Pharmacists in GP surgeries
Managing the risks
Pages 14-17

Launch of the locum campaign
Enough is enough
Page 6

Also inside
Hub and spoke
The potential benefits
Page 10

Can you trust your employer?
The Duty of Candour
Page 26

Flu vaccination service – complaints to NHS England
8

Internet Pharmacy – the risks
18

Conflicts of interest
21

Workplace Banter – the pitfalls
24
The Campaign to support locums

During the 80’s and 90’s I was a director of one of the largest pharmacy locum agencies in the UK and I learned then that many of the large community pharmacy employers attribute value only to profit. I saw their eagerness to do whatever they could to arrest the popularity of locum and try to stop the increase in locum rates.

They made it clear that if they could contain locum rates, then they could contain the pay expectations of their employee pharmacists. Clearly, the treatment of locums was inextricably linked to the treatment of all employee pharmacists. This applied not just to community pharmacy, but also, through the Agenda for Change process to hospital and even primary care practice.

Despite all of their efforts, they failed as every year the locum rates were increased and ultimately, this led to improvements in pay for their employee pharmacist colleagues. The locum rate increases were driven by supply and demand forces.

We all know the reasons behind the current over-supply of pharmacists and that they will stop once the five year integrated pharmacy course commences. This will require schools of Pharmacy to link the numbers of graduates to the exact number of pre-reg placements available and that will result in taking on considerably fewer graduates than today.

Changing the supply and demand dynamics is the key and this is one of the reasons why the PDA over the last five years has spent so much time in seeking to develop new roles for pharmacists.

In the meantime however, the supply of pharmacists is meeting and in some areas exceeding the current demand and this is already leading to problems for many locums and also for employee pharmacists. We cannot simply stand by and wait for the supply and demand balance to change, so on pages 6 and 7, we announce the launch of the national campaign to support locums. This campaign will do whatever is possible to support this important and highly adaptable section of the pharmacist workforce. A committee of volunteers has met on several occasions and a plan is underway. I urge all pharmacists to support this initiative. Whether they are full time or occasional day off locums, or even if they are not locums at all but work as employees of any of the pharmacy sectors. If the employers who seek to take advantage of the current situation are not challenged, then sooner or later their behaviours will become the standard affecting all pharmacists. This will be the case whether in England, Scotland, Wales or Northern Ireland.

Pharmacists working in GP practices

The good news is that already some of the new roles are beginning to materialise, starting with the opportunity for large numbers of pharmacists to work in GP practices.

Medicine is the most common medical intervention in the NHS, representing around 15% of the entire NHS annual budget. However, the biggest complaint that we receive from community pharmacists is that they are being relentlessly focussed upon the supply function and are not able to deploy their unique skills around medicines in a significant way. By constantly reducing the staffing levels, the largest employers have pushed pharmacists further back into the recesses of the dispensary where, working under dangerous levels of stress they are increasingly unavailable to members of the public. They are then set unachievable targets to deliver the commoditised services such as MURs.

The GP practice opportunity can go some considerable way in changing that. If the initial that is successful then it could create somewhere in the region of 4,000 new roles for pharmacists who want to develop their clinical expertise.

This could revolutionise the relationship between the local GP surgery and community pharmacy for the better, driving significant benefits for patients.

This is good news for all pharmacists, whether they would like to develop a GP surgery based role, or whether they seek an improved sense of purpose with their GP surgery relationship.

As with all of these new developments, there are risks along the way – but without risk, no progress can be made. The feature on pages 14 to 17 seeks to explore the various issues to look out for. We are entering a new era for pharmacy practice and I urge all pharmacists to consider the implications of some of these beneficial changes upon their current roles.

Sanctions guidance from the GPhC

Earlier this year, the GPhC consulted on its ideas regarding the guidance for the Statutory Committees as to what penalties (sanctions) should be imposed on pharmacists in Fitness to Practise cases.

The GPhC’s idea was that pharmacists who failed to ‘raise concerns’ or exercise their ‘duty of candour’ with patients should receive a much harsher sanction from the Statutory Committee.

The PDA raised serious concerns about the thinking behind such proposals.

