% rebate on product P in return for first choice place on the formulary ahead of manufacturer Y and product Q.	Manufacturer X offers a 20% rebate on product P. There is no mention of formulary position or competitor products.
Manufacturer Y requests an appointment with pharmacist A but is refused.	Manufacturer Y meets with pharmacist A and offers a 15% rebate on product Q.
Pharmacist A takes the offer to the Area Prescribing Committee, arguing superior clinical properties of product P, and a good rebate deal. His recommendation that it is positioned ahead of product Q is accepted.	Pharmacist A briefs pharmacist B on the deal offers. Pharmacist B takes these to the Area Prescribing Committee, together with a clinical review of the two products. The committee decide that each product should be on the formulary with clinical factors and patient choice being used to determine which product should be prescribed.
A year later a rebate of £150k has been received in relation to prescribing of product P. Pharmacist A has been actively promoting a switch to product P from product Q.	A year later rebates totalling £150k have been received in relation to prescribing of products P and Q. Pharmacist B has been promoting the formulary position as above.
Pharmacist A manages the rebate fund and invests the £150k into a team of practice pharmacists, on the basis that they will make further savings.	The rebate fund is managed by a committee chaired by the Finance Director. The committee receives a bid from pharmacist B to expand his team. It is approved.

WHAT WILL NHS REFORM BRING?

As a primary care pharmacist, you have never yet had to contemplate the phasing out of PCOs. So how can you best protect your interests?

The government's proposals on NHS reform are more far reaching than anyone imagined. In England CCG's are to take over the roles of PCOs. The changes are already taking effect and this has caused uncertainty and stress. As a Union, the PDA will stand by primary care pharmacists who may be affected by changes.

Handling more than 4,000 incidents each year, the PDA has considerable experience of dealing with often difficult employment situations.

We will do our utmost to ensure that the individual contractual employment rights of members are protected and also, strategically, we will seek to identify and then exploit any new opportunities that may emerge for the benefit of members.

The full extent of what the NHS reform will bring for primary care pharmacists is as yet unknown, but it is inevitable that the process will not be without stress. However, members can be assured that the PDA will do its utmost to ensure that their interests are protected.

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