A PERFECT STORM?

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The storm is gathering on several fronts: Rebalancing Medicines Legislation and Pharmacy Regulation Initiative

Knowing the brief that the board has been given and also the government’s track record, suggests that in the worst case scenario the re-balancing initiative could lead to:

1. Remote supervision - pharmacies without pharmacists.
2. The movement of roles from pharmacists to pharmacy technicians.

Things may not be as cut and dried as the government might have thought. Excluding any community pharmacy employee representatives, the board will have difficulty in changing this exercise with its credibility intact and should therefore consider any evidence seriously. Despite the fact that the board members were hand-picked and given a specific programme to brief (page 5), already there are signs that the programme may not all go the DH’s way.

This has already been evidenced, when, at its first meeting, the board decided to move the issue of decriminalisation of dispensing errors up the pecking order to become a top priority: something that had previously been nullified. DH officials told us would only be done at some point in the future.

The profession must now present its evidence and arguments to the board in a way which is persuasive and patient safely oriented.

Other storm fronts include:

P Medicines on self-selection

This issue could do much to cause problems for pharmacies and could also damage the image of the PDA’s petition www.the-pda.org/pms expenditure

The excess of pharmacists

The supply and demand forces bearing down upon pharmacists could harm the professional and standards agenda.

A lack of professional autonomy

We desperately need models of practice that allow pharmacists to operate with professional autonomy to best serve patients – this is a leadership issue.

No ability for meaningful negotiations

A recent Central Arbitration Committee (CAC) hearing ruled that the PDA union should be allowed to proceed to the next stage in its bid to represent Boots pharmacists in industrial action over terms and conditions, however, Boots have applied for a Judicial Review of that decision (page 26).

Throughout this edition of Insight (especially pages 6, 8, 14, 21 and 26), we describe how we are setting out our case to protect patient safety and improve pharmacist prospects as we plot a course for safer ground. When the time comes, we will be appealing for your support.

Mark Kuziel, M.R.Pharm.S.

GPhC makes incorrect allegations against a pharmacist

The GPhC recently failed in its attempt to place the total blame on a pharmacist for the incorrect supply of a CD on the grounds that he was the Responsible Pharmacist (RP) who did not dispense or pass out the drug to the patient. Early on in the investigation, the GPhC had expressed concerns to the Fitness to Practise Inspector about proceeding with such allegations.

The situation involved a patient’s carer who presented herself for methylphenidate. The medication was previously dispensed and checked by another pharmacist and stored in the controlled drug cabinet. When the pharmacist requested the medication for his key, he gave her no further information and on the basis of his previous dealings, the pharmacist trusted the prescription for the CD key, which he gave her without question and on the basis of the long-standing working relationship in which her subsequent acts were always shown to him for checking. She mistakenly took another patient’s medication from the cupboard, and gave it out without referring to the pharmacist. The supply contained the same medication, but the dose, format and patient’s name was incorrect. The pharmacist was “simply let down” by his pharmacist/technician who had taken abuse of the opportunity to supply the wrong medication.

The PDA became aware earlier this year of false and misleading statements being made by the Boots Pharmacists’ Association (BPA) that pharmacists and pre-registration graduates working in Boots. The PDA wrote to the Chief Executive of BPA seeking an apology and a retraction of these misleading statements. We sought an undertaking for the BPA not to repeat them again and for the BPA to agree to donate $5,000 to a charity of the pharmacist’s choice, in recognition of its wrongdoing. The BPA has agreed to these requests and the matter has now been concluded. The BPA will be disseminating its apology to all Boots pharmacists over the coming months. The apology is as follows: “In or around October 2012, the BPA made certain statements about the PDA. It has been brought to our attention that they were incorrect. The statements were published in our newsletter, in a letter issued by our CEO to all pharmacists dated October 2012, in a media statement issued by our CEO, and in the magazine entitled ‘Counselor’ distributed in all Boots stores nationwide. The statement suggested that the BPA was primarily an insurance company and may have been interpreted to infer that the PDA’s objectives were less credible than the BPA’s. The BPA apologises to the PDA and PDA Union for making these allegations. Our apologies to all Boots pharmacists for any confusion that may have [been] caused. In fact, the PDA is not for profit organisation, and is not an insurance company. The PDAU is an independent trade union in accordance with the Trade Union and Labour Relations (Consolidation) Act 1992 and is not funded by an insurance company. Both organisations are funded by membership subscriptions.”

BPA issues apology to PDA

The evidence established that the technician who gave out the medication did so without applying any further diligence other than that which had already occurred through the original dispensing chain of circumstances. She did not involve the pharmacist at the point of supply to the patient, nor even follow the SOP’s in so much as checking the name and address of the patient. She made an entry in the CD register and showed this and the annotated prescription to the pharmacist.

The chairman of the tribunal remarked that: “On the basis of what he [the pharmacist] had seen, he had no way of suspecting that the wrong medication had been given to the patient”. He further commented that the pharmacist had every right to trust the technician as they had worked together for some time.

The committee could find no evidence that the pharmacist was not a careful practitioner nor that his practices were in any way detrimental to the patients interests. It was determined by the panel that the pharmacist’s fitness to practise was not impaired. In this particular situation the chairman seemed to agree with the PDA’s view that the pharmacist was “simply let down” by his trained technician of many years standing, and he had a right to trust her competence.
Rogue proprietors not paying locum fees

The PDA has called for regulatory action against pharmacy employers that routinely fail to pay locum pharmacists. The Association is aware of certain companies that avoid paying their locums by repeatedly putting their business into liquidation.

“The practice by some pharmacy business owners of employing locum pharmacists without any intention of paying them is completely unacceptable and unprofessional,” said Mark Pitt, PDA Membership Services Manager.

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Representing pharmacists’ interests in Europe

In recent years the affairs of the EU have become much more relevant for pharmacists working as employees or locums in the UK.

Much of medicines regulation, employment legislation and working time directives are fashioned by EU initiatives. It has become increasingly important to ensure that the EU Commission can understand the issues that concern UK pharmacists. If the interests of employee and locum pharmacists are to be supported by the EU and any threats or opportunities created by the European Commission are to be influenced before they land on UK shores, then the PDA must be well positioned in the European theatre.

The European Association of Employed Pharmacists (EPHU) is an umbrella organisation of pharmacist representative bodies based in EU countries. EPHU is recognised by the EU Commission as representing the interests of employees and locum pharmacists across the whole of Europe, and earlier this year the PDA was admitted to full membership.

There are several influential EU commissioners maintaining close links with EPHU, so this is a key organisation. The first assembly attended by the PDA took place in Paris in April, where delegates were keen to learn about the conditions under which pharmacists in the UK work. A presentation was delivered setting out the statistics of PDA member defence activity. The assembly was shocked to learn of the large scale and nature of incidents where pharmacists needed support from the PDA.

In contrast, whilst other EU countries also handled disputes between employers and employees, this was both qualitatively and quantitatively a far less hostile situation. The pharmacy president from one of the largest EU countries commented that:

“The UK was the best ‘worst’ example of what happens when multiple pharmacy ownership is allowed to dominate community pharmacy.”