The Francis Inquiry into the Mid Staffordshire Hospital Trust found that in many instances where the Duty of Candour had not been exercised or where staff had attempted to raise concerns, they had either been suppressed by the organisational culture of the employing organisation, or their concerns had simply been received, but not acted upon. The PDA’s experience showed that pharmacists who raised concerns were often seen as trouble makers within their organisations and were likely to be subjected to diminished career opportunities or even disciplinary proceedings. Without the support of the employer or at the very least without the reassurance that there will be no internal disciplinary sanction for discussing the details of an error or other problem with patients/healthcare professionals, the Duty of Candour and the requirement to raise concerns becomes much more difficult for pharmacists to exercise.

Placing the emphasis of the guidance on sanctions against pharmacists in the absence of placing any kind of requirements upon employers and non-pharmacists is tantamount to unbalanced and disproportionate regulation.

The PDA told the GPhC that it saw many examples where pharmacists were instructed by their employer not to make any contact with patients in the event of an error. They are told that contact will be made by the employer. When such contact is made, it is often done very belatedly and through standard template letters which fail to satisfy the Duty of Candour. The PDA believes that this is being driven by employers wanting to keep control of the situation possibly to minimise the risks of the involvement of the regulator or others.

The PDA told the GPhC that it must balance its guidance with a requirement placed upon employers to provide a supportive workplace environment for pharmacists that enabled them to exercise their Duty of Candour or to raise concerns without fear of employer reprisal.

Sanctions guidance from the GPhC

Earlier this year, the GPhC consulted on its ideas regarding the guidance for the Statutory Committees as to what penalties (sanctions) should be imposed on pharmacists in Fitness to Practise cases.

The GPhC’s idea was that pharmacists who failed to ‘raise concerns’ or exercise their ‘duty of candour’ with patients should receive a much harsher sanction from the Statutory Committee.

The PDA raised serious concerns about the thinking behind such proposals.

The Francis Inquiry into the Mid Staffordshire Hospital Trust found that in many instances where the Duty of Candour had not been exercised or where staff had attempted to raise concerns, they had either been suppressed by the organisational culture of the employing organisation, or their concerns had simply been received, but not acted upon. The PDA’s experience showed that pharmacists who raised concerns were often seen as trouble makers within their organisations and were likely to be subjected to diminished career opportunities or even disciplinary proceedings. Without the support of the employer or at the very least without the reassurance that there will be no internal disciplinary sanction for discussing the details of an error or other problem with patients/healthcare professionals, the Duty of Candour and the requirement to raise concerns becomes much more difficult for pharmacists to exercise.

Placing the emphasis of the guidance on sanctions against pharmacists in the absence of placing any kind of requirements upon employers and non-pharmacists is tantamount to unbalanced and disproportionate regulation.

The PDA told the GPhC that it saw many examples where pharmacists were instructed by their employer not to make any contact with patients in the event of an error. They are told that contact will be made by the employer. When such contact is made, it is often done very belatedly and through standard template letters which fail to satisfy the Duty of Candour. The PDA believes that this is being driven by employers wanting to keep control of the situation possibly to minimise the risks of the involvement of the regulator or others.

The PDA told the GPhC that it must balance its guidance with a requirement placed upon employers to provide a supportive workplace environment for pharmacists that enabled them to exercise their Duty of Candour or to raise concerns without fear of employer reprisal.
The PDA Union saga nearing completion

The PDA Union (PDAU) will find out later this year whether the journey through the British justice system in its quest for recognition with Boots will end in success or not.

The complex legal argument centres around the agreement Boots entered into with the Boots Pharmacists Association (BPA). Trade Union Law as it stands allows an employer to refuse an application for Union recognition (in this case the PDAU) if a voluntary agreement exists between the company and another Union (in this case the BPA) even if the new applicant has more members than the Union in possession of the agreement.

What made this case a ‘cause célébre’, however, was that the Boots/BPA agreement specifically excluded the right to negotiate on terms and conditions. The PDAU challenged the probity of this agreement citing European Case Law on the premise that Boots and BPA had breached an individual’s inalienable human right by preventing employees negotiating their terms and conditions through their union.

The Central Arbitration Committee (CAC) found in the PDAU’s favour and allowed the application to proceed but this ground-breaking decision led to Boots seeking a Judicial Review.

The Judge, in an interim judgement, agreed with PDAU’s arguments that it was a breach of human rights but that the CAC had no powers to change the written law on the eligibility of an application for recognition. He then invited the PDA Union to seek a ‘declaration of incompatibility’ with European Law. The signals could not have been stronger.

