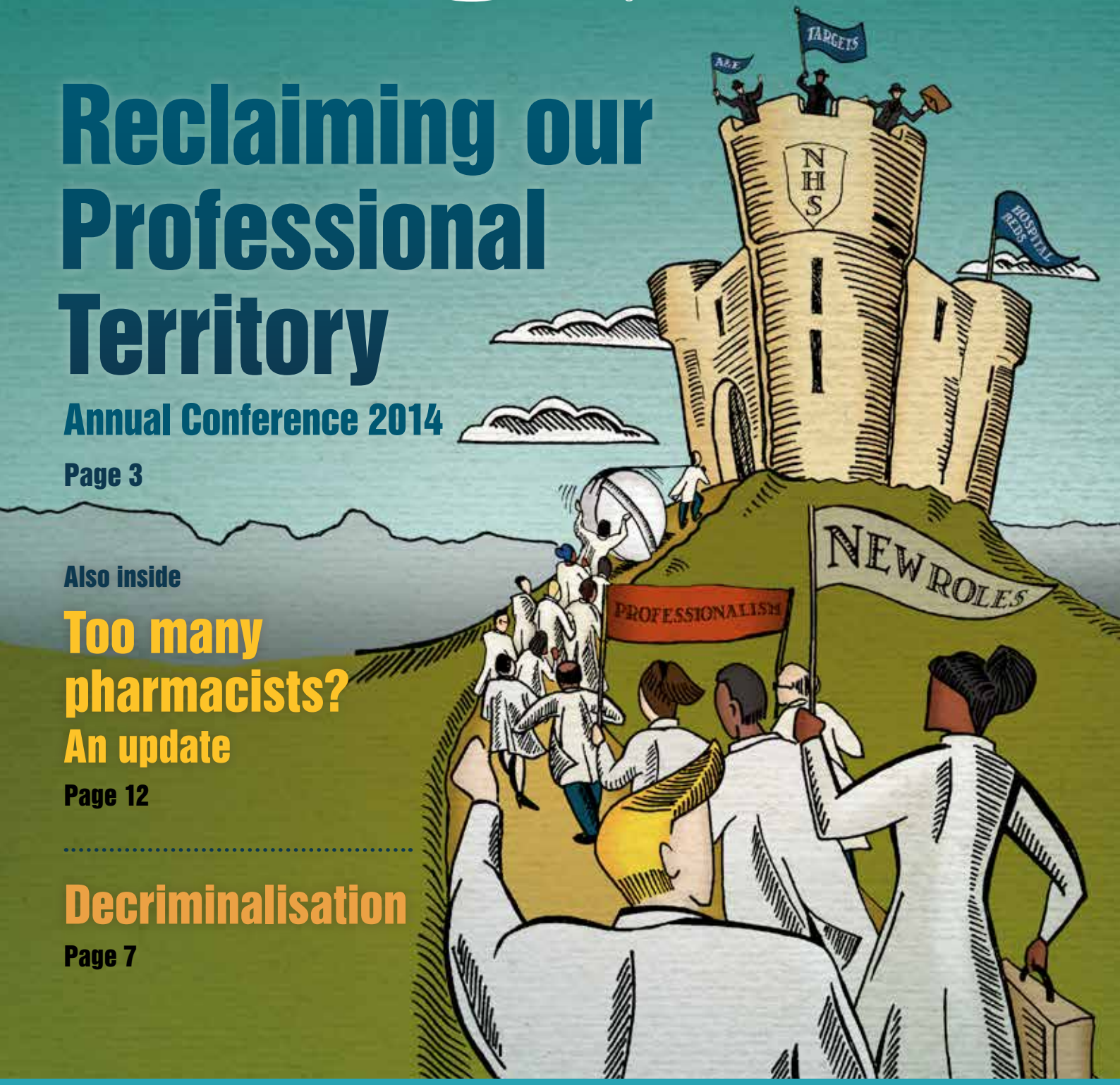
Hospital Pharmacist Edition Winter 2013

insight

pda the pharmacists' defence association

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



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Reclaiming our Professional Territory

The PDA's supports pharmacists who find themselves in difficult situations. With more than 4,000 defence episodes delivered just last year alone, this is being undertaken on a large scale.

Hospital pharmacists tell us that they are weary of having to operate in a regime where the pressures to meet with organisational objectives at times appear to override the primary reason why they are there – to look after patients.

Unsurprisingly, the majority of the PDA defence episodes are due to employee/employer conflicts, where pharmacists are concerned about patient safety but some employers prefer to focus upon meeting targets.

Protecting pharmacists from these and other threats by proactively campaigning to create better working environments to keep them out of harms way in the first place, is a much more effective form of defence. In light of the findings of the Francis inquiry, we now have a good opportunity to ensure that some of these issues are addressed (page 26).

The proactive campaign work of the PDA is carried out across a wide range of fronts.

Three years ago the PDA started a campaign to decriminalise dispensing errors after locum Elizabeth Lee was given a suspended prison sentence for a dispensing error. Progress is being made, but we are concerned about the fact that the current proposals do not protect all hospital pharmacists, so we cannot support them in the current form. We are continuing to apply pressure on the government.

Two years ago, the PDA held a series of conferences to raise the issue of an over production of pharmacy graduates, these helped shape a seven point plan (**www.the-pda.org/sevenpointplan**) which called for (amongst others) a reduction in the number of students in schools of pharmacy. These events helped create a coalition of organisations which together, caused a wholesale review of the approach to undergraduate numbers (page 12). Earlier this year, the PDA organised a series of meetings to allow pharmacists to register their concerns about the GPhC's plan to allow P medicines on self-selection. This campaign has secured the support of pharmacy organisations, senior government officials and has already attracted 5,500 petition supporters. The PDA has recently learned that the GPhC will now hold a consultation on this matter – something that it was not prepared to do previously (page 10).

Although much of this work has yet to cross the finish line, progress is being made. The work has been planned and now the plan is being worked.

By far the most important elements of any PDA campaign however, are when we can create a coalition of supportive organisations and when we can demonstrate that we reflect the views of many thousands of pharmacists. This is where member participation in PDA campaigns is a powerful tool; whether this is through an on-line survey, a petition or best of all through the support of a conference at which policy is created.

Nearly three years ago at a conference in Birmingham we launched the PDA's strategic Road Map vision which called for an individual pharmacist contractor to take over case loads of patients from GP's on Long Term Conditions, delivering Pharmaceutical Care on a named pharmacist registered patient basis. (**www.the-pda.org/scottishroadmap www.the-pda.org/englishroadmap**). This is a role in which only pharmacists have the appropriate skills and training and a role that is not dependent upon owning a pharmacy. Since that launch, other organisations have arrived at the same policy position. In September, the Scottish Government decided that this concept is now to become government policy (Prescription for Excellence page 5). We can barely disguise our delight, since this is something that we have worked for, for some considerable time. It will create additional new roles and new livelihoods for large numbers of pharmacists involving them in delivering the benefits of Pharmaceutical Care to patients and enabling them to practice with professional autonomy, but this is just the start.

We now need to create similar success throughout the rest of the UK and to that end a lot work has already been done (pages 14 & 15).

We make no apology for naming the next stage of our strategy "**Reclaiming our Professional Territory**" – for if we are to create new roles, new jobs and new livelihoods for pharmacists beyond Scotland, then we will need to demonstrate that pharmacists will not only meet the Pharmaceutical Care needs of patients, but that a large number yearn to work with a clinical focus enjoying professional freedom and autonomy from management that is driven by organisational targets.

We believe that this is a role that will see hospital pharmacists being amongst the early adopters.

To help us demonstrate that support, we need to secure the large scale participation of pharmacists at the forthcoming PDA conference to be held in London on Sunday April 6th.

We urge you to make this a date in your diary.

Mark Koziol, M.R.Pharm.S.

The PDA Annual Conference 2014

The defence figures make uncomfortable reading, frequently pharmacists are working in environments where their professional autonomy is being undermined. Usually the conflicts occur because pharmacists are concerned about patient safety and professionalism and some employers are more interested in cost cutting and NHS performance targets.

The research data provides a stark reminder that the model of pharmacy in the UK could be much improved. Non adherence with medication regimes is linked to 48% of asthma deaths, an increase in the risk of death of 80% in diabetes and that Adverse Drug Reactions are implicated in between 5 and 17 percent of hospital admissions – there's much more besides.

Exploiting the excellent opportunities

When these factors are all linked together, what this shows is that not only can pharmacists do much more to improve the current situation to the benefit of patients and the NHS, but that taking advantages of the opportunities that these issues provide through Pharmaceutical Care can create much more rewarding and professionally fulfilling roles for pharmacists than is currently the case.

The question is no longer what but how

Three years ago, at its annual conference, the PDA launched its Road Map Vision which was designed to create new roles for pharmacists. At that time, these ideas were considered by some to be very ambitious. Now, some three years later, after considerable lobbying, the debates about the potential benefits of a more sophisticated approach are largely over and the ideas are taking root. The Road Map concepts are being adopted by other pharmacy bodies, are being seriously considered in other healthcare circles and in Scotland, they have become government policy and enjoying a push, to turn them into mainstream practice.

Emboldened by the progress so far, the PDA commences the next phase of the plan. No longer are we considering the what, now we need to deal with the when and the how to make it happen.

The PDAs 'Reclaiming our professional Territory' 2014 conference will consider how, with a different and much more localised healthcare landscape in England and Wales, the concept of the individual pharmacist Pharmaceutical Care practitioner can come to life.

This conference will give pharmacists, whether working in hospital, primary care, or community an opportunity to develop their thinking and learn about how they can participate in what some have described as a new sector of the profession enjoying professional autonomy and fulfilling new roles.

We urge pharmacists to join us on Sunday April 6th 2014 in London where we will be *Reclaiming our Professional Territory.*

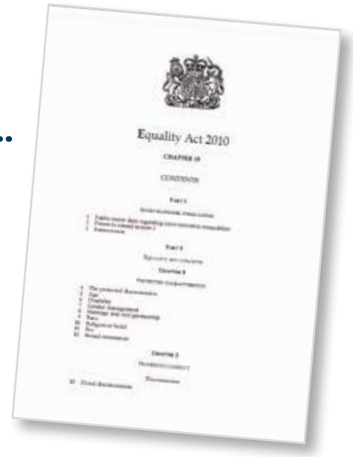
News...

Pregnant Pre Reg – GPhC back down after PDA intervention

The PDA has successfully challenged the GPhC on its policy concerning pregnant preregistration graduates sitting the registration assessment (exam).
A pregnant PDA member approached the PDA after the GPhC refused a request for reasonable adjustments to be made during the assessment, in order to accommodate the physical symptoms of her pregnancy.
This included a request to have additional time granted to compensate for the need for more frequent toilet breaks than non-pregnant candidates.
The GPhC refused this request and just allocated seating closer to the facilities. The pre reg was dissatisfied with this response and asked the PDA for help. A PDA representative wrote to the Adjustments Panel who made the decision, asking for an explanation. In its response, the GPhC stated that the Panel had refused the request for additional time because the condition

"was not necessarily permanent and might not affect her on the day".

