hospital pharmacist edition

the magazine of the pharmacists' defence association

insight

summer 2006

THE WAY FORWARD

FIND OUT WHAT HAPPENED AT THE PDA'S ANNUAL CONFERENCE IN OUR SPECIAL 4-PAGE REPORT

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editorial.

by Mark Koziol, PDA Chairman.

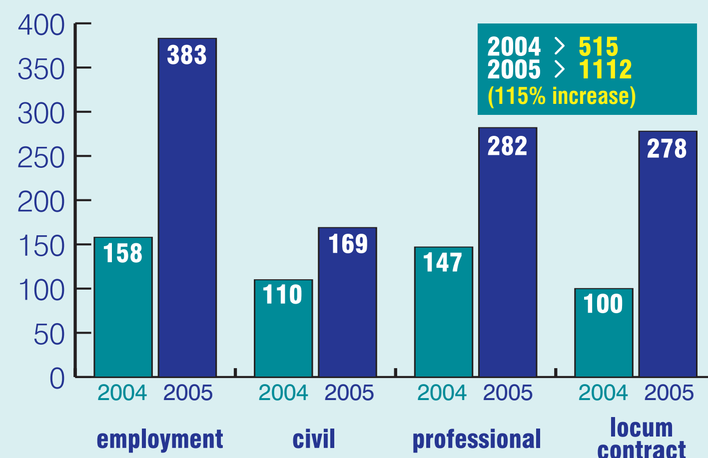
THE PDA NOW HAS MORE THAN 11,000 MEMBERS…

There has been a massive increase in the number of cases that the PDA has dealt with. Also, the range of services available is coming to be more widely relied upon by members. As the figures indicate, the number of incidents handled by the PDA during 2005 rose to 1,112; this is a 115% increase over 2004. Moreover, in 2004, one in 17 members turned to the PDA for support because of a problem; in 2005, this rose to one in 10.

On average, during 2005, the PDA was notified of approximately four new cases every day. Many of these required extensive support and advice from the in-house pharmacists and legal specialists; others would have had the support of lawyers, specifically taken on to handle individual cases that were of a more serious or complex nature.

What is also apparent, is that the problem of disputes between employers and employees and locums is worsening. The percentage of all incidents in this specific area rose to 58% (661 individual cases) in 2005 (see graph). **Surely, these statistics show very clearly that any employee or locum who still believes that the Clinical Negligence Scheme for Trusts (CNST) will always protect them must seriously think again.**

The best way of providing defence for members is not just by treating the symptoms, but also by dealing with the causes. To this end, at its annual conference, the PDA announced a number of its intentions for 2006. These include the launch of the PDA's staffing levels policy and lobbying parliamentarians as to the dangerous effects of remote supervision – the plan to operate a pharmacy in the absence of a pharmacist which appeared in the new Health Act. The PDA also launched an important new project: to develop an individual pharmacist NHS contract to enable pharmacists to contract directly with the NHS without the need to own a pharmacy.



Finally, the PDA has also made clear that because of changes in the roles and responsibilities of pharmacists, it would be undertaking comparative research to establish a fee and salary scale structure for employees and locums which will be published later in 2006.

More information about the PDA's activities is contained inside this edition of Insight.

Perhaps, with such a busy programme, there should be little surprise that in January 2006, the membership of PDA passed the 11,000 mark.

Mark Koziol, Chairman, the PDA

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Don't forget!

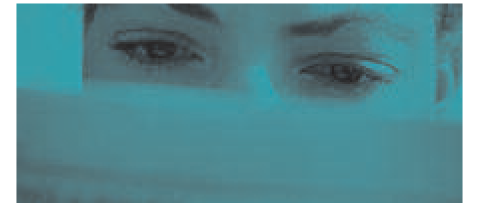
You can download the Insight online

www.the-pda.org/publications/pub_insight1.html

On the cover: PDA Director, John Murphy welcomes the delegates to the annual PDA conference.

news

Find out what's happening in pharmacy



The PDA calls for a more "strategic approach" to disciplining of pharmacists

The PDA has written to the Secretary of the Infringements Committee expressing its concern regarding the perceived inequality between sanctions it applies to individual pharmacists and to a body corporate or superintendent pharmacists following the due disciplinary processes.

In the letter, Mark Koziol, the PDA Chairman, points out that there are many contributory factors that may be outside the control of the individual pharmacist under investigation, which may include:

- Unacceptable staffing levels, excessive workloads and lengthy working hours
- Sub-standard technology and poor dispensary layout
- Demands placed on pharmacists by patients and employers for speed of service at the expense of accuracy and the relevant compliance information

"It is our experience," explained Mark, *"that the focus of most investigations is predominantly on the person who is in charge and a disproportionately small amount of time is spent on the effect of the environment and the person or organisation that is responsible for it."*

The PDA is also bringing to the attention of the Infringements Committee Chairman, that there are an increasing number of situations where an employer or its representative, antagonises a member of the public with tardy or inappropriate responses to complaints resulting in a referral to the RPSGB. Mark continued to express his exasperation when he pointed out to the Committee that, *"It is the pharmacist who made the error, who had no opportunity to diffuse the complaint, who faces the RPSGB's disciplinary processes, not the employer whose behaviour initiated the complaint."*

The PDA contends that the narrow focus that is sometimes a facet of current pharmacy regulation does not lead to a proper understanding of the causes of errors nor appropriate corrective action being taken.

The Association calls upon the RPSGB to take a much more strategic view in its regulatory investigations and that it concerns itself far more with trying to treat the causes of errors rather than focusing on disciplining individual pharmacists.

"This approach will not only be more in the public interest, but will also be in the interests of fairness and transparency," said Mark.

Mileage claim: locum arrested at instigation of employer's security staff

Security staff illegally detained a pharmacist against her will who was working in a pharmacy. She was forcibly searched and then the police were called. The security staff alleged that she had 'obtained money by deception' when they deemed her claim for mileage to be excessive.

Before this disturbing incident, she was contacted on her mobile phone by a pharmacy, while staying with friends away from home. She was asked if she would go to their outlet immediately for two days because the regular pharmacist had phoned in sick. As is normal practice, she submitted her mileage claim during the day she was working and estimated the return mileage as accurately as she could. She simply doubled the one-way mileage to cover the return journey to where she had come from, which was perfectly reasonable to do under the circumstances.

When the pharmacist was challenged and told that according to the employer's mileage policy she had over-claimed, not wanting any fuss (and with hindsight perhaps rather naively), she offered to pay back the difference demanded (between the home-to-pharmacy and the true distance travelled) without question.

The consequence was that she was initially arrested and taken to the police station. However, her behaviour was clearly not criminal as there was no dishonest intent, vindicated by her rapid release from custody without charge or further action by the police, following a taped interview, in accordance with the Police and Criminal Evidence (PACE) Act 1984. Neither was the pharmacist's behaviour unprofessional – her expenses claimed simply reflected the mileage travelled. Strictly speaking, the dispute between the contractor and the locum was of a purely civil nature, being no more than one of contract law. The pharmacy has since issued a 'banning order' on her entering any of their shops in the UK, claiming that if she does so, she will be dealt with as a trespasser and the police called.