Now that such a productive line of communication has been established with the EU Commission, the PDA will seek to discuss its concerns about the UK government’s plans for remote supervision – the plan to operate a pharmacy in the absence of a pharmacist.
News... 

Road Map – exciting developments

Scotland

The PDA’s Road Map strategy focuses on pharmacists being enabled to work as autonomous healthcare practitioners on individual contracts with the NHS. Through such a vehicle, they should be able to deliver pharmaceutical care, develop clinical relationships with patients, and work in a much more integrated way with GPs. Pharmacists working in this way could deliver these services from various locations, such as community pharmacies, care homes etc, and make a big difference through providing high quality pharmaceutical care by reducing unnecessary hospital admissions and improving care for patients with long term conditions (LTcs). Added to this are the benefits of reducing medicines waste and ADRs, as well as improving capacity for GPs, enabling them to tackle more acute presentations because they have referred their LTC patients to such pharmacists.

Last year these PDA Road Map proposals were welcomed with enthusiasm by the Scottish Government, which is in the process of reviewing pharmaceutical care in the community in Scotland. The final outcome of their work is expected in winter of 2013 (see www.the-pda.org/ScottishRoadMap).

England

More recently, a series of opportunities have aligned themselves to provide an excellent pretest for the launch of PDA Road Map proposals in England. These include the current A&E and hospital admissions crisis, the Francis Report, and the recent call from government for ideas on how to improve services to patients with LTcs. Additionally, there is the creation of the Royal Pharmaceutical Society’s Faculty, which will enable the creation of a structured career and skills framework in community pharmacy (page 8). Many of these developments underpin the very foundations of the PDA’s strategic initiative for creating new roles for pharmacists. As a result of these opportunities, the PDA is currently submitting its English Road Map proposals to both the Health Minister and the Minister for Care (see www.the-pda.org/EnglishRoadMap).

“We have waited some time for the ideal conditions under which to share our thinking with government in England,” said Mark Koziol, PDA Chairman. “We believe that our radical proposal on how pharmacists can help will go some considerable way towards helping to solve some of the serious problems currently faced by the NHS.”

The PDA has been invited to partner RPS Wales and the Welsh Pharmaceutical Committee in an important strategic development initiative seeking to develop the roles of pharmacists in Wales. The work of this group is aimed at developing and then outlining the professional aspirations for pharmacy, and to submit these ideas to the Minister for Health in Wales. It will seek to propose how patient care can be provided closer to home. The PDA’s contributions will focus on the delivery of pharmaceutical care by individual pharmacists, as described above. Reports will follow in a future edition of Insight.

The Commission on Future Models of Care

Director of Policy at the Nuffield Trust Research Foundation, Dr Judith Smith, who is currently chairing the Commission on Future Models of Care through pharmacy, recently visited PDA HQ to discuss the thinking behind the PDA’s Road Map. The final report of the Commission (Autumn 2013) will suggest how policy makers, commissioners and the profession can put into practice such new models of care.

Commenting on the work of the commission, PDA Chairman Mark Koziol said:

“The current models of care do not reflect the difference in the aspirations of pharmacists compared to those organisations that own pharmacies, and this is why we have ended up with models of care such as MUs, which coalesce pharmacists have found very difficult to deliver to a high standard and to defend professionally. We were delighted that Dr Smith came to see us and explained that the litmus test of the success of this commission will be that it recognises these two sets of interests and provides both with an exciting way of achieving their hopes and ambitions”.

Employers provide professional indemnity insurance – oh really?

Some pharmacy employers have recently explained to their employees that they do not need to take out their own professional indemnity (PI) insurance because they will insure them in the event that something goes wrong. However, pharmacists are urged to think through the implications of such a proposition very carefully as employer-provided professional indemnity is a very different proposition to the independent indemnity carried by an individual.

The employer-provided indemnity allows the employer to control the defence. This can lead to situations where the brand and reputation of the employer can become the primary concern for the lawyers handling the defence, and not the protection of the employee. This can (and has in the past) led to poor outcomes for the individual pharmacist.

PI insurance carried by the individual pharmacist will focus upon protecting the pharmacist, and will not seek to protect the reputation of the employer. Defence efforts will look carefully at whether the error was down to the pharmacist or another member of staff, defective employer systems, inappropriate skill mix, poor working environments or staff shortages that were an onus to a disaster waiting to happen. If such problems exist, then lawyers acting on behalf of the pharmacist will make sure that the employer takes some, or even all, of the responsibility. This may entirely extract the pharmacist from the firing line and could even result in the employer being investigated by the regulator.

Challenging the employer’s view

It is perhaps unsurprising that some employers would find such an approach challenging, and could be a reason why they may prefer their employees to rely on the company-provided PI insurance. A recent statement from one major pharmacy employer, entitled ‘Indemnity provisions for pharmacists’, says that the company does not require its employee pharmacists to arrange their own cover. In describing the detail of the company-provided PI insurance it describes certain conditions, which include:

• In some cases the company may, as a condition of the indemnity, require pharmacists to give their full cooperation. The company reserves the right to settle any claim in a manner in the event of such a claim, and pharmacists would be expected to provide reasonable assistance in its defence settled

• The company may, at its discretion, withdraw or discontinue an indemnity previously offered if an employee does not follow advice from the company’s legal or other advisors. This makes it very clear that the company would have ultimate control over the defence, and could even deny protection if the employee did want the defence strategy to be organised in a particular way. This cannot be in the best interests of pharmacists.

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Have excellent interpersonal and communication skills

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Scotland

England

Wales

www.the-pda.org www.the-pda.org
Skill Mix in Pharmacy
it’s time for an intelligent debate!

Some senior pharmacist government officials believe that the involvement of pharmacists in what they call ‘dispensing’ is a waste of valuable resources. Fuelled probably by a greater knowledge of pharmacy practice within the hospital service, they view ‘skill mix’ as a means by which community pharmacists (by placing a greater reliance upon pharmacy technicians) are supposed to move away from dispensing and progress onto other as yet undefined activities. But to what extent will it be appropriate to expect pharmacists to move away from ‘dispensing’ and for pharmacy technicians to do what? Where exactly can patients expect safety to fit into the current plans for Skill Mix being drawn up by the Department of Health?

There has been no detailed debate within the profession and currently no definition of the role of the pharmacy technician, nor has there been a discussion about how the respective roles of pharmacists and pharmacy technicians fit together to ensure patient safety. Despite that, the government changed the law and since 2011 pharmacy technicians have been required to register with the GPhC.

There is no doubt that pharmacy technicians have important roles to play. However, the lack of wider thinking and debate about the real opportunities offered by Skill Mix in pharmacy has left only the government’s philosophy that technicians should take over roles previously undertaken by pharmacists on the table. This has created a position where the term Skill Mix is viewed with uncertainty by pharmacists. Pharmacy technicians too are cautious since there is no clarity of role and the human desire for advancement and the development of a one at board room level and has not emerged on any significant scale. In the hospital setting, the greater involvement of pharmacy technicians occurred as a consequence of a successful Skill Mix amongst pharmacists leading to the much more appropriate use of their unique skills and making them much more accessible to their patients.