The PDA legal team wrote back to the Council and set out in some detail why its policy towards pregnant candidates was contrary to its obligations under the Equality Act 2010 which provides protection for such individuals.
The GPhC then reversed its earlier decision and decided to grant the additional time requested; our member was able to sit the assessment without worrying about the impact her pregnancy might have on the time available to


Equality Act 2010

answer questions. Upon passing the exam the newly qualified pharmacist contacted the PDA and said

"I passed the preregistration exam! Just wanted to say once again how grateful I am for all your hard work and effort in supporting my case with the GPhC"

Universities should welcome PDA's presence at student FtP hearings

Universities now have the powers to conduct Fitness to Practise hearings in which they hold students to account for misdemeanours contrary to the Student Code of Conduct.

The Code reminds students of their responsibilities and sets out standards expected of a health undergraduate. These expectations are not confined to university activity but also encompass their conduct and behaviour in their daily lives.

The PDA supports the concept of getting students to understand the impact of unreasonable behaviour and the consequences of falling below some of those ethical and behavioural standards that they will face when they are in the professional world. However, it is important that students who do find themselves in difficulties have independent and professional expertise to support them through the process.

This is just one of the reasons that PDA provide free membership for pharmacy undergraduates.

In the opinion of Baljit Bagha, the PDA lawyer and union representative who supports students at most of the university Fitness to Practise (FtP) hearings, some universities have a distorted impression of what the PDA does and how it can help students. Consequently, she has experienced universities trying to make it difficult for the PDA to operate on behalf of the member.

"We have experienced more than one university changing its own rules and procedures to try to refuse to disclose important evidence," said Baljit,

"We do not attend these hearings to be litigious or to make the academics look silly. Our mission is to ensure that the student is prepared, has insight into the behaviour that has brought them before the committee in the first place, to ensure that all their evidence or mitigation is presented well and that the student is subject to fair treatment by the committee."

Over the last six months PDA has been involved in a number of student FtP issues. These include, cheating in exams or academic coursework, inappropriate abuse of social media, possession of drugs, road traffic convictions and allegations of dishonesty.

"The majority of universities are open to us representing their students, even if some were a bit wary at first," said Baljit

"We believe that universities and students benefit from our involvement. We have a lot of experience in Fitness to Practise hearings and I am sure that the universities and the PDA want the same thing; a transparent process and a fair outcome for the student."

Baljit urged students to seek advice from the PDA at an early stage to enable it to communicate with the University from the outset.

News...

Boots and PDA clash twice in 48 Hours

By an unusual quirk of fate, the PDA Union executives found themselves facing Boots legal team at two separate hearings within 48 hours of each other.
In September, the same teams from both sides of the fence appeared initially at the High Court of Justice and latterly at the Central Arbitration Committee (CAC) Head Quarters in London.

At the High Court, in an effort to overturn the CACs original decision to allow the PDAU application to proceed to the next stage of the process of gaining statutory recognition within Boots on behalf of pharmacists, Boots sought a Judicial Review. The CAC maintained that it interpreted the law based on a recent finding by the European Court of Human Rights. Boots argued that the CAC had exceeded its power and that under UK law the PDA Union application was inadmissible. The CAC decided not to defend its decision in the court and this left the PDAU's legal Counsel to face Boots single-handed. The Judge reserved his judgement.

On the following day, the PDAU and Boots legal teams locked horns again. The CAC had to satisfy itself that the PDA had enough support within Boots for an agreement to be recognised. They could choose to allow the application summarily, order a ballot or reject the PDAU's application on the grounds that there was insufficient support. The Committee Chairperson deferred its judgement.

At the time of going to press, the PDA awaits the verdict of both determinations.

A prescription for Excellence

180 delegates gathered in Glasgow on Wednesday 13th of November, they were made up of owners and managers, locums, academics, senior representatives of the profession to include government officials and a good representation of pharmacy students. The main aim of the conference was to discuss the Scottish Governments new pharmacy policy "Prescription for Excellence" which has caught the imagination of pharmacists and wider stakeholders. (see feature page 14)

The policy is built upon the principle that individual pharmacists (and group practices of) will provide complex pharmaceutical care to patients with Long Term Conditions who have been referred to them on a caseload basis by GP's. This more integrated approach to primary care would have the effect of dramatically improving the patient journey and it can be delivered by pharmacists who do not need to own a community pharmacy.

The conference concluded that;

1. Professional and clinical leadership was needed to support this policy.
2. Newly qualified pharmacists and students preferred to practice clinically.
3. Educational support mechanisms were needed to enable experienced practitioners to participate.
4. A detailed pharmacy workforce plan should now be developed.
5. What is already known about pharmacist prescribing needed to be disseminated.
6. An all-inclusive roundtable exercise was now needed to develop WIN WIN operational models of practice behind which the profession could unite.

Hospital Pre Regs lead the field at June Assessment

The GPhC preregistration assessment is an anxious time for trainees who face this important hurdle before registration as a pharmacist. For the June 2013 assessment, 641 hospital candidates sat the assessment with 91% passing. This compares to 76% of candidates from the community pharmacy sector being successful, with the overall success rate for candidates being 78%. These pass rates confirm that hospital-based candidates performed significantly better than their community-based colleagues.

There are likely to be a number of factors involved in this striking difference in the level of performance of candidates from different sectors, including the quality/consistency of training, the standard of the preregistration tutor and the working environment.
In a recent survey of newly qualified pharmacists conducted by the PDA, hospital preregistration graduates reported fewer problems with training or lack of support than those who worked for multiple pharmacies. Hospital trainees felt more valued than their community colleagues.

The PDA is concerned by a number of aspects regarding the training of pre reg graduates and has made submissions on this topic to the Higher Education Funding Council for England (HEFCE). For further information on the PDAs HEFCE submission see page 12.

News...

Coroners Inquests involving hospital pharmacists on the rise

There has been a significant increase in the number of Coroners' Inquests in which the PDA is representing its members.

Coroners inquire into unnatural deaths or sudden deaths of unknown cause and deaths which have occurred in custody or state care – such as in a hospital setting. An Inquest is held to establish how a person came by their death; assist in the prevention of future deaths if possible; and to provide public reassurance.

Pharmacists can be called as a witness if they have any information that will help the Coroner or as an Interested Party if their actions may have contributed to the death of the patient. It is recommended, particularly if a pharmacist is summoned as the latter, that they have their own independent representation.

"We are surprised at the number of pharmacists who attend as Interested Parties without legal representation," said Orla Sheils a PDA solicitor *"It is noticeable that doctors, nurses and the organisations that the health professionals are employed by for example the Trust, all appear with their own representative."*

The PDA has recently been at an Inquest whereby more than one pharmacist was implicated but only the member was represented.

"It puts those that are unrepresented at a disadvantage in cases where there is a conflict of interest with the employer." said Orla, *"Sometimes, in an attempt to exonerate their client – the Trust, other legal representatives may leave the unrepresented pharmacist exposed to criminal or civil proceedings. The legal representatives of other 'interested parties' may not realise that the GPhC will normally always be in attendance in some capacity. Additionally, some pharmacists who feel that they have nothing to hide and decide that they do not need any representation may unwittingly give their evidence in a way that could implicate them in some manner. It is always best to have your own representation which is independent of your employer".*

Members are strongly advised to contact the PDA if they are required to attend a Coroner's Inquest.

How I remember Gordon Appelbe

By Mark Koziol

Some pharmacists will remember Gordon Appelbe as Head of the old Pharmaceutical Society Law Department. Many will be familiar with his famous book *'Dale and Appelbe's Pharmacy Law and Ethics'*.

I was sad to hear of his death in September.

The first time that I encountered Gordon was when I was a delegate at a BPSA conference and he was a pharmacy icon hosting the Society's reception. He was a much respected and perhaps even feared individual.

During my early career, as a director of a locum agency, I had to have frequent 'dealings' with the old Law department. I came to realise that Gordon Appelbe was not only fair but surprisingly sympathetic to the difficult situations that employee and locum pharmacists often found themselves in when roughly handled by their employers.

When he retired in 1991, I asked him to provide a support service for locums. Subsequently, on numerous occasions his help rescued locums from difficult professional situations. We came to work closely together in 1997, when we were both on the RPSGB Council and he became the treasurer. He was experienced and wise and taught me a lot about pharmacy's history, its traditions and what the profession is all about. His arguments were often humorous and sometimes profound, but they made me understand why it was so important for pharmacists to have a strong professional leadership body – a principle that I uphold all these years later. His experience was vital when the Save our Society campaign fought on both the legal and the electoral front and managed to stop the government's plans to turn the old RPSGB solely into a regulator. This would have left pharmacists with no professional leadership body.

When the PDA was formed in 2003, Gordon was delighted to be invited to join the senior advisory board. The PDA is built upon the sum of its many parts. Gordon played a crucial role, enthusiastically writing many of the early features in the Insight magazine and supporting some of the most serious PDA defence cases with zeal.

In his early career, Gordon Appelbe was known for holding pharmacists to account, but I believe that the time when he really came into his own was when he was able to help protect pharmacists and the broader profession from injustice, commercialism and government folly.

I will miss him.

Decriminalisation of dispensing errors... Please try harder!

In 2009, Locum Elizabeth Lee received a suspended prison sentence for committing a dispensing error, subsequently and supported by the PDA, she had her prison sentence quashed in the Royal Court of Appeal. However, her ordeal resulted in a commitment from government to address the current situation, where pharmacists may face criminal proceedings for committing an unintentional error.

It is not in the public interest for a pharmacist to have to face lengthy questioning under caution at a police station, endure a detailed examination of their lives and then wait many months before being told whether they would be formally charged all as a result of committing a single dispensing error.

The PDA's ultimate goal is to ensure that dispensing errors, are dealt with by the professional regulator and not the criminal process, unless of course an episode of gross negligence manslaughter had occurred.

The Department of Health's (DH) track record on delivering decriminalisation is not good. Its first attempt was a plan to work with the Crown Prosecution Service to change the approach on dispensing errors – it failed. Its next attempt was to introduce a 'due diligence defence' into legislation. This was a flawed approach which would have made matters worse. Eventually, upon the advice of the PDA and others it was withdrawn by the Minister.

Rebalancing medicines legislation and pharmacy regulation

The DH has now established a steering committee to try and deliver a number of government plans such as remote supervision, the movement of roles from pharmacists to pharmacy technicians and decriminalisation amongst others. (Insight summer 2013)

The first draft of the committee's proposals on decriminalisation has now been disclosed and leaves a lot to be desired.