{ The actions taken by the employer were wrong and unjust }

"She had made no written contract and had never discussed the exact basis for her travelling expense claim – this often happens in emergency bookings of this nature. Just because her claim did not comply with the employer's policy does not in any way make it criminal or unprofessional. Even had the policy been explained to her, she was perfectly entitled to re-negotiate it. The chemist contractor cannot impose its terms retrospectively," said John Murphy, Director of the PDA

"The actions taken by this employer were wrong and unjust; we feel very strongly about contractors using intimidating, unwarranted, disproportionate action when faced with a simple contract dispute. It is vindictive, potentially defamatory, uncalled for and entirely unnecessary. The PDA are taking legal advice and contemplating civil action against the employer for assault, wrongful detention and damages to her reputation, as well as reporting the contracting company conducting the retail pharmacy and its superintendent pharmacist to the RPSGB for bringing the profession into disrepute"

resources:

PDA's legal counsel has provided advice for pharmacists who face this type of dilemma, which you can obtain via the PDA website home page on www.the-pda.org

www.the-pda.org

news

'Remote supervision' is not in patients' best interests

The PDA mobilised a campaign after a Government proposal to allow remote supervision, the plan to allow a pharmacy to operate in the absence of a pharmacist that appeared in the newly proposed Health Act.

The possibility of allowing one pharmacist to supervise more than one pharmacy is also being considered.

The PDA has grave concerns about these proposals as they will impact on patient safety issues.

Hundreds of PDA members completed an online questionnaire, showing that they are alarmed by these proposals and the PDA has issued a resource pack to enable PDA members to write to their local MPs.

Meetings about remote supervision are also being held. The PDA has been invited to meet with the Department of Health and meetings have been held at the Houses of Commons and Lords, where the PDA has successfully solicited support.

PDA active at the Houses of Parliament

The impact of the PDA's activities has already produced results. During the second reading of the Health Bill at the House of Lords, the views of the PDA were considered and searching questions have been asked of the Government.

In the debate, Baroness Murphy said:

"It seems to me and this has been raised by the Pharmacists' Defence Association too - that the provisions [relating to remote supervision], if not properly implemented, may have the unintended consequence of lessening the public's access to a community pharmacist.

The primary role of the pharmacist is to ensure the safe sale and supply of medicines in the pharmacy, and he or she is uniquely qualified to do that. The PDA deals with the many dispensing errors and near-misses, and knows, even though 80 per cent of medicines are now pre-packed and bar-coded, that drug errors still occur; and that technicians and dispensing assistants are not equipped to cope with an unexpected incident where an intervention may have to be made quickly to avoid harming a patient. The prolonged absence of a pharmacist will undoubtedly leave many decisions to assistants and technicians.

It looks as if it could be possible under these proposals for a pharmacist to supervise more than one pharmacy at once, by being officially in one pharmacy and providing cover remotely as a supervisor at another. I fear that companies with several pharmacies will simply reduce the number of qualified pharmacists they employ in some areas. The commercial reality of the pharmacy industry in inner-city areas, and in some remote rural areas where there are already recruitment problems and great difficulty in finding locums, could lead to the creation of a two-tier system of well staffed and poorly staffed pharmacies."

Baroness Barker added her concerns:

"The proposals to change the control on supervision of pharmacists, as the Minister has said, are the subject of some concern. Pharmacists play a very important role in talking to patients and checking for adverse drug reactions. To do that, pharmacists need face-to-face interaction with the people they serve. The proposal that registered pharmacists may oversee more than one pharmacy has caused some concern."

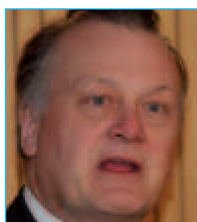
Baroness Murphy formally tabled some questions to the Government:

"How many hours will a pharmacist have to spend in the pharmacy per day or week or month in order to be designated as a responsible pharmacist? Has that been considered with regard to patient safety? Will the Minister explain how regulations can be, as it says in the Government's Health Bill information paper, tightly drawn to ensure that the absence of a pharmacist will be permitted only in specific and defined exceptional circumstances, yet designed to ensure the responsible pharmacist has sufficient time and flexibility to offer other services away from the pharmacy? How can a pharmacist supervise a remote pharmacy over extended periods without compromising safety? How long might he be away for?

What about pharmacies that open 100 hours a week or more to satisfy the exemption from control of entry regulations to NHS prescribing status? Can we be reassured that there will be one responsible pharmacist for every community pharmacy? Will the Minister clarify under what circumstances a responsible pharmacist could supervise more than one pharmacy? Finally, what is the remote pharmacist permitted to do when he or she is away from the pharmacy? I hope, because this is one of my fears, that it will be providing healthcare rather than simply driving around town between his six other pharmacies".

The PDA is now anticipating written answers to these questions from the government and intends to elaborate further upon its concerns when these are received.

MP Mark Todd shows support for pharmacists



Mark Todd, MP for South Derbyshire, shared his views on the potential of pharmacy with the Young Pharmacists' Group 20th Annual Conference at the end of February.

Mark is an enthusiastic advocate of pharmacists, demonstrated by the fact he is Secretary to the All-Party Parliamentary Group on Pharmacy. In his presentation to the conference he highlighted the Government's 'choice' agenda as a driver for pharmacy development. The diverse location of pharmacies and the development of the electronic prescription service would both allow consumers to exercise more choice in obtaining healthcare; likewise the development of pharmacist and nurse prescribing offered considerable potential benefits.

The pharmacist's role in the support of self-care would be an increasingly challenging and important one if the profession grabbed the opportunities presented by the management of long-term conditions.

He went on to outline the public support for a wider role for pharmacy that had been highlighted in the recent White Paper consultation. Primary care trusts have a key role in promoting the new pharmacy services to the public and in commissioning services at a local level to meet the needs of the population. The future was bright, but the profession has to rise to the challenges that were outlined in the White Paper.

news

PDA responds to the 'Code of Ethics Review' consultation

The PDA recently made a submission to the Royal Pharmaceutical Society's 'Code of Ethics' review process in response to the direct question 'what do you believe are the limitations of the current code?'. The Association considers that it is not clear enough to be able to support the professional autonomy of pharmacists in situations where line managers are non-pharmacists and a conflict between line management responsibility and professional responsibility emerges. This issue, it contends, will become even more apparent when the newly proposed model of 'responsible pharmacist' replaces the current model for supervision and personal control.

The Association was also critical of the fact that the current code is very orientated to community pharmacy and also to situations where pharmacists deal directly with patients. Increasingly, many more pharmacists are not in patient-facing roles. Any new code needs to ensure that it is appropriate in a wide range of settings.

In a substantial document, the Association systematically addressed the questions that the Society put to a wider constituency, which included ''What do you like about the current Code of Ethics?', 'What is no longer relevant?' and 'In what areas are specific detailed guidance required?'.

Omissions to the current code, according to the Association's submission, include the fact that pharmacists should not allow situations to exist where commercial principles can override the interests of the patient. The Association also wants more emphasis to be given to the notion that at some stage pharmacists will, in their professional judgment, need to act outside the edicts contained in service specifications. The Code needs to articulate that pharmacists may do this, aware of the fact that they will be called to account for their actions.

In addressing the issue of principles that should be included in the Code, the Association expects one of the core principles to be that pharmacists are treated with dignity and respect by other pharmacists, especially in master-servant relationships. This principle must also extend to the treatment of pre-registration students where the completion of potential pharmacists' professional training is dependant upon fair treatment by the tutor and/or employer.

The PDA is specific in its belief that the introduction of a new Code must be undertaken using transparent and proper constitutional mechanisms such as a general meeting of the RPSGB.