Worryingly, the government, in almost a complete reversal of what happened successfully in the hospital setting, has expended much energy in seeking to develop the role of the pharmacy technicians, without first developing a structured career and skills framework for community pharmacists. Furthermore, through the concept of remote supervision they intend to make the pharmacist less accessible to the public in the community pharmacy and not more so.

Worse still, the absence of a career and skills framework for pharmacists in community pharmacy has given the government no alternative other than to develop ‘supply plus’ services such as MURs and NIMS which base themselves largely on the notion that they can be delivered remotely by any and every pharmacist in any community pharmacy irrespective of their career, experience and training history alongside the supply activity. Through targeting, they are being commoditised and this undermines the professional autonomy of pharmacists. Consequently, these services are a long way short of genuine pharmaceutical care which would support patient care.
It would be based on prescribing skills, an appointment led service and the authority to change medication regimes in light of a clinical assessment in a clinical setting. Arguably, the current MUR programme has ended up actually harming the development of a large scale genuine pharmaceutical care programme within community pharmacy.

Added to these strategic problems, are the more operational ones. The inherent design of the current MUR and NMS services means that community pharmacists are expected to deliver them on top of their current excessive workload whilst they are simultaneously trying to ensure the safe and effective operation of the pharmacy.

Their design fails to properly and safely harness the skills, let alone the support of community pharmacists. They have become iconic examples of the painful relationship between professionalism and commercialism in pharmacy (page 12) and they are not the great transformational hope that they were intended to be. This is evidenced by the current levels of dissatisfaction amongst pharmacists, patients, other healthcare professionals and ultimately frustration within government circles as they fail to understand why their ‘new opportunities’ are not enthusiastically taken up by this large pharmacy sector.

Creating Skill Mix amongst pharmacists

Skill Mix amongst pharmacists in the community setting must become an important tactical objective. This must rely upon a structured career framework so as to produce a skills pyramid which has pharmacists operating at a variety of skill levels, differing levels of experience and a range of expertise which is driven by additional training such as pharmacist prescribing.

Creating a framework that involves Practitioners at its base, Advanced Practitioners, Specialists and Consultant pharmacists is an approach which could manage much more sensibly the increasing pressures placed upon community pharmacy.

This would allow the service to be much more versatile and quality driven, more accessible and patient facing.

A Structured Career Framework Proposal

Consultant
Specialist
Advanced Practitioner
Practitioner

Specialization
Additional Training
Accreditation
Experience

It would be much more able to handle reactive and proactive interventions with the public both on a ‘walk in’ and appointment led basis. Providing generalist services such as public health and safe supply of medicines, whilst at the same time using second pharmacists with additional training to develop clinical relationships with patients and to deliver detailed pharmaceutical care and continuity of care. A more structured and integrated approach involving community pharmacists within a skills framework could also significantly reduce the workload of GPs as they could refer more of their routine patients with Long Term Conditions to specialist pharmacists based in the community pharmacy. Such an approach could also allow individual pharmacist practitioners to deliver pharmaceutical care to elderly patients based in residential homes.

In such a way, pharmacists could reduce unnecessary A&E presentations and make a beneficial impact upon the medicines waste and ADR agenda.

Such a framework would give context, structure and clarity to the role of pharmacy technicians and their relationship with pharmacists and patients. As the experiences in hospital pharmacy showed, within such a framework, pharmacy technicians would have important roles to play ensuring that pharmacists became more accessible to the public.

A clear structure would remove confusion, provide an attractive way forward for both pharmacists and pharmacy technicians to develop much more comprehensive roles and services and reduce the risks to patient safety that are inherent with the current approach. The combined effect of this could be a vastly improved patient journey, making much better use of pharmacists, pharmacy technicians and community pharmacies and utilising the valuable resources of the NHS to much better effect.

Conclusions

Currently, the government is planning to use Skill Mix to develop the roles of pharmacy technicians but it is proceeding without first articulating a workable and viable vision nor any model of care for pharmacists that genuinely relies upon their unique skills in the delivery of pharmaceutical care.

It appears not to have learned the lessons from the successful development of Skill Mix in hospital pharmacy which has allowed pharmacists to spend much more time in patient facing situations and technicians to develop increasingly important roles. Nor has it commenced a debate about the impact of its proposals upon patient safety.

More worryingly, in seeking to rely upon pharmacy technicians so as to develop its proposals for remote supervision (the plan to operate a pharmacy in the absence of a pharmacist), it will make pharmacists less accessible to the public in a community pharmacy and not more so.

If it truly wants to optimise the use of the valuable resource that pharmacists represent, then it must lift its game when considering Skill Mix in pharmacy.

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Co-operative pharmacy criticised by Discipline Committee Chairman after collapse of MUR fraud case

A PDA member recently appeared before a GPhC Fitness to Practise (FIP) Committee accused of Medicines Use Review (MUR) fraud. After three days of evidence from the Co-operative pharmacy, an application was made by the PDA for the case to be thrown out due to a lack of any credible evidence. The FIP Committee agreed and the case against the pharmacist was dismissed. Whilst that was good news for the member, the background to this case which became apparent as the hearing progressed is shocking. The conclusion was that the Co-operative pharmacy was wrong to view this matter as fraud, managers had badly mishandled the investigation and had it done so properly, the company would never have referred the pharmacist to the GPhC for fraud.

The allegations were that the pharmacist had caused false MUR figures to be submitted to head office and to the NHS; these allegations were vigorously denied by our member from the very outset. Our member felt that this was a very busy pharmacy and that there was no pressure to reach MUR targets and at a pharmacy and not to leave until two MURs had been completed. He also made it clear via his memo that there would be no acceptable reasons for pharmacists not delivering two MURs each day. This email from Mr Handley containing threats about not achieving MUR targets was heavily criticised by the Committee members, who also felt his attitude on the witness stand showed a concentration on profit to the exclusion of patient benefit, and demonstrated a lack of understanding of the clinical importance of MURs.

RDM concentrates on profit to the exclusion of patient benefit

A key witness for the Co-operative pharmacy was Brian Handley, a Regional Development Manager (RDM) who was a non-pharmacist and had previously worked as a business manager for Punch Taverns. The committee learned from a corporate email that one of Mr Handley’s tactics to pressure pharmacists to reach their MUR targets was to arrive at a pharmacy and not to leave until two MURs had been completed. He also made it clear via his memo that there would be no acceptable reasons for pharmacists not delivering two MURs each day. This email from Mr Handley containing threats about not achieving MUR targets was heavily criticised by the Committee members, who also felt his attitude on the witness stand showed a concentration on profit to the exclusion of patient benefit, and demonstrated a lack of understanding of the clinical importance of MURs.