In essence, the proposals provide an exemption from criminal sanction to pharmacists who have made an unintended dispensing error as long as they can show that the patient had been notified that such an error had been made. This exemption only applies to prosecutions under Section 63 and 64 of the Medicines Act – these sections mainly deal with the wrong or with an adulterated substance being dispensed. This means that pharmacists will still be vulnerable as the proposals do not provide protection to offences under Section 85.5, which deals with incorrect labelling being applied to the dispensed item. It was a labelling offence that led to Elizabeth Lee receiving her custodial sentence. In addition, the proposed exemptions exclude any non registered pharmacies, such as is common place in the hospital setting.

Another pharmacist endures police investigation

There is another, more fundamental concern over the current proposals. Recently, the PDA had to accompany yet another member to a police station after a dispensing error led to the hospitalisation of a patient. This pharmacist had to face five and a half hours questioning under caution and still awaits to hear whether they will be criminally charged – a process that may take several months. When it was explained to the police that the legislation in relation to dispensing errors was changing, the police explained that even under the proposed changes a dispensing error would be an absolute offence and would still involve a criminal investigation.

The defences being proposed by the Rebalancing Committee may be of use later on in the criminal process but they will not deliver the primary aim of this exercise, which is to ensure that dispensing errors are handled by a regulatory and not a criminal process.

The current proposals

- Protection for Section 63 and 64 offences - wrong product and adulteration
- No protection for Section 85.5 offences - labelling errors (a significant proportion of all dispensing errors)
- No protection for many hospital pharmacists
- Initial criminal investigation still in play

They must try harder

Added together, these are serious deficiencies and they have prompted the PDA to write to the chair of the Rebalancing Committee setting out its concerns. Left as it is, the proposals are not enough to deliver satisfactory protection for pharmacists. This is an important opportunity to change the legislation so it must not be wasted. It is not too late to make amends and the Rebalancing Committee should re-double its efforts and craft proposals that will produce the necessary changes.

Ten Years and counting

By John Murphy
PDA Director

The 10th anniversary of the inauguration of the PDA in September 2003 has largely slipped by unnoticed. In this article, John Murphy Director of the PDA gives a personal view of the events that led to its set up and how the association has developed over the last decade.

In truth the journey started more than ten years ago, twelve in fact, when Mark Koziol was nurturing the idea of an organisation that could sustain a strong practical and supportive relationship with employed and self-employed pharmacists that no other organisation would be in a position to provide.

The philosophy developed out of his experiences of running a locum agency for twelve years and serving on the Council of the RPSGB for the previous three. He saw first hand how individual pharmacists were helpless in a profession that was becoming increasingly dominated and led by large employers and government.

At this time, Mark became aware of significant changes occurring in pharmacy, which were creating a much more challenging working environment for pharmacists. These changes exposed individuals to more litigious and hostile action than ever before whether they were employed or self-employed.

Pharmacy chains were emerging and those in existence were growing through acquisition and consolidation making them more powerful in the employment market and more prepared to protect their 'Brand' at the expense of a pharmacist's professional autonomy. Medical negligence claims were becoming the norm rather then the exception and healthcare regulation was in the spotlight. In addition, there was of course the notorious Peppermint Water case, which reminded us all that making a dispensing error was a criminal offence.

It became obvious that locum pharmacists had no support mechanisms at all. Although employee pharmacists had some support from their employer they were vulnerable in employment disputes, or when the employer needed to protect its own interests if there was a professional misdemeanour, which often left the employee facing the regulator. At this time the professional body, the RPSGB, was too busy trying to prove its worth to government as a regulator to be overly concerned about its membership responsibilities.

And so, the seed of the idea of a defence association which would cater for all employee and self-employed pharmacists in all sectors started to germinate. Mark approached me in late 2001 to articulate the idea and entice me on board with the project – we had been colleagues on the executive of the Boots Pharmacists' Association in the mid eighties. I was struck by the idea that we could create an independent body, which would not only provide a reactive defence service for members but that we could be a rallying point for the individual pharmacist's views to balance out the growing power of corporate pharmacy. It was a very exciting prospect.

Following nearly eighteen months of development, we launched at the British Pharmaceutical Conference in Harrogate on Monday 14th September 2003. It was such a closely guarded secret that we took the whole profession and the industry by complete surprise. We captured the imagination and attracted 5000 members within months of inauguration which has grown to over 22,000 today.

At a very early stage we recognised that 60% of the incidents reported were employment/locum disputes. This proportion has never varied significantly over the years even though at present we are dealing with 4000 incidents per annum in total. This growing level of employment disputes encouraged us to consult with our membership to determine the next key development stage of the organisation. PDA members urged us to take up Union status in 2008.

Union status secured

This momentous event gave the PDA statutory rights of representation for our members and confounded those that tried to inhibit the PDA's influence by not allowing us access to disciplinary and grievance hearings involving our members. We further consolidated our position by gaining Independent Union Status conferred on The PDAU in 2011.

> Over the ten years we have flown the flag for the individual's cause and lobbied heavily on their behalf.

The ever-increasing workload on all fronts over the years persuaded Mark and I to develop an in-house PDA team of specialist employment and regulatory lawyers whilst at the same time establishing more pharmacist expertise within the organisation to deal with professional and ethical queries and dilemmas.

Over the ten years we have flown the flag for the individual's cause and lobbied heavily on their behalf. We have not been deflected from our cause irrespective of the pressure and financial might that has been brought to bear against us.

Our efforts have culminated in what could possibly be described as our proudest moment yet. The launch of our flagship programme proposing that pharmacists as individual practitioners get rewarded for the investment they have put into their clinical and professional development; The Road Map for pharmacy. Much of which has been taken up in Scotland with the expectations of other devolved nations buying into the principals at the very least.

Somehow, ten years on, this feels like the excitement of the start up of the PDA, all over again!

A pharmacist spent a day at PDA Headquarters

By Luke Hallahan

Recently, I spent a day at the PDA office in Birmingham, taking a look at some of the work they do on a daily basis and getting a flavour of what they are all about. In the morning, I attended an inter-professional meeting comprising of pharmacists and lawyers, and we discussed some ongoing cases that the PDA are handling.

It was very interesting to see two different sets of professionals working in close liaison, drawing upon each other's areas of expertise and offering their thoughts on cases that another member of the team might be dealing with. These meetings happen once a week and their importance was very clear to see; having professionals from different backgrounds is a significant strength of the PDA. Having the opportunity for these professionals to seek other opinions on matters they deal with means that PDA members can rest assured that they are in good hands, should they ever need assistance.

One thing that struck me most from this meeting was that there seemed to be an overwhelming sense of fear amongst a lot of pharmacists whose cases were being discussed (anonymously of course). It was a common pattern that some pharmacists were very reluctant to raise a grievance against their employer, despite the fact that they had good grounds to do so. This seemed to be because many pharmacists were wary of repercussions from the manager against whom they made the grievance.

Although the employer may not be entitled to dismiss the pharmacist after raising a grievance, members still felt that their life could be made very difficult afterwards. Quite often the pharmacists would want to just 'keep their head down, get on with their job and not rock the boat'.

What also surprised me was the number of non PDA member pharmacists who came to the PDA for help once they had already found themselves in difficulty. Although it was obvious that the PDA personnel had a lot of sympathy for their often difficult situations, the organisation was limited in the extent of support that it could offer. To me this spelled out the importance of all pharmacists having fully up to date PDA membership to fall back on in the event that something went wrong.

Later on in the day, I was given the chance to look at a few cases in more detail. The PDA deals with a wide range of issues, such as employer-employee disputes, fitness to practice issues and dispensing errors. One thing I learned whilst looking at these cases was that it is crucial to stay as open minded and objective as possible; even if something may seem obvious there are always two sides to every story.

In terms of employer disputes, there were some instances where I wasn't sure as to why the employee was advised to challenge a relatively minor sanction following a disciplinary process. It was only after discussing this with PDA staff that I realised that some employment contracts had clauses resulting in a loss of bonus (which is discretionary) if they had received a disciplinary sanction. Therefore, however minor the sanction may seem, it had to be challenged if it was unfair. This made me realise how crucial it was to consider even the finest small print of any employment contract.

I really enjoyed my day at the PDA and found their work fascinating. It was amazing to see just how much work and effort goes into each case and very comforting to know that they would do a very professional job should I ever need their assistance. It also came home to me that pharmacists need to be as honest and transparent as they can with the PDA advisor because in the end if they are not, the appropriateness of the advice they get and ultimately the outcome will be to their detriment.

As the world of pharmacy continually evolves, with even more employer power due to an unprecedented number of pharmacists, there is no doubt of the increasing importance of the role of the PDA.

The Old Fire Station, Birmingham – PDA HQ

The P-meds campaign a progress report...

Ever since the General Pharmaceutical Council first announced plans to allow P medicines to be sold on self-selection, concern has been expressed by pharmacists, pharmacy bodies and even patient representative groups. This policy is not now due to go live until sometime in 2014.

In 2013 PDA and RPS officials met with GPhC representatives to call a halt to these plans but they did not accept the concerns. As a minimum, GPhC was asked to hold a consultation to allow practitioners a say – but they refused.

So what's happened since?

MAY

1 10 PDA roadshow meetings were held throughout the UK and views gathered.

2 The RPS published a Medicines Ethics and Practice guide in which it stated that restricting P medicines from open display constituted good practice.

3 The PDA petition launched. By November this stood at 5,500 signatures.

4 Several government Chief Pharmacists publicly state that the GPhC needed to heed the advice of the profession and that the restrictions on open display should remain.

5 The NPA changed its position on P meds and joined the PDA, RPS and the IPF in its condemnation of the GPhCs position.

6 The GPhC publicly concedes that it had failed to bring the profession on board and that a consultation would now be held.

NOVEMBER

7 GPhC publishes a 'Background paper' which seeks to elicit views.

The GPhC Background Paper

Entitled "Developing guidance to support the safe and effective supply of P Medicines", it contains some fundamentally flawed suggestions e.g.

1. The decision about open display of P medicines will be made by employers, but it is suggested that this will be done in collaboration with 'empowered' employee pharmacists. Experience of community pharmacy reality tells us that a policy that requires employee's to stand up to an employer's commercial demands will not work; MUR targeting is a good example. This is not because pharmacists are weak, but because the employer's position in the master servant relationship is very powerful and more-so due to the pharmacist over-supply situation. Neither do these arrangements embrace locums. These factors render the GPhC's proposed approach inoperable. The PDA's files are full of cases where pharmacists have been disciplined for allegedly not being team players, simply because they raised patient safety concerns.
2. Pharmacists when faced with a difficult interaction, such as when trying to retrieve inappropriate medicines from the hands of a patient should take active measures – they should make a written record.
3. Staff who face difficult interactions with patients should take comfort – through additional training in communication skills.
4. A pharmacy risk assessment should be undertaken by the owner to help it decide whether P meds should be on self-selection. Such an assessment will involve looking at several factors some of which will fluctuate daily. If followed, this guidance would cause P medicines to move on and off the counter routinely. In reality, it is inconceivable that the large corporate merchandising planners will be changing things at the request of the pharmacist on duty. What will happen is that a risk assessment exercise will be undertaken by the employer (probably remotely or via a non pharmacist area manager) any concerns expressed by a pharmacist will be disregarded (see point 1) and P medicines will be placed on open selection where they will stay.