Concern over medicine use review 'targets'

Some employee pharmacists are having difficulty in coming to terms with their employers setting them performance targets for the number of MURs they should complete each day or each week. One pharmacy superintendent wrote to pharmacists implying that they were failing to take their professional responsibilities seriously, by not completing their targeted number of MURs. Some employers are insisting that pharmacists also complete domiciliary visits.

"Conducting MURs is an important stepping stone in developing the role of the community pharmacist," said Mark Pitt, PDA Membership Services Manager. *"I can understand that employers may have concerns that too few are being completed to generate income for advanced services, but targeting pharmacists to deliver unrealistic numbers, with the implication that there will be sanctions if they don't, is counter-productive."* Of more concern is that a number of non-pharmacist area managers are setting totally impracticable targets for delivering MURs, without having any comprehension of the risks this can place on both pharmacists and patients.

The PDA has learned that many pharmacists, who wish to complete more reviews, feel they are restricted from doing so, due to insufficient qualified support staff, or because of the pressure, they are under to deliver core NHS services.

The PDA recommends that pharmacists consult with their employers to ascertain the most appropriate time for planned interventions at quiet times and if necessary, the additional support they would require from trained staff or other pharmacists.

The service specification states that MURs should be conducted primarily in a community pharmacy environment. MURs completed in other locations should have the prior approval of the Primary Care Organisation (PCO).

Job opportunities at the PDA in Birmingham

Looking for a role that is different but professionally rewarding?

Due to continued growth of the PDA, we are looking for several pharmacists to join the PDA team to assist with the further development of services.

Part-time advisors

We require two part-time pharmacists to join our existing pharmacists and lawyers in providing telephone advice services to PDA members.

You are:

- Experienced in the practice of your profession
- Confident in your telephone manner
- Sympathetic to the needs of professional colleagues
- Willing to work as part of a team

Full-time PDA teacher practitioner

We are also looking for a pharmacist to develop the PDA's risk management agenda at both student and qualified pharmacist level.

You are:

- A well organised self-starter keen on meeting people and not averse to travelling around the UK on a regular basis
- Experienced in arranging meetings and organising speakers and delegates
- Confident when giving presentations and have good written skills
- Able to demonstrate effective influencing and ambassadorial skills

For further information please contact:

John Murphy, Director
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email enquiries@the-pda.org

The PDA policy on staffing levels and rest breaks

Richard Flynn, a member of the PDA advisory board, announced a policy initiative at the PDA Annual Conference in Birmingham on Sunday 26th February.

Given the unique impact of medicines upon the public, and in particular, the harmful effects of errors if they occur, the PDA believes that a much more practical system of ensuring appropriate staffing levels and rest breaks should be in place. Moreover, the PDA believes that the regulatory authorities should play a greater pro-active role in enforcing such safety standards.

Current working practices

There are no nationally agreed standards for both staffing levels and working hours for pharmacies in the United Kingdom. Unlike in other industries, historically, the regulatory bodies have felt that staffing levels and rest-break issues are largely contractual matters between employers and employees. Consequently, they have not dealt with the specific practicalities of safe staffing levels and working hours in anything other than a very general way.

Currently, the requirement placed on pharmacy owners, superintendents and pharmacist managers in hospitals as stated in the Medicines Ethics and Practice Guide, Vol 29, page 86 A.2, is:

(e) Not seek to impose conditions on pharmacists which may adversely affect their ability to comply with their professional and legal responsibilities

(f) To ensure that adequate support staff and information about the pharmacy are provided to enable all pharmacists including temporary staff and locums, to perform their duties effectively.

As a result, some employers have been able to develop policies that appear to be more influenced by cost-control strategies and less by a focus on patient safety issues and the avoidance of workplace stress. In the absence of a regulatory-led policy, what has emerged are a series of 'accepted working practices', which have been led predominantly by those who are concerned with cost control.

The responsible pharmacist

The newly proposed Health Act proposes the replacement of the concept of 'personal control' with that of the responsible pharmacist and it places a statutory duty on the responsible pharmacist to ensure the safe provision of medicines to the public. This will markedly change the balance of power. Whereas hitherto, the environment of a pharmacy was usually determined by an employer, now, the 'responsible pharmacist' will need to be able to exercise a much greater level of influence over the working environment and, in particular, over the staffing-level profile of a pharmacy operating under SOPs that are the pharmacist's direct responsibility. It is apparent that an open and transparent mechanism must be found to enable this to occur.

Richard Flynn

In the event that something goes wrong, such a system will be able to provide an audit trail and a solid mechanism that can underpin the 'responsible pharmacists' decision-making process in deciding to operate the pharmacy through SOPs.

It is against this background that the PDA believes that now is an ideal time to launch a national policy for staffing levels and rest breaks.

> **employers have been able to develop policies that appear to be more influenced by cost-control strategies and less by patient safety issues**

Setting a national industry standard

In most industries involving predictable workloads, standards have been developed for governing the ways in which people work.

For instance, the TUC has produced standards for staffing levels for manufacturing and other industries to ensure the safety of the work force. The Royal College of Nursing has also produced proposals in this area, while the government, through legislation, uses the tachograph system to police the working hours of the drivers of heavy goods vehicles to ensure the safety of both the drivers and the public at large.

In the industries where they are introduced, national standards promote greater safety for both workers and the public.

To address the problems, the PDA has launched its policy on staffing levels and rest breaks. This initiative has three aims:

- To raise awareness of the issues and problems caused by inadequate staffing
- To lobby for the acceptance of a national policy to address this undesirable situation
- To provide a process that enables pharmacists to manage, individually, unacceptably low staffing levels

The PDA Policy

The PDA will work towards ensuring that:

- A compulsory requirement is placed on every pharmacy to have a satisfactory staffing-level policy in place

Each pharmacy should decide its own staffing requirements and this would be based upon current good practice. Ideally, this initiative would be led by the responsible pharmacist, as the person that would take statutory responsibility under the new Health Act. The policy would need to be informed by issues such as workload, hours of opening, additional services being undertaken, and the quality and experience of staff. The proposed staffing level should then be negotiated and agreed with management so as to ensure that adequate resources are made available.

- The policy will outline the quantity of staff required to run the pharmacy safely
- The policy will include details of the quality of staff required in terms of the number of pharmacists, qualified technicians and unqualified assistants, as appropriate

The policy would need to be specific, itemising the actual number of staff required and at what times/days and also the number of pharmacists, qualified technicians and support staff the pharmacy requires to run safely.

- Details of the staffing level policy must be readily available to all staff working in the pharmacy

This information should be transparent to all pharmacy staff, and should be displayed openly for all staff to read. Importantly, the policy needs to be clear that it relates to staff required to ensure that the entire range of professional services provided by that pharmacy can be delivered safely. This means that the staffing policy relates to members of staff working in the professional/pharmacy areas of the pharmacy and does not involve staff who have been deployed to other non-specific pharmacy areas of the premises e.g., ward visits. (Unless this is at pre-agreed and specified times of low pharmacy activity).

The PDA has developed a template that responsible pharmacists may use to specify what will be an appropriate staffing level for their pharmacy, that they are happy to agree with owners.

- **All staff have an absolute minimum of one 20-minute break during each six-hour working period.**

In most industries where public and/or employee safety is at risk, standards exist for regular rest periods. For instance, drivers of heavy goods vehicles must take regular breaks. Working-time directive legislation places an onus on employers to ensure that employees are provided with at least a minimum rest break opportunity.