RDM’s approach could compromise patient safety

Shortley before our member became aware of the allegations from the Co-operative pharmacy, she complained to Mr Handley about inadequate staffing levels and heavy workload at the branch; concerns which were shared by staff members. Mr Handley dismissed these concerns out of hand and explained that according to his calculations the pharmacy was actually overstated. The Committee criticised his approach to the concerns expressed by the pharmacist manager, stating that it was inappropriate. The Committee explained that his approach was likely to result in an increase in the likelihood of errors and compromise patient safety.

Investigation and evidence gathering processes were significantly flawed

The Committee considered that there was some force in the PDA’s suggestion that the investigation carried out by Mr Handley was not even-handed. It also found that when the Co-operative Pharmacy’s NHS standards pharmacist was asked to become involved, she did not review the matter independently, but simply accepted Mr Handley’s investigation and adopted the material she already found in the file. The Chairman was particularly unhappy with the preparation of witness statements by the pharmacy manager at the pharmacy’s department. Under PDA cross examination witnesses were asked why three independent staff statements were very similar in parts and contained terminology that the staff members did not agree with some of the contents of their own statements.

Senior Co-operative Pharmacist criticises the RDM

The Co-operative Pharmacy’s NHS standards pharmacist, Gilian Stone, whilst on the witness stand was placed in the uncomfortable position of agreeing with the Committee that the actions and behaviour of Mr Handley as a senior manager in the business were inappropriate and not endorsed by the company. She tried to distance herself and the company from what the RDM had said and done in the pursuit of MUR targets for profit. Ms Stone also agreed that Mr Handley’s attitude towards the pharmacist when she raised concerns about workload and staffing was inappropriate and could have put patient safety at risk as well as make errors more likely.

Conclusion

The PDA has a portfolio of threatening, offensive and intimidating communications received by members which shine a spotlight on the culture prevailing at a senior level within some organisations. As a consequence, the PDA has frequently raised concerns within government and the profession about the commoditised approach to the provision of MURs. This has led to unethical behaviour by business managers and a relentless pursuit of MUR numbers solely to maximise profits. The PDA has also raised concerns about the unacceptable situation whereby individuals in a position of authority over pharmacists are not required to be registered with the GPhC and therefore there are no meaningful regulatory sanctions to protect the public from the impact of their behaviour.

Other Co-operative Pharmacy RDMS have sent threatening emails to pharmacists highlighting the consequences of not reaching their target of 400 MURs, each year and Co-operative pharmacists continue to face disciplinary allegations for not completing enough MURs. The Co-operative has previously been criticised by the GPhC for its approach to targeting MURs.

The PDA has written on two occasions previously to the pharmacy superintendent of Co-operative Pharmacy to highlight these matters. Unfortunately the company has not taken up our offer to meet to discuss the problem and we continue to be involved in other cases.

John Nuttall, the Managing Director of Co-operative Pharmacy recently blogged on the Chemist & Druggist website:

“Targets per se are not the root cause of the problem, it is the way some managers and healthcare professionals only see tasks to be performed and patients as no more than a number.”

In the interests of fairness, we asked the company if it wanted to comment on this case:

A spokesperson for The Co-operative Pharmacy said:

“We acknowledge that mistakes were made rather than fraudulent action taken, but The Co-operative Pharmacy has a duty to make the GPhC aware of any concerns regarding the conduct of a registered pharmacist or technician. It is for the GPhC to determine whether there is a case to answer and whether there should be a referral to the fitness to practice committee. In this case the GPhC hearing concluded that no further action should be taken against the pharmacist in question and we have learnt lessons from this case.”

“Since the case came to light three years ago, the NHS has reviewed its guidance on MURs and we have updated our procedures accordingly. We have clear guidance for all staff to follow and we ensure that the message regarding completing MURs is to improve the quality of patient care. Despite this, the PDA continues to handle incidents involving MUR pressure within The Co-operative Pharmacy.

Due to increasing concerns about the general conduct that prevails in the area of MURs, the PDA has brought this particular case to the attention of the Department of Health.

www.the-pda.org
The Perfect Storm

The Perfect Storm

There are now a number of storm clouds on the pharmacy horizon. These need to be identified, analysed and tackled – there is much to do. This feature provides some insights into the opportunities that can be exploited and the work that must be done to ensure that pharmacy can set a course for safer ground.

A very large slice of the entire NHS budget is spent on medicines, and the evidence that there is a lot of waste and harm caused by ADR’s and non-compliance is widely available. Recently, the national media has focused on the A&E admissions crisis, GP capacity, and the NHS direct crisis, prompting governments throughout the UK to ask healthcare professions to suggest radical ways to help resolve the crisis. The PDA is responding to this challenge and its Road Map proposal is being seriously considered by many in decision making positions (page 6).

The Francis Inquiry

In the wake of the Howard Shipman crisis, a huge wave of regulatory changes swept through all of the healthcare professions, making healthcare regulation virtually unrecognisable and pharmacy was no exception. Inevitably, the Francis Inquiry will have an impact of similar magnitude. The PDA is now preparing and crafting its arguments to ensure that this impact does not encourage employers to create unacceptable working environments and enforce improper practice conditions upon pharmacists to the detriment of patients.

In the community setting, MURs are being relentlessly targeted and staffing shortages are affecting the safety of the supply process. In hospital, pressure by bed managers to discharge patients has reached critical proportions, and in primary care pharmacy a focus on cost cutting is increasingly a primary consideration. These and other factors that impact on patient safety and demonstrate what happens when employer diktat undermines the professional autonomy of pharmacists. The PDA will be using the Francis Inquiry recommendations to critically focus on these matters and to demonstrate the importance of allowing pharmacists to operate in such a way that puts the patient at the centre of the process (page 21).

The Which? report

Yet again, community pharmacy is forced to react to another Which? report challenge. What the report does show is that when pharmacists are involved in the patient interface the overall patient experience is improved.

The conclusion that one draws is surely an obvious one: remote supervision – the plan to operate a pharmacy in the absence of the pharmacist – can never provide an improved outcome for patients. Additionally, this report can (and will) also be used to support the arguments against the proposal to allow P Medicines on self-selection.

The Royal Pharmaceutical Society (RPS) Faculty

The launch of the RPS Faculty provides a very powerful tool for the profession across all sectors of practice to be able to achieve its ambitions of developing new roles, but this is especially so in the case of community pharmacy. For decades, community pharmacists have been hampered with a flat career structure and no meaningful way of training up to more advanced status and commensurate rewards. This can now change, for if the strategic discussions about more advanced roles for pharmacists (as found in Road Map and elsewhere) are going to materialise, they will need to link into an accreditation process. The fact that one has now been created by the RPS is very encouraging.

The storm clouds

There are a significant number of storm clouds on the horizon – usually they are interlinked in some way and often they are complex. Here we examine some of the more serious ones and describe how they can be mitigated.