The application for incompatibility, which was suggested by the judge, was to be heard by the same judge who had decided that the PDAU’s arguments should hold sway.

It was a shock therefore when Her Majesty’s Government decided that a change in law was unattractive and mounted a big challenge at the ‘incompatibility’ hearing. Judge Keith reversed his interim decision and agreed with Boots.

The Appeal Hearing therefore, to be presided over by three learned Judges, will have to decide which decision was the correct one. The CAC’s, to allow the original application, Judge Keith’s interim Judicial Review judgement that a ‘declaration of incompatibility’ should be applied for, or his final judgement in deciding that a mechanism already exists to protect individuals’ human rights albeit through a BPA member seeking derecognition of the BPA union agreement.

Healthcare regulation – not fit for purpose

A recent report from the Professional Standards Authority (PSA) is highly critical of the current operation of all healthcare regulators and says the whole system needs to be reviewed. The PSA oversees all of the statutory bodies that regulate healthcare professionals in the UK and social workers in England.

The PSA slams current Health and care regulation as being inequitable and expensive with little evidence for its effectiveness. The report states that regulation needs a radical overhaul if it is to support rather than stand in the way of the serious changes being proposed for our health and care services. Health and care will not be able to change unless the way it is regulated changes.

It argues for right touch regulation principles and the need to understand better what regulation can and can’t do to control the risk of harm. Derelegation should happen in some areas and regulation should focus more effectively in others. Barriers between professions should be removed and new roles created.

The PSA share many of the concerns raised by the PSA, particularly the view expressed in the report of the link between the behaviour and competence of people providing care and the environment in which they work. The PSA has long held the view that the current regulatory regime focuses too much on the individual and fails to tackle poor working environments and cultures prevalent in many pharmacy companies.

The PSA state “It is time for a more nuanced, more sophisticated use of professional and system regulation working in concert to ensure that professionals are personally able to provide good care and are supported to do so within their workplace”.

We couldn’t have put it better ourselves!

PDA meets with Robert Francis QC

Following on from the concerns expressed about non pharmacist managers, PDA officials went to see Sir Robert Francis QC, author of the Francis Inquiry (The Public Inquiry into Mid Staffordshire NHS Foundation Trust). The discussions enabled the PDA to register its concerns that whilst the recommendations he made would likely impact upon hospital pharmacy, they would not impact upon community pharmacy. The concern being that in the community pharmacy setting non-pharmacist managers were an especial problem because they often undermined the professional autonomy of pharmacists.

Sir Robert Francis made useful suggestions as to how the PDA could best approach this issue and agreed to meet with PDA officials to generate some ideas about a range of work place orientated patient safety issues relating to pharmacy.

Pharmaceutical Care services moving ahead

In the last edition of Insight, the PDA announced that it was working with the internationally renowned pharmaceutical care expert Professor Linda Strand from Minnesota USA so that she could assist with the operationalisation of the PDA’s Road Map strategy. This involves caseloads of patients with long term conditions and on polypharmacy regimes being referred to group practices of pharmacists by GPs. In September 2011, senior officials of the PDA and the Head of a School of Pharmacy went to Minnesota to visit the offices of Professor Strand to study further how she has managed to deliver her pharmaceutical care model in the USA and how she has managed to provide pharmaceutical care to more than 1 million patients.

The PDA will be trialling and evaluating a UK model in the next few months.
Locum Campaign

The Locum Campaign

Assisting locum pharmacists who are the victims of poor treatment at the hands of some employers is one of the core roles of the PDA. The association has frequently been able to persuade employers to remedy their actions, through legal processes and other means. However, with problems emerging on such a large scale, a national campaign is now required to support a sizeable proportion of the locum population.

The PDA Locum Membership Group Committee recently convened a meeting which was attended by a number of concerned locums and an action plan which included targeted measures was agreed.

The main aim will be to address the unprofessional behaviours of some employers in relation to locums and also to focus on protecting patient safety wherever it is being threatened by a cost cutting agenda.

The first stage of the plan is to undertake some labour force mapping through surveying the locum population and then to gauge the extent of the specific nature of the problems. It will be important to understand the extent and scope of unprofessional behaviour at the hands of some pharmacy employers and how these concerns may link to patient safety.