Using this existing legislative standard, the PDA is championing the minimum standard of at least one 20-minute break during every six hours in the pharmacy. Research has shown that many pharmacists are required to work through their breaks by either their management or through circumstance. Often, this means that pharmacists will attempt to take breaks while in the pharmacy so that they can still be available to undertake any routine activities that may be required of them.

The result is, that in many instances, pharmacists simply do not take breaks at all, working through break times in the belief that they are acting in the public interest.

The break proposed in this policy must allow the pharmacist a complete physical and mental respite from the activities of the pharmacy because such an arrangement will be more appropriate to the public interest.

- The regulatory authorities —the RPSGB and the relevant NHS bodies — place these requirements on all pharmacies

While the position of the responsible pharmacist will provide pharmacists with the legal basis to influence the staffing levels strongly, the acceptance of this policy by the RPSGB and other regulatory authorities such as local primary care trusts will ensure a rapid and wide take-up. The PDA will lobby the RPSGB and the DOH to ensure that staffing standards become recognised nationally and that they form the foundation of good practice throughout pharmacy in the UK.

How it will operate in practice

In the event that a responsible pharmacist — be that an employee or locum — becomes concerned that the staffing level falls below the pre-agreed levels, then he/she will be able to risk-manage the situation by pursuing a number of different avenues. This could be as simple as accepting that for a short-term temporary period, because of sickness or temporary absence, special measures may need to be put in place to ensure that patients can rely on safety, eg, by amending the SOPs. In other situations, such as the permanent resignation or long-term absence of staff through maternity leave or sickness, this may mean requiring the management providing extra staff. This may be done by writing formally to the management and requiring them to rectify the problems. In the worst case, such as a persistent disregard by managemnet for concerns about routine staff shortages, it may become necessary to involve the regulatory authorities on the grounds of public safety.

> The PDA believes their should be greater control on safety standards

This inter-relationship between responsible pharmacist, management and regulatory authorities should go a long way in delivering the staffing-level solution that has evaded the profession up until now.

synopsis:

The PDA is committed to the national implementation of its staffing levels and rest-breaks policy. The PDA strongly believes that its implementation will mean that understaffing and dangerous working patterns will be easier to identify and rectify, with the following benefits:

- Improved public safety
- Reduced stress because of more appropriate workloads
- Better working conditions for pharmacy staff

resources:

A full copy of the PDA staffing-levels policy to include all of the templates and sample escalation letters to management is available in downloadable format. Alternatively, the full policy and templates will be mailed to PDA members upon request.

www.the-pda.org

John Murphy and Mike Sobanja discuss unionisation with delegates

Duncan Jenkins - the individual pharmacist contract

BREAKING THE MOULD...

the second annual pda conference.

Unionisation - is this on the PDA's agenda?

Among the many hot topics at the 2006 PDA conference, the idea of unionising the PDA led to much comment from members

One of the highlights of the PDA conference was the lively debate on the issue of unionisation of the PDA. John Murphy, Director of the PDA and conference chairman, kicked off proceedings by outlining the good things that unionisation could bring, as well as the bad. Mr Murphy said that the PDA, with 11,000 members, is now the largest organisation with the potential of representing individual pharmacists. Of cases with which the PDA deals, 58 per cent are employment-related. He stressed that because of this, the RPSGB could never get involved in issues where it was defending the interests of one sector of its membership (employees) versus the interests of another sector of its membership (employers) and that a legal test case had clearly shown this to be the case (the Jenkins judgement). One of the issues for the PDA is that apart from a few who are enlightened, employers do not allow a PDA representative to be present at disciplinary hearings — a situation that is quite lawful. However, if employees are members of a union, they are entitled to have a union representative accompany them to any hearing. If the PDA was given union accreditation, then its members would gain this benefit.

Another advantage of unionisation would be that the PDA would be in the position of raising standards by scrutinising the actions of employers more closely. This would lead to an improved service to, and better protection of, its members. Moreover, there is a lot of money available to organisations affiliated to the TUC, given in the form of grants to develop the employee agenda.

However, there is still a stigma about professionals joining a union. Older pharmacists remember the bad old days of the 1960s and 70s when it seemed that the unions had too much power. Most people would not want to bring back that era.

Mr Murphy told the audience that the options were to: carry on as the PDA - unchanged; join an established union; become a listed union or staff association; become an independent trade union. Mike Sobanja, chairman of NHS Alliance, facilitated the resultant debate and took questions and opinions from the floor to gauge the feelings of delegates to the idea of unionisation. These are some of the opinions that members expressed:

"I do not want the PDA to become a union. Unions only get involved when there is a dispute. The PDA is more than this."

Another member disagreed with this view and said it was too narrow. If the PDA became a union, it would be able, not only to look after its members, but also engage in talks with many organisations such as the Society, PSNC and government. At the moment, there was no effective body to talk to Government on behalf of employee pharmacists.

One delegate asked the audience whether anyone felt that the Society itself could ever represent the individual pharmacist and this was met with derision and laughter.

John Murphy welcomes a full attendance to the event (above) while a delegate gets involved in the Q&A sessions (right) and RPSGB President, Hemant Patel, addresses the conference (far right)

Another delegate said that he wanted someone to explain what this "stigma about unions business" was. Although some may feel that unionisation will detract from pharmacists' professional standing, a union could give us the power and motivation. "If it helps, do it!", he said.

"If the British Dental Association and British Medical Association can be registered trade unions, why can't pharmacists also have a union?", said another.

"Now that the Society was going down the regulatory road, pharmacists needed a strong organisation that looked after their interests."

"Trade unions are very good and very powerful in negotiating salaries for members but it is not their role to deal with professional matters. There could be a conflict."

Some delegates sought clarification and questioned the costs and other practical implications.

"If the PDA becomes a union, will it still receive a grant from the PIA foundation?"

John Murphy and Mark Koziol were also challenged on their views as to which way the PDA should go. However, they said that they preferred to hear the views of PDA members.

"With the rise and rise of multiple pharmacies and the size of the NHS as an employer, the nature of pharmacy is changing dramatically. We need a union. If you are in an effective union, you get more respect."

"The PDA has given employees and locums a voice. Being a union would give it teeth with the employers."

The session allowed all members to have a say in the debate. At the end of the debate it was decided by general agreement that at this stage to have a vote or even to take a straw poll would be inappropriate. However, if the noise levels that came with the clapping from the audience was anything to go by, the majority of these delegates at least seemed broadly supportive. It will be interesting to watch further developments in this controversial area.

Remote supervision - A step too far?

Remote supervision was at the top of the list of topics discussed at the 2006 PDA Conference

Professor Joy Wingfield – Law and Ethics specialist, David Reissner – lawyer and Mark Koziol PDA Chairman expressed their views on this controversial new piece of legislation

Joy Wingfield, Professor of pharmacy law and ethics at Nottingham University reminded delegates that for 37 years, community pharmacists have been tied to their pharmacies because without their presence, the pharmacies could not operate. However, all this was about to change due to a proposal in the new Health Bill. One of the changes could be that, instead of personal control by a pharmacist, there would be a 'responsible pharmacist' who would have control of the pharmacy. Another proposal was that of remote supervision, the proposal to allow a pharmacy to operate in the absence of a pharmacist Professor Wingfield said that there had to be a limitation on the period of absence. *"It does not mean that the responsible pharmacist can be supervising from the Bahamas. He should be contactable and able to return to the premises promptly."*

Professor Wingfield argued "We must pause and think what it means in practice, not only for pharmacists, but also for customers and patients. "If pharmacists are not there in control, how will they be accountable? There is room for abuse and we are going to need to put in place risk-management processes".