Rebalancing medicines legislation and pharmacy regulation

Decriminalisation

Described on pages 2 and 5 is the background to this new development. Every cloud has a silver lining – and in this case, the fact that delivering decriminalisation of dispensing errors is an aim of this board and one which has been moved to top priority is to be welcomed. However, the Department of Health’s (DH) track record on delivering decriminalisation is not good. The first effort of the DH during the period of the Elizabeth Lee case where it worked with the Crown Prosecution Service did not achieve decriminalisation. The second (and major) attempt was the DH proposal to change legislation and introduce ‘due diligence defence’. However, when we learned about this, the PDA provided the DH with senior counsel opinion to show how that proposal actually worsened the prospects for the legal defence of pharmacists. This effort got all the way to committee stages in Parliament and then had to be withdrawn by the Minister. The ‘rebalancing programme board’ has now been charged with the task of resolving this complex matter once and for all. However, its efforts are already being hampered because the DH has chosen not to appoint anyone to the board with experience of defending pharmacy prosecution.

The PDA genuinely wishes them well in this important task and eagerly awaits the proposal.

Responsible Pharmacist regulations

There are very many concerns with the RP regulations – too numerous to list in this feature. The rebalancing programme board has been charged with the task of resolving some of these, in particular balancing the interplay between the responsibility of the RP and the superintendent. It is hoped, however, that the board can tackle the much wider problems with these regulations, many of which were identified by an independent report – for example, that they be dis-applied altogether in the hospital sector.

Remote supervision

It will also be important for the board to conclude that, just because you have a sign up on the wall naming the RP and making them responsible, this does not mean that the pharmacy will be operating safely in the absence of the pharmacist. It is still very difficult to understand the thinking behind the government’s plan to operate a pharmacy in the absence of a pharmacist through remote supervision. Not since this proposal was conceived in 2006, has it ever explained its rationale in a patient-centred fashion. In that regard, the findings of the Francis Inquiry and the Which? report will become highly helpful in focussing the board on what is important. The recommendations of Francis are so powerful, that they easily outstrip speculative proposals from government that could dilute down the safety of the public. There is absolutely no doubt that a pharmacy is a safer place with the pharmacist present than with the pharmacist absent, and the PDA will be forcefully making this point to the board.

Roles for pharmacists and pharmacy technicians

A major policy platform for the DH was the creation of a register of pharmacy technicians, and this was completed in 2010. This is a positive development, ➔
but it will be important to establish how it affects the interplay between pharmacists and pharmacy technicians, in terms of their respective roles, how they fit together, and how they maximise safety for patients. Additionally, in terms of pharmacy, it is important to define a professional and technical framework, and therefore provide clarity for both pharmacists and pharmacy technicians.

The danger is that the board makes its decisions based on considerations that are political, subjective and that do not look at patient safety considerations. Additionally, that they base their thinking upon the experiences of pharmacy technicians in the hospital sector (since this is where a significant amount of board members are experienced in), for in reality community pharmacy arrangements are very different.

The PDA is undertaking an extensive piece of work in this respect, and will report its findings to the board. Already more than 1,300 pharmacists have participated in initial surveys and more will shortly follow. Extensive telephone research searches are being undertaken and examples of the interplay between pharmacists and pharmacy technicians from all over the world are being studied. Interesting findings are already emerging, such as the fact that of the 21,831 current registered pharmacy technicians, 10,358 (76 percent) of them qualified under grandfather clause arrangement.

The findings of the PDA will be submitted to the board.

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P Medicines on self-selection

In May, PDA roadshows were held throughout England, Scotland and Wales to solicit views of pharmacists on the changes proposed by the GPhC. The good news is that, since this issue was brought to the fore through a series of national PDA meetings in 2012, the government has agreed to take control of the student numbers from 2015.

This still leaves the problems of the interim oversupply to contend with, and to this end, it is crucial that new models of practice are developed creating an increase in pharmacist demand. A very considerable amount of work is being done in this respect (page 6).

Setting the compass for safer ground

This feature has explored a small sample of tactical activities that will be needed to drive the overall strategy required to ensure that the vagaries of the ‘perfect storm’ are driven away. Additionally, there are areas where a debate in pharmacy will need to be commenced and where initiatives will need to be developed:

1. Ensure that the benefits of pharmacist involvement in the safety of the supply function are identified and emphasised.

2. Accelerate the development and roll out of new roles – curtail commoditisation of services in the community pharmacy setting. Develop new contractual models (page 6).

3. Create a structured career framework in the community setting. Consider Skill Mix among pharmacists before roles between pharmacists and technicians are clarified (page 6).

4. Explore the definition of professional and technical, so as to clarify the roles and interdependency of pharmacists and pharmacy technicians (page 6).

5. Harness the opinion and support of patient groups in relation to remote supervision.

John Murphy, Director of the PDA, says:

‘PG Mutual has proved to be a perfect fit with our organisation and our members are reaping the benefits of our partnership. Members tell us that our trust in PG Mutual has not been misplaced; their staff are friendly, accommodating and not ‘pushy’. Applications are not onerous, or acceptance unreasonably discerning. Most importantly, they pay up in full in over 98% of claims, and members welcome having the option of rates for ‘first day cover’ due to absence. Finally, the knowledge that as they are contributing to a mutual fund and that they may have a lump sum at their retirement can only be good news – which is why we continue to recommend PG Mutual to you.’

*£286.80 calculated on a 4-week month based on Employment Support Allowance at £71.70 a week. DWP Website, June 2013. **PDA Survey, November 2012.

Partnership with PG Mutual provides protection for PDA members

As a PDA member, you will probably already be familiar with PG Mutual, and the fact that we are a not-for-profit provider of income protection insurance. You may also know that we’re committed to ensuring our members receive an income if they are unable to work due to injury or illness, and that we paid 98% of claims in 2012. However, did you know that if you were struck down by an accident or illness that stopped you from working, and you didn’t have income protection insurance, you could end up living on the minimum state sickness benefit? Do you know that this equates to just £286.80 each month? Could you survive on this?

When it comes to the importance of income protection, don’t just take our word for it – see what your fellow PDA members who are already with us have to say:**

1. Helpful staff when I needed to claim – a fantastic, smooth process

2. Being self-employed, not working means no money – so for me, getting income protection was a simple choice

3. A very professional company, absolutely no complaints when joining and the not-for-profit status is a good thing for the members.

Do you know that if you end up on long-term sickness leave, you could lose your income and be left living on state sickness benefits? No one can predict ill health, so make sure you’re covered with an income protection plan from PG Mutual.

Did you know that if you sign up to PG Mutual’s terms and conditions, apply via the PDA website and use the code ‘PDA21’ you will receive 15% off your first year’s income protection plan? Visit www.pgmutual.co.uk/Quotation and enter ‘PDA21’.

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PDA MEMBER EXCLUSIVE INCOME PROTECTION OFFER

UNEXPECTED ILLNESS?

WHATEVER THE OUTCOME, YOUR INCOME STAYS HEALTHY WITH US

15% OFF YOUR FIRST THREE YEARS’ INCOME PROTECTION COVER*

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*Please note this offer is subject to PG Mutual’s terms and conditions, applies to new PG Mutual members only and excludes uplifts. It cannot be used in conjunction with any other offer. **Available to new PG Mutual members only. Further terms and conditions apply. PG Mutual is part of the RBS Group. PG Mutual is authorised and regulated by the Financial Conduct Authority, Firm Reference Number 110023.
Patient safety: dispensing errors affecting children

The PDA has noted an increase in the numbers of dispensing errors involving children. This article addresses the significance of such errors, discusses the most common errors, and offers practical ways to minimise risk.