The GPhC has explained that its expertise is not in pharmacy but in regulation. Suggestions like these and others found in this background paper show the extent to which the GPhC lacks a grasp of the realities of practice.

So what next?

The promised GPhC consultation is likely to occur in the New Year. The PDA will submit a formal response. It will urge members to participate, issuing them with the feedback from the Roadshow events.

What you can do

- Sign the petition (if you have not already done so) **www.the-pda.org**
- Persuade colleagues to do so. This helps with the lobbying activity.
- Participate in the GPhC consultation– PDA will issue a call to action.

The GPhC is at odds with many in the profession on a matter which is core to the professions identity – that of guardian of the nation's medicines. PDA will continue to seek a reversal of this flawed policy, success will be reliant on the continuing support of members.

8 Steps to Successful Financial Planning

Start making your money work for you

Financial planning isn't a dark art reserved for the super wealthy. Anyone can, and should, have an idea of what they want to achieve in life. Financial planning simply aligns your finances with your aspirations, making them more achievable.

As the appointed financial planners of the PDA, we've put together this step by step guide to help you with your financial plan.

1 Assess your situation

Even with the best map in the world, you need to know where you are before you can plan where to go. Taking stock of your current situation is the first crucial step to an effective financial plan.

You should gather as much information as possible; incomings and outgoings, savings and debts, pension and property valuations. Write all this down in one place. If you're not sure exactly where you're headed financially, this process alone could well point you in the direction.

2 Define your objectives

Where do you want to be in five, ten or twenty year's time? These are your objectives. Maybe you want to buy your first house, set up your own pharmacy or go on an extended holiday.

Write your objectives down, making sure they are measurable and achievable.

3 Prioritise

Decide which of your objectives are most important to you. Be honest with yourself. We'd all like to retire comfortably, but if you're saving for a mortgage deposit or to pay school fees, is it best to lock your money away in a pension? Retirement planning shouldn't be neglected, but neither should your current lifestyle.

4 Make a plan

Once you have a firm idea of where you are now, and where you want to be in the future, you can work out what you need to do to get there. Essentially, this will consist of how much money to save and when.

If your plan does focus on retirement, or other long term goals like mortgages, you should take into account interest and market forecasts.

You also need to consider arranging protection. Should you suffer illness or injury that prevents you from working, this will ensure your plan continues.

5 Consider all options

One of the most difficult aspects of financial planning is making sense of all that is available.

You should thoroughly investigate all your options, based on your individual circumstances.

6 Stick to your plan

This might be easier said than done. But, it does become much easier to stick to a plan that you have invested a lot of time in. Comprehensive and realistic budgeting is crucial.

7 Review regularly

Your situation will change. Your objectives will change. Therefore, your plan should change. Annual reviews are required at the least, to be sure you are still on track.

8 Speak to an IFA

Independent Financial Advisers (IFAs) make all of the above much easier. They work on your behalf, not the bank or life companies, to find you the most appropriate solutions. They deliver results too. In fact, research conducted by www.unbiased.co.uk indicates individuals who had consulted an IFA were better off by £2,780 per year in retirement. Even so, the biggest benefit in using an IFA is often the peace of mind in knowing you're on the right track.

We're appointed by the PDA to provide members with specialist, independent advice. If you would like more information on how to set up your own financial plan, call 01823 250750.

THIS ARTICLE IS A GUIDE ONLY. IT SHOULD NOT BE TAKEN AS FINANCIAL ADVICE.

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FINANCIAL PLANNERS CII CHARTERED

Higher Education Funding Council takes views on oversupply of pharmacy graduates

PDA urges controls on student input

There is now concern in government circles that the uncontrolled input of pharmacy undergraduates into the system is causing the over-supply of a highly trained pharmacist workforce. In addition, there will already be a large cohort of graduates who will never register as pharmacists, because there are simply not enough preregistration placements available.

The alarm surrounding this issue is best demonstrated by the fact that the Higher Education Funding Council for England (HEFCE) and Health Education England (HEE) has initiated a consultation to assess the views of stakeholders.

HEFCE provides funds to university on a 'per capita' basis for higher education and the aims of HEE amongst other things revolve around being the lead for, planning the workforce of and accounting for funding of education and training for health professionals.

The consultation entitled ***'Ensuring a sustainable supply of pharmacy graduates'*** asked three major questions.

Question 1

Should we allow the market to determine how many students should be taken on by Schools of Pharmacy?

PDA came out strongly against leaving the status quo to prevail. Market forces work best where there is a simple relationship between the demand and supply; where the supply can respond quickly to changes in demand; and where demand and supply are broadly distributed.

The "market" in pharmacy graduates is none of these. There are many stakeholders who have an interest in the output of pharmacy graduates and they place necessary constraints on the way that the market operates. It takes a minimum of seven years for a student to gain A levels, higher education qualifications and preregistration experience to enter the profession and any change in demand cannot be accommodated in much less than a decade.

Although there appear to be a large number of employers who require pharmacist resource, in practice there are a very few who employ the majority of graduates; they operate in a highly regulated pharmacy market, face the same challenges and pressures; and work closely together in a number of pharmacy forums. The demand side of the equation is well organised and not broadly distributed. It is the very reliance on 'market forces' in a system that cannot operate in a "free-market" manner that has resulted in the current over-supply problem.

The consequences of allowing the 'market' to dictate outcomes is now becoming apparent.

There has been a doubling of the numbers of students entering a pharmacy degree course over the last decade. This is because of the number of new establishments offering MPharm courses as well as pressures being applied to the managers of those existing courses to increase the number of places on offer. In the past, Pharmacy has proved an attractive course for high quality applicants who are seeking a "safe" vocational degree with a guaranteed job thereafter. Whilst there were no controls placed upon them, universities have been taking advantage of the demand.

At the same time, employers have seen an increase in the number of pharmacists on the register and can now fill the majority of their vacancies from the current stock of pharmacists. They no longer see the need to train a large number of graduates and are already forcing reductions in salaries.

Based on the statistics available before the 2013/14 cohort took up their preregistration places it was estimated by the 'Centre for Workforce Intelligence' that by the end of this decade as many as 7000 pharmacy graduates will not be able to register because of the unavailability of preregistration training places. This was on the basis that student output from universities and the number of preregistration training places remained roughly static.

The PDA has since sought information from the GPhC through a Freedom of Information subject access request that indicates that the two largest employers of preregistration graduates, Boots and Lloyds, which last year (2012/2013) offered a combination of 1002 training places have reduced that number to just over half (507) for the 2013/4 intake ***(See Fig 1 below)***. The whole of the CCA affiliated organisations are only offering 54% of the places that they made available to graduates last year.

Against the backcloth of student oversupply, there will be intense competition for training places with the result that some graduates will take places without remuneration. The PDA has been made aware of at least one preregistration graduate working for free yet the contractor will be entitled to claim the £19000 training subsidy. The PDA is concerned that this will become an increasing trend.

In the short term employers will benefit from the oversupply of pharmacy graduates by cutting costs through reducing their expenditure on training, driving down pharmacist salaries, (of this there is already considerable evidence available).

The largest employers must not be allowed to fail the profession in this regard and it is for this reason that PDA is advocating that that the numbers of preregistration training places should not be left to market forces, but should be made a condition of holding NHS contracts on a quota basis. In addition, that preregistration graduates should not be employed by their trainers, but should receive NHS bursaries.

Question 2

Should HEFCE introduce an intake control at each institution for entrants to pharmacy programmes?

The PDA is of the view that this course of action is the only feasible option. However, such controls should be predicated on a workforce plan. The plan should inform the decision makers as to how many trainee pharmacists are required. In the absence of that knowledge, all that can be achieved would be a reduction in the numbers produced in the hope that the current oversupply can be reversed and that the lower numbers will be sufficient to meet future needs.

In the consultation, the PDA called for numbers of students admitted to schools of pharmacy to be reduced and controlled centrally and that the General Pharmaceutical Council (GPhC) must do more to raise standards in schools of pharmacy – in particular, the perception held by some schools that pharmacy is a science and not a healthcare course must be addressed.

Question 3

Should a break-point during study should be created which restricts the numbers of students going on to qualify as registered pharmacists?

The PDA did not entertain this preposterous suggestion at the expense of other more important issues that it wanted to bring to the attention of HEFCE and HEE in its submission. Taking considerably more students than could qualify as an MPharm would be iniquitous and dishonest, as a significant proportion would end up with a qualification other than that which they believed they were studying for. This suggestion merely panders to the commercial agenda's that are already nakedly exposed in some universities and leaves many graduates left by the wayside.

Relying on the market to fix the problem of oversupply of pharmacists is unrealistic. Figures generated by Modernising Pharmacy Careers workstream 1, has estimated that the over production of pharmacy graduates will cost the tax payer in excess of £600 million. Controls, which will still not have any impact for at least six years should be implemented as soon as possible.

A full copy of the PDA's submission to HEFCE can be found on *www.the-pda.org/HEFCE*

PDA Recommendations to the Submission

- Numbers of students admitted to schools of pharmacy should be reduced and controlled centrally.
- NHS England must create a pharmacy workforce plan outlining numbers of pharmacists required that would inform the number of students that should be admitted to schools of pharmacy. To do this, NHS England must first generate a solid narrative on the future role of pharmacists.
- Preregistration pharmacy graduates should not be employed by their trainers, but should receive NHS bursaries.
- Numbers of preregistration training places (in community) should not be left to market forces, but should be made a condition of holding NHS contracts and be decided upon on a quota basis.
- The General Pharmaceutical Council (GPhC) must do more to raise standards in schools of pharmacy – in particular, the perception held by some schools that pharmacy is a science and not a healthcare course must be addressed.
- Preregistration training should also be undertaken in the primary care setting.

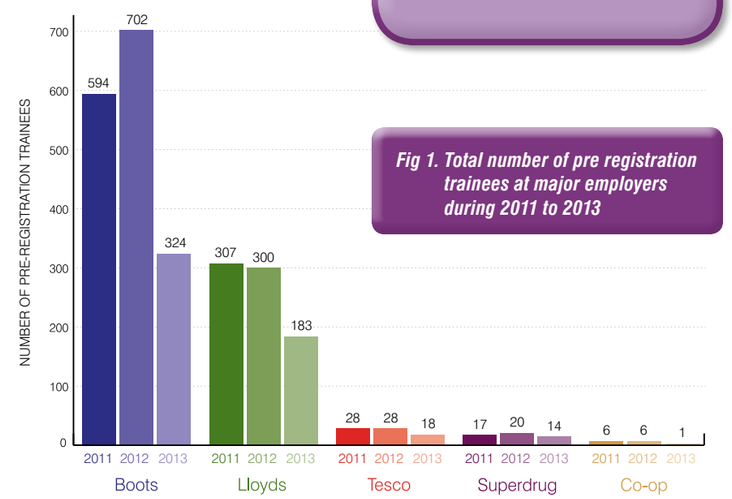


Fig 1. Total number of pre registration trainees at major employers during 2011 to 2013

The pda Road Map

What happens next?