"The proposed Health Bill has the appearance of being rushed. We must make sure that the regulations do not lead to the same sort of anomalies as already exist," said Mr Reissner, a lawyer with a special interest in pharmacy law.

The 1968 Medicines Act had defined personal control as pharmacists being on the premises so that they could supervise medicine supply and intervene when appropriate. As yet, the 2006 Health Bill has not defined what remote supervision will mean. Mr Reissner said *"We know that supervision of the sale of pharmacy-only medicines by CCTV had not proved satisfactory, but the rationale behind remote supervision is that it*

the exhibition:

Year on year growth…

Last year the exhibition that ran alongside the PDA Conference attracted seven companies and around 150 delegates. This year however, the numbers had significantly increased. Altogether fifteen companies took part in this years exhibition and they were visited by more than 400 delegates. Overall the exhibitor and delegate feedback on the exhibition was highly positive, with some exhibitors even taking orders for products from conference delegates. The event was bolstered by several events running concurrently, such as the YPG Annual Conference and the PDA/BPSA Pre-reg conference. This year, all proceeds from the exhibition went to the YPG Pharmacy Project – the YPG plan to buy and operate its own pharmacy.

The PDA will continue to develop its conference and exhibition programme in future years.

will allow pharmacists to spend more time with GPs and use their clinical skills. We do not know if the Act will allow absences for non-pharmaceutical or general business reasons."

The responsible pharmacist will still be responsible for all medicines, including GSLs. Mr Reissner then talked about responsible pharmacists and their duty to secure the safe and effective running of pharmacies. From a legal viewpoint, he believes that future liability for civil claims will not be very different from the present situation. "Of more significance," he said "is how the Society and Statutory Committee will view things when we have responsible pharmacists. When things go wrong, their knee-jerk reaction is to bring to the Statutory Committee the superintendent of the chain, whether it has 10 branches or 100. In future, when the statutory duty is on the responsible pharmacist, that is where the buck should stop." *Turning his attention to control of entry, Mr Reissner reminded the audience that*

One of the highlights of the PDA conference was the lively debate on the issue of unionisation of the PDA.

since April 2005, control of entry had been relaxed and pharmacies could open for 100 hours per week. "How will this tie in with the abolition of personal control?" he said. "If the Department of Health is not careful, the Act will drive a coach and horses through control of entry — pharmacies will be able to open for 100 hours a week but the pharmacist won't be there for those 100 hours!"

Mark Koziol brought the session on remote supervision to an end by summarising what the PDA liked and disliked about it. On the positive side, the proposals featured a clear indication from the Government, that it was keen to widen the clinical role of the pharmacist and also that it was keen to encourage a greater reliance on support staff. The concept of the responsible pharmacist, proposed in the Act, was excellent news for the individual pharmacist agenda according to Mr Koziol. *"The closer the responsibility of the pharmacist is to the patient, the better it is for the patient and for the pharmacist,"* he said. He felt that because the responsible pharmacist was to be given statutory authority for the safe supply of medicines to the public, that meant that, increasingly, it would be the responsible pharmacist and not the employer who would dictate the workplace environment. This would include staffing levels among many other issues. These added responsibilities would invariably lead to a significantly improved career structure and salary scale for pharmacists. Even the proposal on remote supervision found in the new Health Act had some positive aspects to it, in that it meant that certain problems such as handing out completed and bagged-up prescription medicines in the absence of the pharmacist could now be done, subject to an SOP.

However, according to Mr Koziol, the PDA is most concerned about other aspects of remote supervision which the PDA believes will be detrimental to patient safety issues. In particular, many near-miss drug errors could well become major incidents; furthermore, in the absence of a pharmacist, there would be many situations where members of the public would push staff members outside of SOPs and beyond their level of competence through insistence or desperation. The idea that a pharmacy could operate in the absence of a pharmacist for any extended period of time would actually reduce patient access to professional advice, even though it is intended that the pharmacist is contactable at all times through the use of modern technology. *"The idea that this should be done so as to enable the pharmacist's wider clinical role to be developed just makes no sense at all. Imagine a pharmacist who has gone to provide a service to an elderly patient at her home, starts to counsel the patient, but cannot complete the consultation because he is constantly disturbed by electronic devices requiring him to intervene in an episode at the pharmacy – this is the quickest way of ensuring that the wider clinical role for pharmacists fails the usability test. This has just not been thought through and could have very unwelcome consequences, not least of which is that others such as nurses will be deemed to be a safer bet for wider clinical roles,"* he said.

He added that by far the best way to develop wider clinical roles would be to use the large resource of primary care, prescribing, hospital and locum pharmacists to develop them, without the need to take simultaneous responsibility for a community pharmacy in their absence. Such an approach would be better for the profession and better for patient safety issues.

Finally, he told delegates that the PDA had mobilised a campaign to try and stop the worst

aspects of the proposals. He urged all PDA members to use whatever influence they had in their localities to bring these concerns to the forefront of the decision-makers' minds.

Individual pharmacist NHS contractors - a great opportunity

Announcing a major new strand of work for the PDA, pharmacist Advisory Board member and specialist in pharmaceutical public health, Dr Duncan Jenkins described the proposal to allow the development of individual pharmacist NHS contractors.

"The NHS brand is changing from bricks and mortar to providers of services, and we can play an increasing role," said Dr Jenkins, In his session, Dr Jenkins shared with delegates his belief that there are great opportunities in the NHS for pharmacists to work as individual contractors even though they do not have pharmacy premises. According to Dr Jenkins, NHS modernisation has given patients a choice. The new White Paper, "Our Health, Our Care, Our Say" shows that money will follow the patient. There will be a tariff structure that will extend into community services and drive competition forward. The main commissioning bodies will be the primary care trusts (PCTs) and Dr Jenkins believes that they will have greater flexibility. *"There is an increasing pressure for PCTs to stick to commissioning and relinquish their provider status. This provides an opportunity for the individual,"* said Dr Jenkins. He pointed out that the conventional activities of pharmacists are changing. They are now providing services that are more reliant on their intellectual and clinical skills rather than dispensing. 'A vision for pharmacy in the new NHS' stated that, "Local contracting will also make it possible for the first time for agreements to be made with individual named pharmacists, as well as pharmacy owners." In other words, it is not necessary to have a pharmacy in order to get a contract with a PCT.

He went on to describe why there were now so many opportunities for pharmacists to work as individual contactors. NHS reforms had certainly contributed but there were other factors as well. Population trends, such as an ever-increasing diabetic population, show that a lot of work needs to be done and pharmacists will need to be innovative to provide enhanced services. Workforce trends have led to a shortage of GPs and professional body erosion has given rise to pharmacist and nurse prescribing.

There were also threats, he said. Big organisations have more influence and can mobilise themselves better. This had happened with the nurses, who, through their professional body, were given the right to prescribe before pharmacists did. Inter-professional competition, marginalisation (pharmacists are not "one of the club") and lack of marketing and negotiating skills can all be seen as threats to pharmacists playing their part as individual contractors.

Dr Jenkins then went on to describe the forthcoming PDA development programme, much of which was already underway which is intended would lead to the facilitation and launch of the individual pharmacist contract.