The UN Convention on the Rights of the Child defines a child as a person below the age of 18, although there is no single law that defines the age of a child across the UK, and the BNF definitions of age refer to children as those being 12 years or younger. For the purposes of this article, errors affecting those under 18 years have been considered. The development of drug management plans in children are fraught with difficulties. Differences in the pharmacokinetics between adults and children can make it very much more difficult to predict drug effects. There is often a lack of paediatric trial data assessing safety and efficacy, which may affect drug compliance and contribute to the increased overall risk of errors. Dispensing incidents involving children often understandably elicit emotive responses from parents/guardians, who may then wish to progress matters. There are many ways in which this could affect pharmacists. For example, the risk of a complaint being made to the GPhC, which is obliged to investigate any such complaint, but won’t become involved in the issue of compensation. There is the possibility of a claim for compensation and the consequent soaring costs involved. More recently, dispensing errors more often come under scrutiny by employers and can lead to disciplinary action. Typically, this arises where the SOPs have been breached, which is invariably always the case at some point if an error occurs.

The law on claiming compensation

Claimants usually have three years from the date of the error in which they can lodge a claim for compensation if they have suffered harm. The rules are different in children, however; a child has from the date of the negligent act through until three years from the date of their 18th birthday in which to lodge a claim. Therefore either the claim must have been settled, or court proceedings must have commenced, before they reach their 21st birthday. This rule gives the guardians of the injured child the choice of either to pursue a claim immediately, or to wait.

The former will involve the agreement of compensation to be awarded and placed in a court fund until the child reaches the age of 18. Alternatively, they can wait until the child reaches the age of majority and let them make their own decision as to whether they wish to pursue a claim for the injuries they sustained as a child. Where the claimants’ guardians have settled on behalf of a child before making any payment, an approval of the court to the agreement is still formally required. During these proceedings, known as a Child Settlement Order, certain information may need to be provided to the court. For example, details of the circumstances of the error, details of whether and to what extent the defendant admits liability, a schedule of past and future losses, and an opinion on the merits of settlement given by a solicitor acting for the child. It is the judge that determines whether the proposed settlement is acceptable and in the best interests of the child. Such an order inevitably adds to the costs of a claim – usually in the order of £3,000 – £4,000.

The total numbers of dispensing incidents logged with the PDA involving patients under the age of 18 shows an upward trend, trebling from 4 per cent in 2008 to 10 per cent in 2010, and the increase seems to be continuing. Analysis of the types of incident has revealed that the single largest type of error is that of the mis-labelling of dosage instructions for oral antibiotics. It comes as no surprise, given the frequency of prescribed items such as amoxicillin, penicillin and trimethoprim suspensions for this patient group. Fortunately, such cases are not as high up the scale of clinical significance, and the effects are not permanently damaging. This is not to detract from the level of distress that is often caused to both the patient and the parents.

Case studies

A prescription was presented for ramipril suspension 5mg/5ml, at a dose of 5mls three times a day, for a three month-old infant. The labelling and dispensing was carried out by a pharmacy technician, and presented to the pharmacist for checking, who conducted an appropriate clinical check, but omitted to notice that the 75mg/5ml strength solution had been selected. The parents pursued compensation from the pharmacy owner, whose insurer (the NPA) passed it on to the pharmacist directly involved in the error.

The child’s mother claimed that she administered the wrong strength for three days, and the infant was admitted into hospital for observations. In this case, the parents made the claim without resorting to a third party lawyer. Although we would advise the parents to seek legal advice on any settlement, they may choose to take the offer of settlement and to give the insurers a ‘parental indemnity’. This allows them to settle quickly and indemnify the insurers against any further claims, but does leave them to a third party lawyer. (however unlikely) should the child or child’s representatives decide to sue them for an inadequate settlement at a much later date.

Another medicine commonly involved in dispensing errors is fluoxetine liquid 20mg/5ml. A recent case involved a teenager being prescribed a dose of 10mg each day, but was labelled and given as 10ml to be taken each day, resulting in four times the prescribed dose.

The most costly error involving a child handled by the PDA was the dispensing of a hormone ethinylestroadiol 4mg daily, intended to bring on delayed puberty. The incorrect dosage of 1mg. 4od dispensed resulted in excessive acceleration of the child’s puberty, and a series of tests over two years were required to assess whether the harm done would have longer-lasting side effects. Although parties have agreed compensation, the court has yet to give it the seal of approval. The total compensation figure involved in this case was in the order of £75,000. The court may yet decide to rule that it would be in the child’s best interests to wait until she reaches adulthood and reassess the long-term harm.

Some frequent mistakes that have occurred in the dispensing of children’s prescriptions

<table>
<thead>
<tr>
<th>Prescribed medicine</th>
<th>Given in error</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chloramphenicol 0.5% eye drops</td>
<td>Chloramphenicol 5% eye drops</td>
</tr>
<tr>
<td>Sodium chloride 0.9% nasal drops</td>
<td>Sodium bicarbonate 5% ear drops</td>
</tr>
<tr>
<td>Clobazam suspension</td>
<td>Clonazepam suspension</td>
</tr>
</tbody>
</table>

Risk management

• Flag up children’s prescriptions at the first point of contact, so all members of the team have a heightened awareness about the patient.
• Make the age on a prescription the first thing that you look for, and when conducting a final check, try and build up a mental image of the patient piecing together all of the information.
• Have a system where all such flagged prescriptions are automatically referred to the pharmacist to counsel and hand out.

• It possible, allow some time at the end of the day to review all high-risk prescriptions, especially all children’s prescriptions.
• Ensure care is taken when items are put away upon delivery, to minimise the risk of a selection error.

Members are reminded to report all errors that have caused, or have the potential to cause, harm to a patient to the PDA as soon as they are aware of them, even if there are no obvious signs of escalation.
Pharmacists’ employment status may not always be as it seems. Ruth Williams, PDA Legal Advisor, explains

The PDA receives a high volume of enquiries from members unsure of their employment status. Many do not have a written contract defining the relationship between them and their employer and query their status at the point of a dispute or if contacted by HM Revenue & Customs.

Employee
All employees are workers, but as employees they have a wider range of employment rights and responsibilities that need to be taken into account for the employer. Employees have a right not to be unfairly dismissed, provided they have one year’s or two years’ of qualifying service after April 2012) continuous service. They have rights to paid holiday and are protected from being discriminated against. National Insurance and income tax deductions are made at source by the employer.

Self-employed
These individuals are usually operating their own business providing services to multiple clients. They have far greater control over how and when to deliver their service and the ability to substitute themselves. Employment legislation does not generally cover them because they are in effect not employees. They do, however, enjoy protection under health and safety and anti-discrimination legislation.

Worker
Different from the genuinely self-employed, the status of worker includes individuals working under a variety of contracts. The key requirements for establishing ‘worker’ status are that they:

- Perform work or services personally and cannot send a substitute or sub-contract the work
- Are not undertaking the work as part of their own business.