As many PDA members will know, the PDA's Road Map is a strategy which seeks to enable individual pharmacists (and group practices of pharmacists) to contract directly with the NHS for the provision of pharmaceutical care in the community.

Pharmaceutical Care is defined as;

"A patient-centred practice in which the practitioner assumes responsibility for a patients medicines-related needs and is held accountable for this commitment."
Cipole, Strand, Morley 2004

Central to the proposal is that GPs refer case loads of patients with long term conditions on poly-pharmacy regimes to suitably qualified pharmacists so that they can deliver Pharmaceutical Care. This provides new and challenging roles for pharmacists whether they are based in the community, hospital or primary care setting. It improves GP capacity enabling them to concentrate on keeping patients out of hospital and it delivers dramatic improvements to the patient journey.

This feature provides a synopsis of the common Q & A's linked to the Road Map proposal and a description of what happens next.

Q. Why is everyone excited about what has happened in Scotland?

A. The good news is that following a wide-scale consultation, the recently launched Scottish Government policy entitled "Prescription for Excellence" is committed to the concept of the individual pharmacist contractor (or group practices) providing Pharmaceutical Care as described in the PDA's Road Map submission to the Scottish Consultation. In Scotland, the debate has moved on from 'the what' and is now concentrating on 'the how'.

Q. What is the PDA going to do to support the process in Scotland?

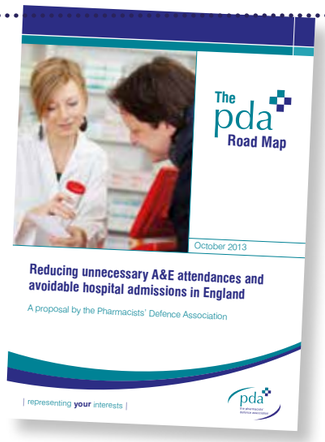
A. Efforts will now be required to ensure that individual pharmacist contractors are properly represented and protected as the detailed agreements on how to deliver the concept are made. What happens in Scotland, if successful, will influence what happens in the rest of the UK. PDA officials have already addressed Scottish pharmacists, met with organisations who are keen to support national roll out and held meetings with government officials.

On March 9th 2014, a PDA Conference in Scotland will be held in Glasgow to ensure that Scottish pharmacists are fully informed and engaged in the next part of the process. PDA members who are from wider afield but who may wish to learn from the Scottish experience are also welcome to attend.

Q. Will England be more of a challenge?

A. Yes, in England targeted services such as MURs and NMS were initially heralded as the great hope for pharmacy. However, because of the way that they have been commoditised and ruthlessly targeted by some employers they have not secured the widespread support of practicing pharmacists. The corporate voice is powerful in England and it is here where the biggest struggle for recognition of the individual pharmacist agenda exists. There are other specific challenges notably;

1. Unlike Scotland, NHS England appears to have no credible developmental leadership plan for pharmacy. Instead, it is expending energy on promoting remote supervision – the plan to operate a pharmacy in the absence of a pharmacist. It is strongly driving the agenda for pharmacy technicians but appears not to have any real programme for what the pharmacists are meant to be delivering in the future. Recently a senior official warned that there may be as many as 3,000 pharmacies too many. It would be easy to conclude that for pharmacy, the approach taken by NHS England is more a part of the problem than a part of the solution, if pharmacy in England is to develop, then this will need to be done through the efforts of the profession and not of the government.
2. The health service in England is now commissioned through localised Clinical Commissioning Groups. A lack of strong leadership at the time of the NHS Future Forum initiative resulted in few pharmacists being appointed to key posts at CCG level. This is in stark contrast to the achievements of the nursing profession. They placed strong demands on government for nurse representation. The challenge for pharmacy is that any new initiatives such as Road Map, will now need to be embedded locally as central government no longer has the influence that it used to at local commissioning level. This is a barrier that pharmacy must overcome.



Q. Are there any developments that could assist with the roll out of the individual pharmacist led service in England?

A. Yes there have been several;

1. In November, the Royal Pharmaceutical Society released its 'Now or Never' strategy. Embedded at its core is the concept of the individual pharmacist practitioner. The PDA has promoted its individual practitioner for a number of years and it made strong representations to the work of this commission, it is delighted with the outcome. Both the professional leadership body and the PDA now share the same vision for future pharmacy roles. This synergy must not be under-estimated as it goes a long way in helping to overcome the intransigence of the government.
2. The A&E crisis in England in particular has provided an opportunity for all healthcare professions to put forward their ideas on helping to resolve the crisis. To that end, in October the PDA brought forward the priority for releasing its PDA Road Map for England. This focuses upon reduced A&E attendances and reduced hospital admissions. The NHS is currently undertaking a review of both the A&E service and also primary care commissioning. The PDA's policy document is being distributed to all the relevant decision makers. **(www.the-pda.org/englishroadmap)**
3. Many community pharmacy contractors, especially the largest have come to recognise that a new model of practice needs to be developed as the traditional supply contract is producing diminishing returns. Some of them are currently undertaking a detailed analysis of the contents of the Scottish "Prescription for Excellence" policy, the RPS "Now or Never" paper and the PDA's Road Map strategy. One would assume that they will seek to protect their position. Independent contractor representatives will need to ensure that they are not left behind. It is entirely possible that in the near future discussions to establish mutually beneficial solutions for pharmacists, contractors and patients could be held.
4. The PDA is organising a national conference entitled "**Reclaiming our Professional Territory**" which will be held in London on Sunday April 6th.

   This will focus upon the opportunities and seek to work out how to overcome the challenges. (See page 3)

Q. What is happening in Wales and Northern Ireland?

A. Both Wales and Northern Ireland have instigated their own strategic policy development exercise; the PDA is engaged in both. The exercise is called "A Pharmaceutical Care plan for the people of Wales" and "Making it Better" in Northern Ireland. The PDA is on the Welsh steering group and is also an appointee to the steering group in Northern Ireland; recently submitting its "Making it Better" consultation submission. **(www.the-pda.org/niconsultation)**

Q. How can I get involved?

A. The PDA's policy work is all about developing new and additional roles for pharmacists through pharmaceutical care. This means that those pharmacists who are already doing an excellent job undertaking a clinical check on prescriptions, ensuring the safe and accurate supply of medicines to the public and engaging in the public health agenda should continue to be able to focus upon these important roles. Those pharmacists wishing to specialise and develop one to one clinical relationships with patients through Pharmaceutical Care should be able to do so by moving up the skills and competency framework and becoming independent pharmacist prescribers. Importantly, pharmacists must now start to talk about individual pharmacist led services wherever and whenever they have an opportunity to do so as this will add more momentum to the agenda.

Q. There is a view that none of this will ever happen and that pharmacy will continue to be largely a supply function with reduced funding and continued threats to employment from automation and skill mix.

A. The health service is in crisis. It cannot afford to continue to operate in such a wasteful and profligate way. Nearly 15% of the entire NHS budget is spent on medicines and if the NHS is to continue to be able to provide services to the public, then pharmacists will need to ensure that the investment in medicines provides a more efficient and satisfactory result. To do this, pharmacists will continue to have an important role to play. Pharmacists delivering these new services will come from all settings, but will probably end up delivering the new services in places where patients needs are greatest; such as in hospices, residential homes, GP surgeries, in hospitals and in the consultation rooms of community pharmacies.

The PDA is committed to this developmental agenda and is working with its members and various organisations to secure the best prospects for pharmacists, the NHS and patients.

Patient safety:

Medicines Packaging – bland or brand?

The PDA handles hundreds of dispensing errors each year, ranging from those of little clinical significance to the most serious of errors some of which resulting in patient death. Reflection is an integral component of trying to establish why an error occurred with a view to minimising future risk, and when our members are asked why they think the error happened, we are frequently told about the similar (if not identical) nature of the packaging between the prescribed drug and that which was incorrectly supplied.

As long ago as 2003 as part of its launch, the PDA (see page 8) conducted a survey of 2,500 pharmacists seeking their views on their working environment and the impact they believed it had on patient safety. They were asked; "If you had a magic wand, what three things would you change in your pharmacy to maximise patient safety?".

The top three themes were; to improve the quality and quantity of support staff, ensure that pharmacists get proper and regular rest breaks and **to change the similarity of generic packaging for different medicines produced by the same manufacturer.**

The same scenario continues to plague pharmacies up and down the country; stock arrives from the wholesaler, there are insufficient numbers of trained staff to put this stock away onto dispensary shelves, one box looks similar to another and a box is placed in the incorrect location. During the dispensing process the wrong drug is selected, which then goes unidentified in the final check and ends up in the patient's hands. Despite the best checking procedure in the world, it is inevitable that errors will occur, due to the human element. It is therefore, crucial that all of the preceding steps in the assembly process are assessed for risk.

There are many more generic medicines on dispensary shelves today, compared to twenty years ago. One reason is the expiry of drug patents (which are usually granted for a minimum of twenty years). This has paved the way for generics companies (who do not share the same research and development costs) to manufacture medicines and market them at a cheaper price. What was once a

colourful, distinctive, branded box is now more frequently, a bland white box with the generic company logo. The NHS as the largest buyer of pharmaceutical products in the UK, benefits from the use of generic medicines, with a cost saving in the order of billions of pounds. And an ever increasing need to drive costs down within the NHS has seen successive governments promote generic prescribing.

There is also the increased use of original packs and a move away from transferring from stock pots, which has seen the elimination of the step of counting out medicines using a triangle or capsule counter. Whereas once, the dispenser or pharmacist would have been familiar with the distinctive colouring, shape, size and even the smell of a particular medicine, the process is now more often, a pick and stick exercise.

International Safety Organisations call for action

The International Medication Safety Network held a conference in October 2013, including representatives from twenty countries. It identified unsafe naming, labelling and packaging of medicines as a global patient safety threat. It was recognised that a collaborative approach was needed between regulators, pharmaceutical industry, healthcare providers and patient organisations and made the following recommendations:

1. Strengthen regulations to
   a. Demand safer design and field testing [of packaging] before release for use.
   b. Incorporate the human factors theory; namely encompass all factors that influence people and their behaviours as part of the regulators standards including the environment, organisational and job factors and individual characteristics.
   c. Promote safer use in practice.
2. The pharmaceutical industry should ensure that its products are safely named, labelled and packaged to minimise errors in selection and use.
3. Healthcare providers should assess medicines, labels and packages, as well as associated devices and software, before purchasing decisions are made and products are introduced into use, so that risks may be identified and mitigated.