Hospital pharmacists by virtue of their well developed specialities could have a big role to play in the development of the individual pharmacist contract, particularly, because there are many hospital pharmacists who divide their working lives between two or more sectors of the profession.

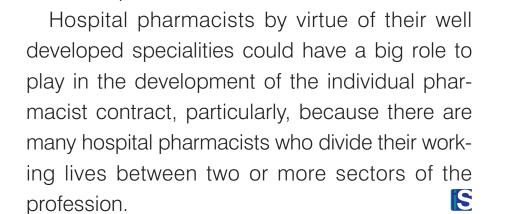
"During 2006, the PDA will be proposing a remuneration structure for employee and locum pharmacists.

The PDA Chairman, Mark Koziol gives his thoughts to the conference."

Guest speaker: Sally Gunnell

The PDA took great pleasure in welcoming Sally Gunnell, OBE, as the celebrity speaker. She is one of the UK's most popular athletes and is the only woman to hold four titles concurrently, as Olympic, World, European and Commonwealth gold medallist, in hurdling. The title of her talk to PDA conference delegates was "Sharing insight to challenge the norms." Using her own experiences, from the time as a 14-year-old when she first set herself the target of becoming a world-class athlete, Sally Gunnell gave a truly inspirational talk. She challenged the delegates when she said that they had to get out of their comfort zones in order to achieve their goals.

Although Sally Gunnell has now retired from the sports arena, she has a full life: she is a figurehead for the British Heart Foundation, writes and broadcasts regularly on television, as well as taking on new challenges. I am sure that Sally Gunnell motivated the pharmacists present with her focused and determined attitude to life.



What's new on the hospital scene?

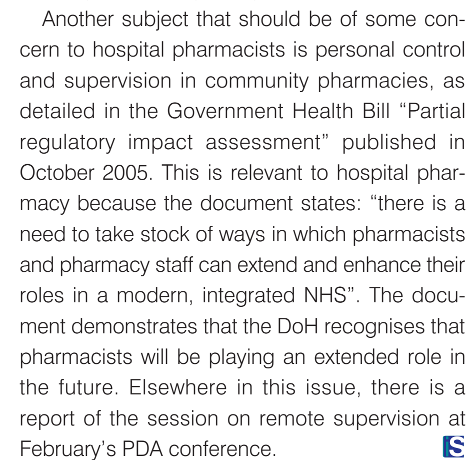
Last month, the government published the White Paper "Our Health, Our Care, Our Say" based on the outcomes of two consultations allowing the public to air its views on what it expected and wanted from the NHS and social care services.

At first glance, the White Paper appears to almost side-line hospitals: it states that the challenge will not be met by improving hospitals alone. The document also states that the Government intends to invest more resources in prevention and community health and social care than in secondary care. Hospital pharmacy is not mentioned at all but some sections of the White Paper give hospital pharmacists food for thought.

The White Paper has two main messages: that health services must be based around patients' needs and that the system must be shifted towards prevention. The Government's intent is to move care out of the acute hospitals and into new community hospitals, ie, from secondary to primary care. GPs, in consultation with their patients, will be able to commission hospital services closer to home. The government believes that medical advances now allow procedures to take place in the community that once could only take place in hospital. In the next year, such areas as dermatology, ear, nose and throat medicine, general surgery, orthopaedics, urology and gynaecology will be investigated to put in place clinically safe pathways within primary care. The cost of treating patients in the new community hospitals will cost one-third of that in secondary care, according to the White Paper. The Paper describes the new community hospitals as "state-of-the-art centres that will provide diagnostics, day surgery and outpatient facilities closer to where people live and work." Of course, there will still be a need for specialist hospitals; the plan is that the specialist hospitals will serve about 100,000 people and provide more complex procedures, for example surgery requiring general anaesthetic or providing fully-fledged accident and emergency facilities.

Evidence shows that among the benefits of community hospitals, they provide better recuperative care than district general hospitals. Local integrated care can also reduce the length of hospital stays dramatically.

So what does all this mean for hospital pharmacists? The Government recognises that there are workforce implications and that a focus on care closer to home is likely to mean a different role for many specialist staff based in hospitals. This includes pharmacists and their skills will be needed more than ever, both working alone and in multidisciplinary teams. Employers, whether they turn out to be the primary care trust or hospital trust, are urged to use the job-planning process in the consultant contract, flexibilities in Agenda for Change and the incentives in new primary care contracts to facilitate the service. Employers must be good employers. The highest performing organisations have good employment practices and fulfil statutory duties on race, disability and gender equality. They also support a good work-life balance, flexible working, childcare provision and healthy work-place policies; these are all important to ensure that staff can perform to their full potential.



Agenda for Change, a subject still on hospital pharmacists' minds, has still not been fully implemented despite being introduced by the Government at the beginning of December 2004. The new AfC grading structure should have been fully in place by the end of September 2005. That deadline came and went. At the 2005 British Pharmaceutical Conference, delegates were told about the difficulties that some hospital trusts had experienced, including industrial action taken by staff who were unhappy with their job evaluations. On the whole, the majority of pharmacists employed by NHS trusts seem to have done reasonably well out of their job evaluations. However, from its experience, the PDA believes that some NHS trusts are abusing the job evaluation process because they cannot afford to implement AfC. At the beginning of 2006, it appears that AfC is still not fully in place. An added complication is that the process is being hindered because there is a dearth of trained and competent staff. The shortfall in staff can be explained in part by the migration of many hospital pharmacists to primary care positions. Ironically, primary care trusts appear to be faring badly at implementing equitable grading.

Another subject that should be of some concern to hospital pharmacists is personal control and supervision in community pharmacies, as detailed in the Government Health Bill "Partial regulatory impact assessment" published in October 2005. This is relevant to hospital pharmacy because the document states: "there is a need to take stock of ways in which pharmacists and pharmacy staff can extend and enhance their roles in a modern, integrated NHS". The document demonstrates that the DoH recognises that pharmacists will be playing an extended role in the future. Elsewhere in this issue, there is a report of the session on remote supervision at February's PDA conference. S

Why do pharmacists need information?

Diane Langleben, MRPharmS

Everyone needs access to good sources of information, and pharmacists are no exception. Moreover, pharmacists are in the frontline of health care and often need to obtain accurate information in as short a time as possible. So where should pharmacists look to seek answers to their questions? The answer will depend on whether the problem is related to, among other things, medicines, employment, working conditions or the legal considerations with which pharmacists have to comply.

> Surprisingly, many pharmacists do not have access to the internet during their working hours.

Medicines information

All pharmacists, in whichever branch of the pharmacy profession they work, will need good, reliable sources to be able to answer queries about medicines for themselves and for others. The first-line port of call is often the British National Formulary but when this publication is unable to satisfy, then pharmacists should look for other options. Most hospitals have medicines information departments and are usually willing to answer queries from health-care professionals not only working in the hospital but also those in community pharmacy and primary care trusts. Those working in industry will usually have in-house medicines information departments, and again, provide a service to a wider field.

Surprisingly, many pharmacists do not have access to the internet during their working hours. For those that do, there are many websites that provide information, although it has to be said that it is better to use a few reliable ones such as www.prodigy.nhs.uk, www.ukmi.nhs.uk and www.pubmed.gov because there are many rogue sites out there.