Case study
A member was a long term locum of some 20 years working solely for one independent pharmacy. There was no contract in place at the start, but a contract of sorts was introduced five years ago.

- The member in effect ran the pharmacy and had responsibility for opening and closing, accepting payments, and dealing with any queries

- She invoiced the pharmacy for her work and paid her own tax and National Insurance.

- If she was not able to work on a particular day then another locum worked instead. On occasion she arranged that locum cover herself.

- In 2012 her employment/engagement was terminated and the company paid her four weeks’ severance pay on termination.

Were there grounds to bring proceedings in the Employment Tribunal for unfair dismissal or holiday pay? To answer that question, the nature of her employment status needs to be determined. The Multiple Factor test is used:

- Is there an ability to substitute?
- Does the worker receive a regular wage or a one-off payment or fee?
- Does the employer have the right of exclusive control?
- Can the employer dictate the place of work and the way it is carried out?
- Who owns the tools or other means of production?
- Bears the main responsibility for profit or risk of loss?
- Who pays the tax and National Insurance?
- Disciple and termination – does the employer have the power to discipline and dismiss?
- Is the employer obliged to provide work? Is the worker obliged to accept it?

Only a detailed analysis of the answers to the questions posed above would provide an answer – each specific case would have to be taken on its merits. In this particular case, the fact that her contract provided her with a right to substitute for herself would strongly suggest that she was a self-employed individual enjoying no rights for unfair dismissal or holiday pay.

Other cases
Recently, there have been two PDA members looking to provide locum services.

PDA receives a wide range of disputes and challenges from pharmacists and pharmacy organisations of different sectors of pharmacy – from community or independent practice to hospital or retail pharmacy. The PDA is also developing practical risk management tools designed to be used by pharmacists in the workplace so as to help them identify, highlight and then take action against problem issues so as to safeguard patient interests. These activities will also reduce a pharmacist’s personal exposure to liability or regulatory activity. Details will be circulated to members in the near future.

Self-employed locum, employee or worker?
The Equality Act places a duty on individual members on how to go about establishing whether you have a disability. For example, there is a distinction between depression and stress, as long term depression would come under the definition of a disability, whereas stress would be regarded as a condition and would not fall under the definition of a disability.

The next step is to notify your employer in writing that you have a disability or have an impairment that may be regarded as a disability under the Equality Act 2010. An employer must know you have a disability in order to take action.

Ask your employer for an occupational health assessment, as one of the questions the occupational health provider will need to answer is whether your impairment falls within the definition of a disability under the Equalities Act.

• Allow occupational health to write to your GP or consultant for more information on your impairment, but you do not have to agree to provide your employer with access to your medical records.

Case study

The PDA dealt with one case for a pharmacist working at an NHS trust at band 8b who agreed adjustments with her employer to alleviate the impact of longstanding depression on her ability to do her job. The adjustments included mentoring on planning and organising her work, and more time to complete reports and prepare for meetings. After the adjustments had been in place for six months, the employee started a disciplinary process against our member on the grounds of capability, which could have resulted in her dismissal. The PDA represented its member at the capability hearing and was able to help the member negotiate further adjustments, such as reduced hours and flexible working arrangements, that would help her work at an 8b standard so that she could keep her position.

In another recent case a member with a visual impairment asked for a range of adjustments from a large pharmacy chain. This company has a salary allocation model in place that allows for pharmacists to spend 1.99 minutes per item dispensed, which he obviously struggled to meet.

EmpLOYERS HAVE A LEGAL DUTY TO MAKE REASONABLE ADJUSTMENTS FOR EMPLOYEES WITH A DISABILITY.

This article discusses what those adjustments are, and how you can obtain them.

Employers have a legal duty to make reasonable adjustments for employees with a disability. This article discusses what those adjustments are, and how you can obtain them.

Only employees who satisfy the definition of a disabled person are entitled to protection. How a disability is defined was originally set out in the Disability Discrimination Act 1995, now incorporated into the Equalities Act 2010. A person has a disability for the purposes of the Act if they have a physical or mental impairment which has a substantial long term adverse effect on their ability to carry out normal day-to-day activities.

Some impairments are easily identifiable and dealt with, particularly visible, physical ones. But a mental impairment, such as depression, where the effects are not so obvious, can be more problematic.

The Disability Act places a duty on employers to alleviate the disadvantage that employees experience in the workplace as a result of their disabilities, and is designed to get employees with disabilities back to work. Examples of adjustments that could be made for a pharmacist with a physical impairment include:

• Making adjustments to the premises by widening doors or moving furniture
• Arranging a full ergonomic assessment with specially designed chairs and stools
• Installing a higher workbench in the pharmacy to reduce bending
• Providing a work bench in a colour other than white so that it is easier for a pharmacist with a visual impairment to see medication

• SuppLying visual aids, such as VisioBook CCTV or magnifiers
• Furnishing a work telephone modified with an amplifier or a test phone where there is a hearing impairment.

Examples of adjustments that could be made for a pharmacist with a mental impairment include:

• A phased return to work, reduced working hours, a later start time, or a reduction in responsibility
• A role as second pharmacist, if available
• Providing more time to check prescriptions - this is particularly important for individuals who find it difficult to concentrate.

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How to obtain adjustments

The PDA dealt with one case for a pharmacist working at an NHS trust at band 8b who agreed adjustments with her employer to alleviate the impact of longstanding depression on her ability to do her job. The adjustments included mentoring on planning and organising her work, and more time to complete reports and prepare for meetings. After the adjustments had been in place for six months, the employer started a disciplinary process against our member on the grounds of capability, which could have resulted in her dismissal. The PDA represented its member at the capability hearing and was able to help the member negotiate further adjustments, such as reduced hours and flexible working arrangements, that would help her work at an 8b standard so that she could keep her position.

In another recent case a member with a visual impairment asked for a range of adjustments from a large pharmacy chain. This company has a salary allocation model in place that allows for pharmacists to spend 1.99 minutes per item dispensed, which he obviously struggled to meet.

• Explore whether you are eligible for a grant from Access to Work to cover the cost of aids, equipment and adaptations, by contacting your local Access to Work centre (for details on how to make an application go to www.gov.uk/access-to-work/how-to-claim).
• Meet with your employer to discuss what adjustments would help you in your job role.
• The cost of complying with the duty to make reasonable adjustments falls on the employer. An employer cannot refuse to make reasonable adjustments on the grounds of cost alone, and a balance needs to be achieved between the needs of the individual and those of the business.
• Employers should look at all factors, such as the extent to which the adjustment is practicable, the disruption to the business, the nature of the employer’s business, its size and resources, and the availability of external finance and grants.
• Once adjustments have been agreed, ask your employer to confirm this in writing, and ensure that it is clearly stated whether the adjustment is permanent or for a fixed period of time.
• If your employer refuses to make adjustments then ask for the reasons for refusal to be set out in writing, and seek further advice from the PDA immediately.