The PDA has always tried to raise awareness amongst its members and called upon regulators to address the issue as a matter of priority. The MHRA acknowledges that similarity in packaging can contribute to medication errors and has issued guidance for the pharmaceutical industry. This guidance makes reference to the judicious use of colour to ensure accurate identification of medicines. However, the PDA believes that the MHRA is ideally placed to go one step further and enforce an industry wide standard.

Owners and superintendents of pharmacy businesses hold the reins of purchasing power, however it takes insight, desire and collaboration between organisations to take a stand and purchase in the interests of risk management to help protect patients. Although the percentage errors remains relatively static there is an upward trend in the number and the size of claims being made to compensate patients for the harm caused. It is in everybody's interest to have a risk management strategy in place which recognises it would be preferable to use medicines with distinctive packaging.

Insufficient thought is given to the risk of medication being stored in the wrong place in error. A hierarchy often exists in pharmacies and the task of putting away stock is sometimes delegated to the newest, least qualified member of the pharmacy team. It is this culture that the Responsible Pharmacists can change, and a positive learning culture needs to stem from and be supported by superintendent pharmacists.

Ultimately, it falls to the pharmacist to ensure he/she has a robust checking procedure in place. Nobody sets out to make a mistake but it is known that the risks of harm are far greater with drugs such as prednisolone, methotrexate, and oral antidiabetics.

There are clear cost benefits of generic prescribing and the supply of generic medicines and some would argue, to patients (by not being restricted to specific brand), however this cannot be at the expense of harm to patients.

Case study

There are few drugs, if any, that are dispensed as frequently as oral prednisolone tablets that have a dose of six to eight tablets each day. Although clinically acceptable for prednisolone, this large dose exacerbates the severity of harm when ingested if a different drug is erroneously supplied or cross-labelled at the intended prednisolone dose. In the very famous case, involving a pharmacist, Elizabeth Lee, the prescription was for prednisolone 5mg tablets, 40mg as a single dose each day for five days. Propranolol 40mg tablets were given in error and the patient consumed these at the prednisolone dose. The patient died soon after but no link to her death could be attributed to the dispensing error by the pathologist. Nevertheless, what followed was traumatic for Elizabeth Lee in so much she was given a prison sentence for offences under the Medicines' Act and the grieving family were convinced that the error had killed her.

The PDA is aware of at least two other cases involving prednisolone, one of which involved the supply of prochlorperazine 5mg tablets, and more recently the supply of gliclazide 80mg tablets, in which case the prescribed dose was six tablets each day. As a consequence of both these incidents the police interviewed the pharmacists involved and made it clear that regardless of whether the CPS decided to prosecute or not (and we hope not) that they had committed an absolute criminal offence under the Medicines' Act.

In all three cases the drugs that were inadvertently supplied were generic medicines in packaging that was remarkably similar to the prednisolone that was intended.

Based on our experiences we believe that prednisolone should be given 'red flag' status in all dispensaries.

We urge all pharmacists to heighten their own and their staff's awareness and apply special vigilance when selecting, dispensing and checking medications such as prednisolone which have large single dosage instructions.

Why the new RPS Faculty can help to support the development of new pharmacist roles

Judging by many of the queries and advice line episodes handled by the PDA, pharmacists have been calling for ways to provide evidence of their capabilities as well as demonstrating their advanced knowledge, skills, behaviours and experiences (competencies) in their area of practice for some time. However, this recognition of advanced practice is now becoming a more urgent necessity due to the rapidly changing healthcare environment and the development of new pharmacist roles.

Many visions and reports have been published that are changing the pharmacy landscape offering new roles and much more challenging professional responsibilities. These require the profession to actively stand up and be acknowledged for its professional development and advancement in practice.

This edition of Insight and the pharmacy press generally is filled with the news of professional developmental opportunities. These include 'Prescription for Excellence' the new Scottish government policy on Pharmaceutical Care; 'Now or Never' the RPS report about the future direction of pharmacy and of course the PDA's Road Map (see page 14).

They all describe a greater clinical role, raise the profile of the profession and encourage greater collaborative working across primary and secondary settings representing a fantastic opportunity for pharmacy. They all however point to the need for a profession wide recognition programme.

How to attain professional recognition

The launch of the RPS Faculty in June 2013 has given all pharmacists access to just such a programme and provides a method of attaining post-nominals which will be recognisable to colleagues, healthcare professionals, commissioners, patients and the public, as demonstrating advanced or specialised practice.

The Faculty provides pharmacists with a way of identifying what they need to know at different stages of practice, across all sectors, allowing them to advance their professional practice.

As such, the Faculty represents a vital quality assurance component of any plan to re-engineer the profession and to secure new roles and much more fulfilling responsibilities for pharmacists. The RPS Faculty enjoys the full support of the PDA, indeed without the Faculty – the development of new and fulfilling pharmacist roles will be much more difficult to achieve.

The Faculty Assessment

The Faculty "Recognition of Prior Experience (RPE)" assessment is currently available and comprises three elements:

- Portfolio review using the Advanced Practice Portfolio
- Peer assessment or review in the form of testimonials
- Demonstration of experience through CV

RPE is available for those with more than 10 years' experience. For those with between 2 and 10 years' experience, the RPS will be launching its full Faculty Assessment during 2014 which will comprise a face to face exploration of individual pharmacist experiences.

All assessments are carried out by a quality assured panel of assessors and ratified by the Faculty Credentialing Panel.

The Faculty Stages of Advanced Practice

Following the assessment, a pharmacist can be awarded one of the following post-nominals.

Advanced Stage I:
Faculty Member Stage I

Experienced:
Established in role, performing well, advanced beyond foundation years.

Advanced Stage II:
Faculty Member Stage II

Excellence:
An expert in an area of practice; routinely manages complex situations and recognised as a leader locally/regionally.

Mastery Stage III:
Faculty Fellow.

Exceptional:
A nationally recognised leader in the area of expertise alongside a demonstrable breadth of experience and expertise

The PDA supports the Faculty because it knows that pharmacists need access to support, networks, access to experts and mentors across all sectors and at all stages of their career. Good risk management dictates that a system needs to be in place that helps pharmacists to build a portfolio of transferable knowledge and skills that is widely recognised

PDA members seeking to develop their roles and their practice and take advantage of the newly emerging developmental opportunities are urged to consider what the new Faculty has to offer.

Professionalism Under Fire

There has always been a tension in corporate pharmacy between the commercial considerations of the employer and the professional responsibilities and duties of the individual pharmacist.

When the PDA first came into existence 10 years ago, these tensions manifested themselves in the form of non-pharmacist managers trying to override the judgement of pharmacists in relation to the sale and supply of medicines. Particularly in supermarket pharmacies, local managers often saw medicines as ordinary items of commerce, to be sold in volume and on customer demand. Adequate levels of trained staff were another source of friction between the level of trained staff an employer is prepared to pay for and what is actually required by the pharmacist in order to ensure a safe service in accordance with their professional accountabilities. The same tensions exist today, but the pressure to get even more done with less resource is getting worse as pharmacy workload increases and NHS prescription income decreases.

> A glimmer of hope

Community pharmacists working for many of the pharmacy multiples will be familiar with the threats from managers that follow the non-achievement of Medicines Use Review (MUR) targets. After extensive lobbying by the PDA and following a recent GPhC case involving the Co-operative pharmacy which exposed the bullying tactics used by a senior company manager, the Chief Pharmaceutical Officer of England Dr Keith Ridge, has now made it very clear in a letter to the PDA that MUR targets are not appropriate [NEWS PAGE 5]. This unequivocal statement can now be used by pharmacists as the basis for discussions between them and managers when MUR targets are being imposed by employers.

> Further threats

The PDA encounters many examples when the professional autonomy and judgement of pharmacists is undermined by employers. A few examples include:

- Staff being told by the area manager to interrupt a pharmacist's lunch break immediately a prescription requires checking – when the pharmacist expressed frustration at the constant interruptions this was causing to their rest break, they were called to a disciplinary meeting.
- A pharmacist being told by their manager, who was also a technician, that one reason he was being graded as "not performing" was because the pharmacist had brought errors made by the technician manager to their attention.
- A pharmacist being informed by their line manager that they were being graded as "not performing" because they had refused to dispense an illegally written CD prescription even though, in the view of the PDA professional team, the pharmacist had handled the situation entirely correctly.

These are just a few examples of pharmacists penalised because they made sound professional decisions or raised patient safety concerns, which did not meet with their employer's approval. The management culture that some multiple pharmacy chains create seems intent on trying to produce a subservient pharmacist workforce unwilling to challenge managerial diktat for fear of being judged as not performing in their role.

> Pharmacists can fight back!

Post 'Francis Enquiry', such examples of management behaviours must no longer be tolerated.

All of the pharmacists above and many others besides have received practical support from the PDA in tackling unreasonable and unprofessional conduct from their employer. The GPhC standards for pharmacy owners and employment or Health & Safety legislation are all effective mechanisms to protect pharmacists treated in this way.

Pharmacy Superintendents are obliged to ensure that there are enough suitably qualified and skilled staff, to enable the safe and effective provision of pharmacy services. Superintendents must also ensure that staff can comply with their own professional and legal obligations and are empowered to exercise their professional judgement in the interests of patients and the public.

Pharmacists should always bring matters of concern to the attention of their employer and speak up if necessary. Those who require advice or support in doing so should contact the PDA by email: enquiries@the-pda.org

Paternity and Adoption Rights

Following on from her article regarding Maternity Rights in a previous edition of Insight, Ruth Williams, Legal Adviser, discusses Paternity Rights.

It was expected that by now this article would be about exciting new developments in flexible maternity and paternity rights. It was the governments intention to allow women, whether in same sex or mixed sex relationships the opportunity to share maternity leave rights with their partners. On November 28th, Nick Clegg announced that the government has now committed to making certain changes by April 2015. Consequently, this feature describes the current position.

Two weeks paternity leave

Paternity leave is intended for the purpose of caring for the baby and supporting the caring of the mother for the baby.

The beneficiary of the leave must either be the biological father of the child or the mother's husband or partner (including same-sex relationships). They are entitled to up to two weeks leave.

Only employees benefit and they must have been in continuous employment with the same employer for at least 26 weeks by the end of the 15th week before the start of the week when the baby is due.

Ordinary Paternity Leave cannot start before the baby is born but can commence on any day of the week and it has to finish within 56 days of the baby's birth. If the baby is born before the week it was due, the leave must finish within 56 days of the first day of that week. The two weeks should be taken together though the date that leave is due to start can be changed subject to 28 days' notice.

Statutory Paternity Pay

From 7th April 2013 amounts to £136.78 per week (which changes from year to year) or 90% of normal weekly earnings, whichever is the lower and is only claimable for two weeks.

Payments for Ordinary Statutory Paternity leave should be paid in the same way and at the same time as normal wages and it attracts Income Tax and National Insurance.