We pay a large fee to be registered with the Royal Pharmaceutical Society and we should be aware that this is not just for entry on to the register but also allows pharmacists access to a wide range of services via an information centre comprising a library and a technical information service. The library is home to 80,000 volumes on pharmacy and related subjects such as pharmacy, pharmaceutical science and health care. The library service of the RPSGB can be accessed not only by a personal visit, but also by telephoning the technical information service. This is an invaluable resource to all pharmacists working 'at the coal face'.

Legal information

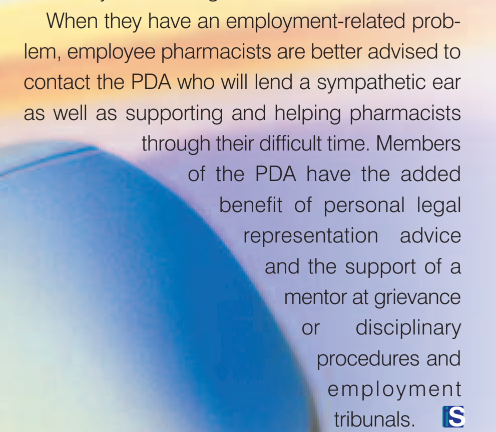
Pharmacists are arguably one of the most regulated of professions and have to abide by a plethora of laws in their daily practice. Although the Society can often be the first port of call for pharmacists who need answers to medicine or health care-related topics, caution should be exercised if they need information about a legal problem. It would be fine to contact the Society's legal department to ask for information to clarify a general point of law. However, care should be taken before picking up the telephone to ask for advice or information about any legal situation in which a pharmacist may find himself. It is far better for pharmacists to approach an organisation such as the Pharmacists' Defence Association for impartial advice on how to proceed in a situation with legal implications. The PDA has experts on board who are able to talk pharmacists through tricky situations and see how best to handle them. That may be preferable to contacting the Society straight away; pharmacists should not forget that the Society is also a regulatory body that could act upon any information inadvertently disclosed to them.

Employment information

Although there are many agencies around that can inform pharmacists about their employment rights, it is better to contact an organisation that has detailed knowledge about the specialised world of pharmacy. The National Pharmacy Association (NPA) promotes its information department as a reference centre that is able to answer a range of pharmacy practice-related questions for its members. However, employee or locum pharmacists may be ill-advised to contact the NPA because the pharmacist's best interests may conflict with those of the employer or owner. It is important to remember that the NPA was originally set up to champion the interests of pharmacy owners and this is still much at its heart.

The Guild of Healthcare Pharmacists includes in its membership mainly hospital pharmacists although not exclusively so. It is now part of the union Amicus. Although it provides a voice in backing large groups, for example, to participate in Agenda for Change negotiations, evidence suggests that its performance on an individual level may not be as good.

When they have an employment-related problem, employee pharmacists are better advised to contact the PDA who will lend a sympathetic ear as well as supporting and helping pharmacists through their difficult time. Members of the PDA have the added benefit of personal legal representation advice and the support of a mentor at grievance or disciplinary procedures and employment tribunals. S



Whose Agenda for Change is it?

Agenda for Change is an agreement between the UK health departments, NHS Confederation, unions and professional bodies to modernise the NHS pay system.

The intention was to work in partnership to deliver a new pay system that supports the NHS service modernisation, and also meeting the reasonable aspirations of staff – with the exception of pharmacists employed by primary care trusts (PCTs) it would appear!

The PDA has been overwhelmed by complaints from pharmacists who are bemused and confused by their grading and the mis-evaluation of their job roles.

It has also become apparent that jobs with similar content have been graded inconsistently across PCTs. In one example, two pharmacists – the title is not important for the purposes of this argument - performing identical roles in two separate PCTs were graded at level 6 in one and 8a in the other.

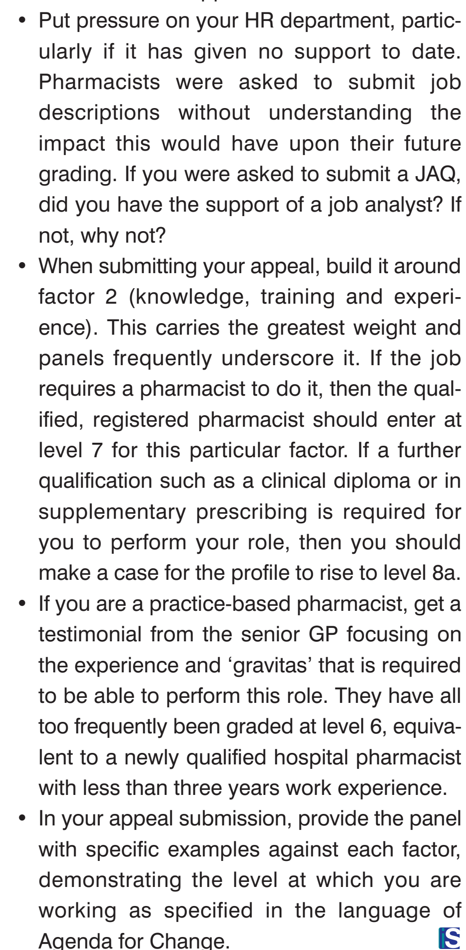
How are roles so inconsistently matched?

There are a number of theories, depending on how cynical you are. The worst possible is that PCTs have a finite budget specific to them, and they are shoehorning roles into bands to ensure that they do not end up with an excessive salary bill.

There must be an element of truth in this. The unions involved, when entering into the collective agreement with government, did so on the understanding that NHS employees would gain an average overall salary increase of 10 per cent over the three years between October 2004 and September 2007. This agreement was bound to produce winners and losers.

If some NHS roles are more highly valued by this process then their salary increases will reflect this. Those who find that their newly profiled role has fallen into a salary range, the maximum of which is below their current salary, will receive no increase at all, until their salary is aligned within the new range. Jobholders will feel that their role has been relatively devalued - a situation that many primary care pharmacists find themselves in.

Make sure your job isn't labelled inconsistently



A much more logical explanation is that in the PDA's experience most PCT pharmacists have not been trained sufficiently in the Agenda for Change process by their employers. Consequently, their job descriptions and their job analysis questionnaires (JAQs) have given the profiling panels insufficient information, which has resulted in an inadequate score. The panels seem to be unable to comprehend the depth and breadth of expertise required by primary care pharmacists.

In evaluating a role, panels either match the post to an appropriate national job profile or seek a local job evaluation by the submission of a JAQ. Part of the reason why most PCTs and practice-based pharmacists believe that there is a misunderstanding about their role is because there are no national primary care pharmacists' profiles. This in turn gives rise to the fear that members of profiling panels have a predetermined construct of what pharmacists do, informed only by the national profiles and their knowledge of well understood hospital pharmacists' roles. It is significant that one of the panels' aims is to match as many jobs as possible to the national profiles. Their job is not made any easier by the quality of job descriptions submitted.

What should I do?