Failing to make reasonable adjustments

A refusal to make reasonable adjustments may give you grounds for a claim in the Employment Tribunal, but strict deadlines apply and a claim needs to be submitted within three months of the date that your employer refused to make the adjustments. It is therefore imperative that you seek advice from the PDA at the earliest opportunity.

In bringing a claim against your employer you would be seeking:

a) A declaration that adjustments should be made, and
b) An element of compensation.

Fortunately, the PDA has not had to assist any members in bringing a claim against an employer for disability discrimination and a failure to make adjustments. We find that, once we become involved, common sense prevails and our members are given the adjustments they need.

If you have a disability and need advice on adjustments to your job role contact the PDA legal team for assistance.

Our member had applied to Access to Work and secured a grant that would cover a third of the cost of the adjustments so the employer would only have to pay £1,000. The employer refused all of the adjustments on the grounds of cost. We explained that, while the target for dispensing applied to everyone, it placed certain individuals at a particular disadvantage. Fortunately, due to PDA intervention, a senior HR manager is now involved and proper consideration is being given to the adjustments our member needs to carry out his role safely and effectively.

By Caroline Gentleman, PDA Legal Advisor

How to obtain adjustments

• The first step is to establish if your impairment falls within the definition of a disability. The PDA can provide detailed advice for individual members on how to go about establishing whether you have a disability. For example, there is a distinction between depression and stress, as long term depression would come under the definition of a disability, whereas stress would be regarded as a condition and would not fall under the definition of a disability.

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Iron fist inside a velvet glove – how employees are dismissed

With a few exceptions, employers generally dismiss an employee for one of two reasons:

1. Conduct – where an individual’s conduct falls foul of a list of such offences set out in the employer’s policies, or the misconduct is otherwise so bad that it could justify dismissal.

2. Capability – where an individual’s ability to perform their role falls short of an employer’s expectations.

Unfortunately, the number of PDAU members being put through a capability process is increasing rapidly.

**Expectations**

An employee is expected to do their job to an acceptable standard and meet reasonable demands made of them by their employer. For its part, the employer is expected to provide the necessary tools, training and resources for the employee to do their job to the standard expected. It is important to remember that it is a relationship where both parties have obligations towards each other.

Problems can arise when weak/unsubstantiated concerns about job performance are used to pressure a pharmacist to do what their manager demands. For example, it is not uncommon for an area manager to want to move a pharmacist to a different branch in the belief that the pharmacy is not achieving its targets because of the pharmacist’s performance. If the pharmacist is unwilling to move, or disagrees that they are to blame, they are often threatened with a capability process to “encourage” them to do the area manager’s bidding.

Another example is when a pharmacist’s inability to reach targets is due to a lack of trained staff, or where professional considerations mean that employer’s targets (e.g. MURs), are unreasonable or even compromise patient safety. The PDAU is also aware of cases where the real motivation for starting a capability process is to cut salary, limit pay rises, or remove bonus entitlement.

A fair capability process that can withstand scrutiny by an Employment Tribunal considering a claim for unfair dismissal should focus on supporting the employee when there are genuine concerns, and not be used as a punitive exercise. However, it is important to remember that such processes are the precursor to a formal disciplinary process that may eventually result in dismissal. Should a pharmacist become aware that their employer is unhappy with their performance it is essential that they are proactive to avoid escalation, and to reduce the risk of being dismissed or being put at a financial disadvantage.

Many companies withhold bonuses or restrict pay rises if someone is being put at a financial disadvantage. This can then be used as evidence to show that your concerns have been raised previously, and that you are not simply belatedly raising concerns in reaction to an employer-led process.

It is essential to include detailed reasons why you are unable to meet targets or reach the required standards on any documents you are asked to sign. These should include lack of staff, unattainable targets, training requirements, or that you believe there are other reasons behind the decision to start a capability process. Never agree to targets that you are unlikely to achieve.

Seek advice from the PDAU as soon as possible. The presence of a union representative is not needed at the early stages and normally not allowed by the employer. However it is important to get advice on how to handle the process based on individual circumstances.

The PDAU is of the view that the increasing use of capability processes by employers is primarily being driven by their unrealistic expectations, coupled with inadequate levels of trained staff, resulting in enormous pressures on pharmacists. It is not because there are suddenly more incapable pharmacists in the workplace.
The PDAU argued that a recent examination that the intended effect of the agreement signed with BPA was to ensure that the BPA would not have any negotiation rights on terms and conditions and that as a by-product the PDAU’s application for negotiating Terms and Conditions would also be blocked. It also alleged that the examination that the intended effect of the agreement signed with BPA was to ensure that no Boots pharmacists could have any negotiating rights over their terms and conditions whatsoever.

The PDAU took this matter to a hearing under the PDAU for purposes of collective bargaining over terms and conditions. The PDAU has submitted an extensive portfolio of evidence which it believes demonstrates the necessary level of support. Many Boots employees also sent in passionate and persuasive comments indicating significant levels of enthusiasm for recognition of the PDAU by Boots.

Nevertheless, Boots has argued in its communications with CAC that members of the bargaining unit are generally content with existing methods of engaging and listening to them. The CAC has now invited both sides to a hearing and this will take place on October 24th to decide whether or not the application should go to the next stage, which is to allow Boots pharmacists and Pre-regs to express their preference via a secret ballot.

The PDAU disagrees with this assertion; however, it is a fact that as a membership benefit, PDAU members enjoy their own personal professional indemnity insurance. This means that in the event of an error or complaint, Boots employees can have their interests looked after independently by the PDA and not by their employer (page 7). Boots has been working with the BPA to persuade employees that they do not need to carry their own personal insurance and can rely upon their employer to support them in the event of errors or complaints. Failing that, the BPA has even been encouraging Boots pharmacists to take out Pi insurance with the NPA (the employers representative organisation). The PDAU makes no apologies for recommending to pharmacists that they should carry their own personal insurance over their employer (or an insurance scheme that is owned by an employer representative body) when something goes wrong.
PDA wins Central Arbitration Committee ruling

Application for formal recognition by Boots proceeds to the next stage

For nearly two years the PDA has sought formal recognition from Boots so that it can negotiate terms and conditions of employee pharmacists with Boots. The company has consistently refused to grant such recognition.

Boots have claimed that employee pharmacists “are generally content with existing methods of engaging and listening to them”.

A recent hearing of the Central Arbitration Committee (CAC), ruled that despite Boots’ refusal, the PDA unions formal application should be allowed to proceed to the next stage of the application process. However, Boots has now challenged this ruling by seeking a Judicial Review of the decision.

The PDA routinely demonstrates its commitment to pharmacists. In recent years it has supported more than 13,000 members through various community pharmacy employment matters. In many cases PDA succeeds via negotiation, in others through legal remedy when our members have been treated unlawfully. This was recently demonstrated when a judge found that deductions of pay from Boots pharmacists resulting from a reduction in premium rates were unlawful.

Already we have secured more than £1million in compensation for our members from various pharmacy employers in this way.

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

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

17,000 pharmacists have already joined the PDA.

Visit our website: [www.the-pda.org](http://www.the-pda.org)
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