Employment Rights (when on leave)

Employment rights are protected while on Paternity Leave to include the right to return to work, any pay rises and accrued holiday.

Additional Paternity Leave of up to a maximum of 26 weeks can be taken only after the baby's 20th week birth date and must be taken within the first 52 weeks of the Baby's life subject to the partner having returned to work and that the partner must have at least 2 weeks of the 39 weeks maternity leave left.

The person who is not pregnant does not have the right to take time off to attend anti-natal appointments unlike the individual who is pregnant.

Locum work during Paternity Leave

The PDA has encountered pharmacists who believe that they can perform locum work whilst they are on maternity or paternity leave. The point of taking leave is to take time off from working to care for the new baby. The PDA stresses to its members that they should not be expecting to be working during that time at all and that the employer could interpret this as a breach of contract.

Adoption Leave

Individuals/couples who adopt a child are entitled to Statutory Adoption Leave of up to 52 weeks provided certain conditions are met. 39 weeks of this leave is paid and individuals must be employees having worked for their employer continuously for at least 26 weeks by the week they are matched with a child. Employers must be shown the Matching Certificate and Adoption Agency details to ensure individuals are genuinely going through an adoption process and entitled to the leave. Statutory adoption pay is calculated on the same basis as paternity leave pay. In the case of same-sex relationships, one of the partners is able to take adoption leave and the other can take paternity leave.

Unfortunately, individuals/couples who adopt a stepchild or have a child through surrogacy do not qualify for Statutory Adoption Leave.

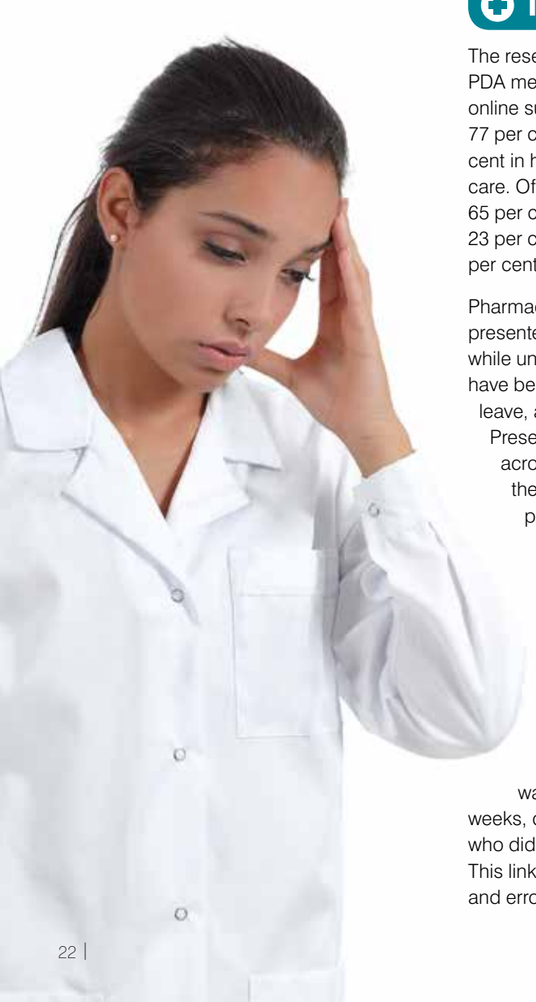
If members have any queries then please contact the PDA

Be safe go sick

Pharmacists are feeling pressure to turn up for work despite being too ill to practise safely. PDA tells members that pharmacists must not bow to this dangerous pressure, which has been proven to increase dispensing error rates and be bad for your own health.

Woody Allen said that simply showing up can result in at least 80 per cent of success in life, but he has never worked in a dispensary. Pharmacists should appreciate more than most the importance of peak performance at work, but a recent study has shown that 76 per cent of them go to work while unwell – a phenomenon known as presenteeism – and this has been proven to increase their chances of making a dispensing error.

The study, conducted in conjunction with the PDA by Natalia Ciborowska, a researcher at the Manchester Business School, and her supervisor Dr Karen Niven, found that pharmacists classed as 'presentees' were more likely to make mistakes. In contrast, sickness absence made no difference to error rates.



Time pressures, difficulty of finding replacements, and the need to compensate for absence on return from leave all made pharmacists more prone to presenteeism. In contrast, higher levels of job satisfaction and job control were linked to less presenteeism.

The study

The researchers surveyed over 1,200 PDA members earlier this year via an online survey. Of those who responded, 77 per cent worked in community, 16 per cent in hospital and 6 per cent in primary care. Of those working in community, 65 per cent worked for large chains, 23 per cent for small chains and 12 per cent in single pharmacies.

Pharmacists were classified as a presentee if they had attended work while unwell, even though it would have been reasonable to take sick leave, at least twice over the past year. Presenteeism rates did not differ much across pharmacy types, although they were slightly higher in hospital pharmacies. Pharmacists were classified as absentee – 43 per cent of the sample – if they were absent from work due to illness at least twice in the past year.

The average number of minor mistakes made by pharmacists who reported presenteeism was 2.54 over the previous 4 weeks, compared to 2.3 among those who did not report sickness presence. This link between sickness attendance and errors in safety-critical contexts had not been made before and defined as "groundbreaking" by the researchers.

Those classed as presentee also experienced more anxiety, depression and emotional exhaustion, as well as reduced work performance, compared to those classed as a non-presentee. In contrast, those classed as an absentee did not have higher error rates, nor poorer psychological well-being and working capacity, than the non-absentees.

The consequences

One of the most profound consequences of sickness attendance is the drastic losses of productivity of up to 20 per cent across a workforce. It is estimated to cost the UK economy £15bn each year, far more than absenteeism. For example, productivity losses from depression and pain have been shown to be nearly three times as great as that caused by employee absence due to the same conditions. Therefore, employees who go to work while unwell cause larger productivity losses than those that stay at home.

Employees who go to work when feeling ill are more prone to worsening their condition not only directly, but also via stress. These individuals have more reasons to worry about their performance and do not give themselves chance to recuperate. People with poor self-rated health who took no sick leave when feeling unwell in the previous three years were twice as likely to experience serious coronary disease compared to those who took one to seven sick day a year, according to one study.

Presenteeism has also been linked to a worsening of mental health. Sick employees who go to work are at a higher risk of developing depression than other individuals, which can have a range of negative consequences in the workplace. These can include difficulty concentrating, not being able to make important decisions and difficulties with communication.

The causes

Factors that lead to presenteeism can be divided into two main categories: personal circumstances and work-related factors. Quality of family life is an important personal circumstance affecting presenteeism; people dissatisfied with their family life are more prone to go to work when ill. Personality traits are also important – presenteeism is more common among people who find it hard to say no to others, those with a strong work ethic, and overachievers.

Time pressure is one of the most often cited work-related factors affecting presenteeism. Having too much work to do and inadequate resource to perform one's role can cause presenteeism, as employees try to avoid accruing a backlog of tasks when they return to work.

Job control is the degree to which employees can adjust the type and amount of work to match their performance due to mental or physical conditions. For example, if cognitive ability is impaired employees may want to focus on tasks that are less mentally demanding but more physically challenging. Employees with low job control are more likely to exhibit the negative consequences of presenteeism because they are unable to adjust their workload so that they can continue unaffected despite feeling unwell.

Employees who work in close teams can feel more under pressure to turn up at work when they should be taking sick leave, as can those who share a lot of tasks and are more dependent on each other. Those who are emotionally attached to their colleagues and count on their social support are also more motivated to show up for work when unwell.

Finally, job security is a key factor influencing presenteeism, particularly in the current financial climate. Employees have been shown to be increasingly likely to choose to compromise their health and engage in sickness attendance as they fear losing their jobs. Workers who do not qualify for sick pay are even more reluctant to take leave.

Considering these factors, individuals in occupations that involve taking care of others, and especially healthcare workers, are most likely to experience presenteeism. This is because they tend to think of their daily duties as "must-do tasks" and tend not to have strong attitudes towards their own health. Studies also report that it is difficult for healthcare workers like pharmacists to find replacements and that the work to be covered on return from sickness absence is far too high.

Case study

A pharmacist working for a large multiple phoned in sick with a norovirus infection. Despite the company's official policy that employees should not come to work with norovirus (because of the risk of spreading the infection, particularly among the elderly, chronically ill and immunocompromised), the pharmacist was investigated with a view to a disciplinary sanction because he had taken one other day off with a sporting injury in the previous three months. The PDA intervened on behalf of the pharmacist pointing out to the Company its advice to customers on its web site and fortunately no further action was taken. Disciplinary sanctions often affect individual performance ratings and can preclude members of staff from bonus payments so the incentive to go to work when ill is made attractive. The PDA has received other reports of employees being coerced with threats, or worse, to come to work when they are ill. This practice is not in the best interests of the employee, patients, nor even the employer in the long term.

PDA recommendations

There must be certain circumstances under which pharmacists do not report for work, because they would be putting themselves and the public at risk

If pharmacists take sickness absence, they should write to their employer stating why they are not fit to work as a pharmacist

Employers must consider the risks inherent in presenteeism and develop their own policies for managing the issue

If a member is threatened with disciplinary action or realises that by taking another day off work when ill it will expose them to such action because of an existing policy, they are advised to contact the PDA for advice.

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 last year. However, what you might not know is that if you were struck down by injury or illness, you could find yourself trying to survive on statutory sick pay of just £86.70* a week. With the average UK household spending around £484 per week, you could find yourself struggling to cope financially.**

When it comes to the importance of income protection, don't just take our word for it – fellow **PDA Member, 'Mr B'**, has been a member of PG Mutual since 2010, and has needed the assistance of PG Mutual on several occasions. He explains:

"Being self-employed there is always a danger of having no money coming in, so the choice to take out an income protection plan was a simple one. Over the years I have taken out a mortgage and started a family – from then on, I knew I needed to ensure my income was protected should I fall ill. I chose PG Mutual due to their expertise in the pharmacy industry, in addition to their not-for-profit status. It's a comfort that PG Mutual know the profession and how hard we work.

Without the support of PG Mutual, things would have been a struggle at times – a friend of mine is undergoing chemotherapy treatment and is only receiving five weeks' sick pay; the lack of support he is receiving is upsetting, however, it is unfortunately common.

PG Mutual's Income Protection Plan is a good product and people need to recognise the importance of protecting their income from unexpected illness or injury. I think the idea of the PDA and PG Mutual working together is brilliant and would urge other members to look into getting cover."

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. Members have the option 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."

*Statutory sick pay at £86.70 per week, DWP, June 2013. **Office of National Statistics, Family spending 2012 Edition, data accumulated in 2011, released December 2012.