The PDA is frequently asked to comment and advise pharmacists when they are inadequately graded. Typically, our advice would include:

- Elicit the support of your manager to ask for a rematch or to appeal.
- Put pressure on your HR department, particularly if it has given no support to date. Pharmacists were asked to submit job descriptions without understanding the impact this would have upon their future grading. If you were asked to submit a JAQ, did you have the support of a job analyst? If not, why not?
- When submitting your appeal, build it around factor 2 (knowledge, training and experience). This carries the greatest weight and panels frequently underscore it. If the job requires a pharmacist to do it, then the qualified, registered pharmacist should enter at level 7 for this particular factor. If a further qualification such as a clinical diploma or in supplementary prescribing is required for you to perform your role, then you should make a case for the profile to rise to level 8a.
- If you are a practice-based pharmacist, get a testimonial from the senior GP focusing on the experience and 'gravitas' that is required to be able to perform this role. They have all too frequently been graded at level 6, equivalent to a newly qualified hospital pharmacist with less than three years work experience.
- In your appeal submission, provide the panel with specific examples against each factor, demonstrating the level at which you are working as specified in the language of Agenda for Change.

The Coroner's Court

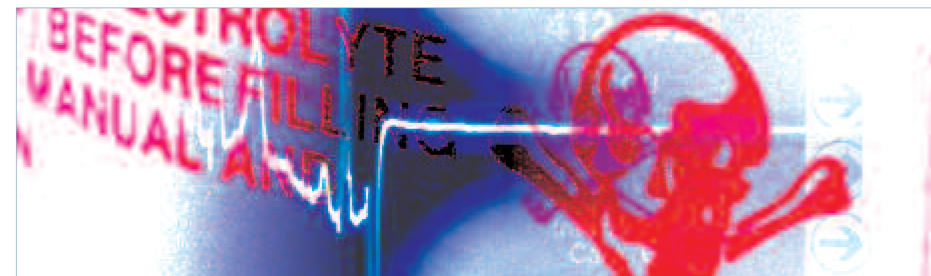
When one of the pharmacy staff told you that there was a patient wanting to speak to you, it never crossed your mind that it would be for anything out of the ordinary

As the regular pharmacist you answer queries many times each day. This time you find yourself faced with a hostile man demanding an explanation of how you came to dispense the wrong item that has killed his mother. Apparently, three days earlier, you had dispensed her prescription including an item that she was not meant to have. She died in hospital yesterday.

This unexpected and shocking encounter is the start of a train of events culminating in attendance at the coroner's court as a witness. Over the next few weeks there is an investigation by your employers. They say that all the proper procedures were in place at the pharmacy but that you had not followed them. The implication is that you, and you alone, are to blame. You feel betrayed, especially when you consider that you have been working there for several years and have built up the business considerably. Moreover, your employers did not take on another member of staff when you asked for help with the workload. The pharmacy owner is a member of the National Pharmacy Association (NPA) and says they will provide legal representation for you. How do you feel about the NPA providing representation for both you and your employers when your employers are blaming you?

As well as coming to terms with what has happened, you also know that the primary care trust (PCT) wants to investigate and the Royal Pharmaceutical Society inspector wants to conduct a formal interview under caution. However, both want to wait for the outcome of the inquest. You have been contacted by the coroner's court, been asked to give a statement and told that you will be required to give evidence. Your only experience of any court is what you have seen on television. What happens in a coroner's court and what will you be asked? Where do you stand? Will the police be involved?

The office of coroner has existed in this country for several hundred years. Deaths which are reportable to the coroner include those related to medical treatment or due to a lack of medical care. Nowadays, the coroner's function is to investigate certain deaths, namely those which are violent, unnatural, unexplained or occur "in prison or in such a place or in such circumstances as to require an inquest under any other act". The coroner may require a report from a pathologist and statements from relevant persons. A witness who is required at the inquest must attend. A coroner has a broad discretion on how an inquest is run. The remit is to decide the identity of the deceased, the time and place of death and by what means the death was caused. However, other factors are taken into account, including the need to try to prevent a recurrence. In short, the facts surrounding the death will be fully, fairly and fearlessly investigated.

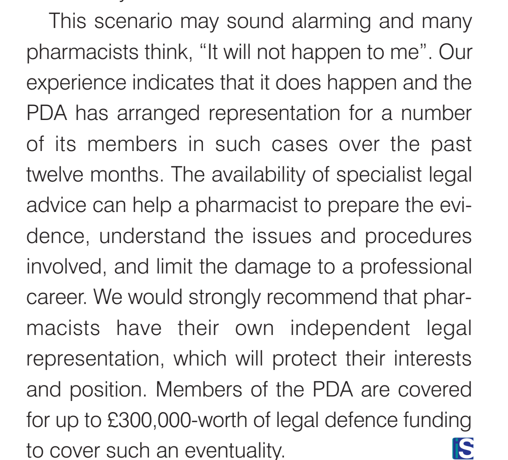


Many pharmacists may think "it can't happen to me"

An inquest is a public hearing at which members of the press, members of the family, Society inspectors and anyone else who is interested may attend. Depending on the circumstances of the death, there may be a jury.

The pathologist will often give evidence early on and then witnesses are called in turn. Each witness will be asked questions by the coroner and by other interested parties, such as the family of the deceased. It is not unusual for a family to have professional legal representation. A witness is obliged to answer any question except those which may be self-incriminating. In short, a witness can be subjected to a full cross-examination. The exemption from answering questions, however, only relates to criminal liability. The witness will be obliged to answer questions which may give rise to civil liability (i.e. a claim for damages by the family) or disciplinary action by the Society and/or PCT.

Once all the evidence has been heard the coroner (or jury) will give a verdict. Often this will be one of classic short-form verdicts of natural causes, accident or misadventure (these latter two are much the same), an open verdict (i.e. insufficient evidence to decide), drugs death (from abuse) etc. However, there can also be a "narrative" verdict, which comprises three or four lines describing what happened. Hence there is the opportunity to refer to administration of wrong medication or a problem with a dispensing system. If there is evidence of gross negligence the coroner must adjourn the inquest and refer the matter to the Crown Prosecution Service. At the end of the hearing, there is still the Society to deal with.



This scenario may sound alarming and many pharmacists think, "It will not happen to me". Our experience indicates that it does happen and the PDA has arranged representation for a number of its members in such cases over the past twelve months. The availability of specialist legal advice can help a pharmacist to prepare the evidence, understand the issues and procedures involved, and limit the damage to a professional career. We would strongly recommend that pharmacists have their own independent legal representation, which will protect their interests and position. Members of the PDA are covered for up to £300,000-worth of legal defence funding to cover such an eventuality.

Article contributed by Nick Glassbrook.
A pharmacist and a qualified solicitor.

POOREST EMPLOYERS PAY THE MOST.

IN COMPENSATION.

In the past nine months PDA has secured almost £100,000 compensation from employers who have treated their pharmacists unfairly or illegally.

who's defending your reputation?

Most employers manage their employees well, but others don't. Historically, employee pharmacists have had little in the way of support if and when they have found themselves in situations where they are being treated harshly or, sometimes, even illegally. To an extent, this has been one of the reasons why some employers engage in poor employment practice. In dispute situations hospital managers often have a substantial HR department to fall back on. They will have their interests well covered – but will you?

We provide our members with advice in employment dispute situations. Since the launch of PDA, we have advised and supported more than 2,000 pharmacists and in some cases have secured compensation payments for them. This has resulted in some employers changing employment practices to avoid problems in the future.

If you feel that you have been treated harshly or unfairly by hospital management, then why not do something about it?

11,000 pharmacists have already joined the PDA. Have you?

- £300,000 worth of Legal Defence Costs Insurance
- Pharmacy employment specialists available
- Hospital pharmacist advisors available
- Lobbying to support the individual pharmacist's agenda

Find out how membership can benefit you;

Visit our website: www.the-pda.org

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pda
the pharmacists' defence association