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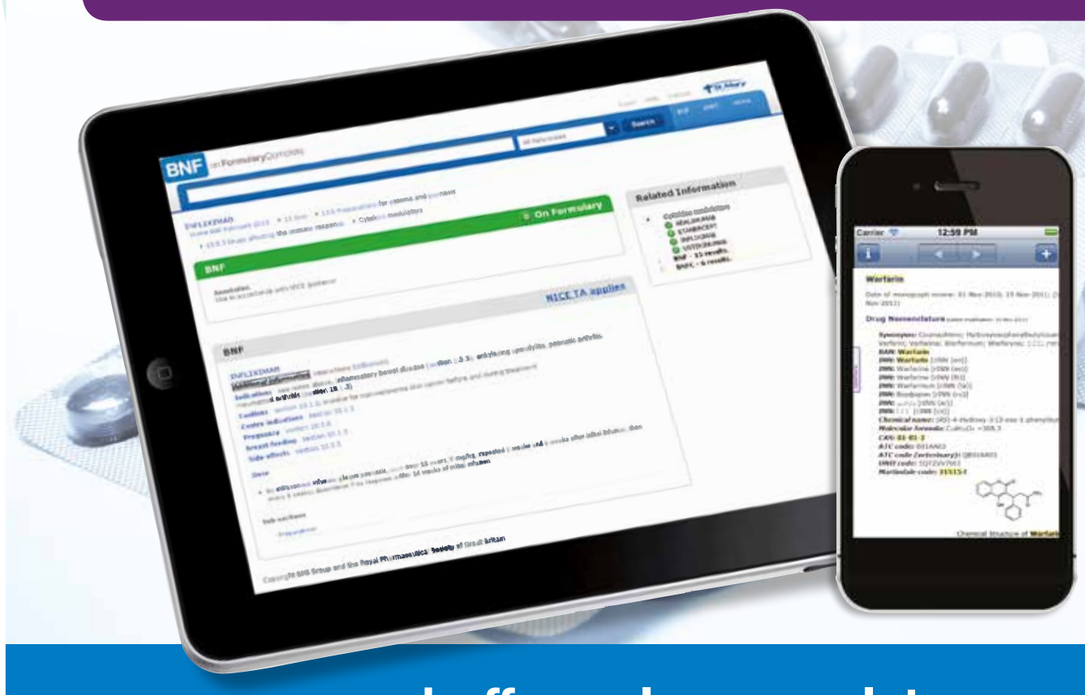

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The risks of bed manager pressure at discharge

By Andrew Jukes, Chair of the PDA Hospital Pharmacist Membership Group Committee

All healthcare professionals know that there are extreme demands on hospital beds due to rising admissions and presentations in A& E. Healthcare trusts are often struggling to meet government targets for A & E waits. Pharmacists have an important role to play and are amenable to facilitating discharges but what happens when tactics are employed to unreasonably hasten or pressurise Pharmacists to discharge patients in order to improve the bed status and therefore create space for new incoming patients?

From information received by the PDA this type of behaviour is creating unsafe working scenarios. It is essential that Pharmacists can operate under their own professional autonomy. They must be able to take an overall view of tasks to be undertaken which include monitoring, review, medicines reconciliation, supply and interventions associated with current inpatients. The discharge prescriptions may be undertaken as part of the whole ward visit once the overall needs of the entire patient population in respect of Pharmaceutical Care, and other appropriate priorities has been professionally assessed by the Pharmacist. It is essential for patients admitted to receive accurate medicines reconciliation and a check on their medicines history so that subsequent treatment plans are optimal and safe for any given patient.

Let us also consider the following research findings;

1. Adverse Drug Reaction are implicated in 5 – 17 per cent of Hospital admissions[1]
2. Prescribing or monitoring errors affect one in eight patients[2]
3. Non adherence has been estimated to be responsible for 48% of asthma deaths, an 80% increased risk of death in diabetes and a 3.8 fold increase of death following a heart attack[3]

As well as the mistakes in the discharge prescriptions that are being demanded with haste, the pressure from bed managers to discharge is eroding the Pharmaceutical Care provided to other patients that are affected by the wider impact of their medicines use.

Additionally, the pressure to discharge is, in some hospitals leading to a lack of respect for the Pharmacists professional autonomy and their relationships with patients and the important wider role that Pharmacists undertake. This behavioural change can also involve the wider healthcare team in issuing discharge instructions to Pharmacists. In some instances, the PDA has even received reports of bed managers coming along to the dispensary (a registered Pharmacy premises) under the direction of a Responsible Pharmacist to 'hasten things along'. Such behaviours present a direct legal and professional conflict for Pharmacists and in light of 'Francis' have wider hospital governance implications.

What needs to be done?

Pharmacists must be able to perform with professional autonomy; they are motivated to achieve discharges but are also responsible for the safety of medicine supply and Pharmaceutical Care. The legal and professional relationships are clear between Pharmacists and Patients. It is important that those who are not required to have a legal and professional relationship with patients are not allowed to expose patients to risk from medication errors or substandard Pharmaceutical Care. It is also important to consider the appropriateness of allowing bed managers into operational Pharmacy areas so as to accelerate the assembly of prescriptions.

To assist hospital pharmacists that are faced with these challenges and to ensure that patient safety and not hospital targets are given the highest priority the tables enclosed outline measures that could be considered so as to risk manage the situation.

Table 1 relates to environmental conditions and ***Table 2*** relates to mechanisms to consider when faced with inappropriate pressure to discharge.

References

1. Co-Morbidity and repeat admission to hospital for Adverse Drug Reactions in older adults. M Zhang et al. BMJ 2009; 338:a275
2. The PRACTICe Study. A report for the GMC,2012
3. Elliot R. Non adherence to medicines – not solved but solvable, J Health Serv Res Policy 2009, 14:58-61

Table 1. Environmental factors that correlate with unsafe working conditions

These factors should be considered collectively throughout the day to establish the extent to which Pharmaceutical Care to patients can be delivered.

Scenario	Risk Assessment	Actions
Staffing levels are too low to safely manage workloads. (i.e. The workload may be too high in terms of new patients to review, supply medicines to and patients that need to be discharged.). The level of support staff in terms of medicines management technicians may not be available, or a sufficient level of cover is not possible.	The Pharmacy coverage will be less if resources are limited. It will not be possible to process the same number of patients (both inpatients and discharge prescriptions.), in the same time interval as when fully resourced with the appropriate level of staff.	• Liaise with colleagues or line management to secure support, or staff to cover another area of responsibility to make more time available on the clinical area/ward concerned • Communicate the concerns about the resource situation with ward management and staff to manage expectations. Prioritise pharmacy tasks; this should be done by the pharmacist acting with professional autonomy • Regular occurrences of this situation should be reported as a safety concern to line management. A record should be kept of any meetings, outcomes agreed and the situation monitored • Consider Submission of a 'Datix' or risk notification to the Hospitals Internal report system
Not enough time to cover tasks allocated. (i.e. A Pharmacist may have multiple commitments such as several wards to cover, dispensary and other activities across any given day). *There can be a disconnect between demands required by wards and fulfilling other demands in other areas provided by Pharmacy services.	This can have the same adverse risk impact as reduced staffing. Undertaking ward based clinical pharmacy with insufficient time is unsafe in terms of medication error risk and substandard Pharmaceutical Care.	• As above
'Skill Mix' of Pharmacy staff available is not appropriate over a given time period.	If there is a reduced availability of Technician cover on the ward then there will be less time for Pharmacist specific tasks such as interventions and clinical prescription monitoring.	• As above
An imbalance exists between new patients as yet to be reviewed by Pharmacy and those requiring discharge.	All of the environmental and staffing level conditions have to be assessed. These then have to be considered according to the Pharmaceutical Care needs of patients.	• As above

Table 2. Inappropriate pressure applied towards Pharmacists to discharge patients

This features high risk behaviours by other healthcare staff that can adversely affect patient safety in terms of medicines supply and the liability to Pharmacists if errors occur. (Table 2, should be considered in the context of environmental conditions described in Table 1).

Scenario	Risk Assessment	Actions
Staff attempt to direct the activity of the Pharmacist towards discharge Prescriptions and interrupt professional activity.	Interruptions increase errors. The attempt to redirect activity towards discharge prescriptions can be causative in errors with both discharge (TTA scripts) and inpatients. It undermines Pharmacist professional autonomy and safe working practise.	• Use the environmental risk assessments in Table 1 to explain the position to the relevant staff • Escalate to the ward manager and line manager • Consider Submission of a 'Datix' or risk notification to the Hospitals Internal report system
Bed managers apply unsafe levels of pressure upon Pharmacists to hasten discharge prescriptions	• As above.	• Use the environmental risk assessments in Table 1 to explain the position to the relevant staff • Escalate if necessary to line manager • Consider Submission of a 'Datix' or risk notification to the Hospitals Internal report system?
Bed managers come into Pharmacy to accelerate the dispensing process to hasten the receipt of discharge prescriptions.	Dispensing is usually undertaken, in premises registered by the GPhC. Such behaviour causes undue stress to staff and increases the risk of errors. The bed managers can make a reasonable request but they lack the necessary legal and professional responsibility.	• Engage in effective communication but don't allow unauthorised staff into operational Pharmacy areas as a rule • Challenge any interference that compromises the safety and integrity of the dispensing process • Discuss with senior managers if this issue is a routine problem. • Consider Submission of a 'Datix' or risk notification to the Hospitals Internal report system?

How can the PDA support Hospital Pharmacist members with these high risk scenarios?

The PDA is committed to challenging situations that expose members to risk and fail patient safety parameters. This issue is one of a range currently under investigation by the PDA as part of its response to the 'Francis' inquiry. The ongoing work currently being undertaken includes:

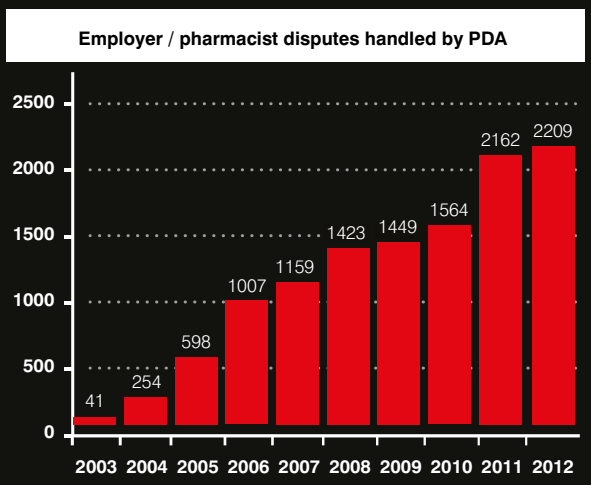
- An evidence based member survey
- Focus Group work to pressure test policies
- Engagement with employers
- Securing the support of the GPhC and CQC
- Supporting members with grievance procedures where necessary.

The PDA intends to develop longer term strategies to address these issues and will issue members with more detailed guidance in due course.

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

THINK AGAIN!

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



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

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

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

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

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

- ✓ More than £1,000,000 compensation already secured from employers who have treated pharmacists unfairly or illegally
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