In a series of short surveys, locums are asked to identify which employers are the victims of poor treatment at the hands of their companies and also the morale in pharmacies is affected both the quality and quantity of patient safety.

Locums are increasingly receiving poor treatment at the hands of some employers: it’s about time that something was done about it!

• Have you had your locum rates reduced or travelling expenses cancelled?
• Been forced to work with staffing levels that represent a risk to public safety?
• Had your bookings cancelled because a cheaper locum could be found?

Locums are the victims of poor treatment at the hands of some employers and they are being pressurised to hit unachievable targets. In some instances employees, for example requiring locums to work through their lunch hour or beyond the normal closing time of the pharmacy for no pay or they are being pressured to hit unachievable targets. In other instances employers have unilaterally decided to withdraw the payment of travelling expenses.

The PDA has also received many complaints of locums who have built up a relationship with a specific pharmacy, with the local patients and GP surgeries for many years, having their bookings cancelled for no other reason than that they are inexperienced locums prepared to work for less, has been found. The poor treatment of locums is part of a much wider concern in community pharmacy where the is a significant cut in overall staffing levels, a drop in standards and a consequent reduction in patient safety.

The initial locum campaign

Asking locum pharmacists who are the victims of poor treatment at the hands of some employers to bring the problems to their attention and seek remedial action. A number of further potential initiatives designed to encourage an improvement in the behaviour of some employers and to maximise patient safety have already been discussed with the locum membership group and these may well be deployed depending on the response to the survey results.

According to the PDA Chairman Mark Koziol, “Locum pharmacists perform an extremely important and difficult role in pharmacy. The conditions under which they work represent some of the most challenging. Good locums are an asset to the pharmacy where they work represent some of the most challenging. Good locums are an asset to the pharmacy and employers who treat locums poorly must now be prepared to move on annual leave or leave their jobs, go on annual leave or leave their jobs, The canaries in mines, locums often being threatened by a cost cutting agenda.

In some instances employers, for example requiring locums to work through their lunch hour or beyond the normal closing time of the pharmacy for no pay or they are being pressured to hit unachievable targets. In other instances employers have unilaterally decided to withdraw the payment of travelling expenses.

The PDA has also received many complaints of locums who have built up a relationship with a specific pharmacy, with the local patients and GP surgeries for many years, having their bookings cancelled for no other reason than that they are inexperienced locums prepared to work for less, has been found. The poor treatment of locums is part of a much wider concern in community pharmacy where the is a significant cut in overall staffing levels, a drop in standards and a consequent reduction in patient safety.

Locums are increasingly receiving poor treatment at the hands of some employers: it’s about time that something was done about it!

• Have you had your locum rates reduced or travelling expenses cancelled?
• Been forced to work with staffing levels that represent a risk to public safety?
• Had your bookings cancelled because a cheaper locum could be found?

Locums are the victims of poor treatment at the hands of some employers and they are being pressurised to hit unachievable targets. In some instances employees, for example requiring locums to work through their lunch hour or beyond the normal closing time of the pharmacy for no pay or they are being pressured to hit unachievable targets. In other instances employers have unilaterally decided to withdraw the payment of travelling expenses.

The PDA has also received many complaints of locums who have built up a relationship with a specific pharmacy, with the local patients and GP surgeries for many years, having their bookings cancelled for no other reason than that they are inexperienced locums prepared to work for less, has been found. The poor treatment of locums is part of a much wider concern in community pharmacy where the is a significant cut in overall staffing levels, a drop in standards and a consequent reduction in patient safety.

Locums are increasingly receiving poor treatment at the hands of some employers: it’s about time that something was done about it!

• Have you had your locum rates reduced or travelling expenses cancelled?
• Been forced to work with staffing levels that represent a risk to public safety?
• Had your bookings cancelled because a cheaper locum could be found?

Locums are the victims of poor treatment at the hands of some employers and they are being pressurised to hit unachievable targets. In some instances employees, for example requiring locums to work through their lunch hour or beyond the normal closing time of the pharmacy for no pay or they are being pressured to hit unachievable targets. In other instances employers have unilaterally decided to withdraw the payment of travelling expenses.

The PDA has also received many complaints of locums who have built up a relationship with a specific pharmacy, with the local patients and GP surgeries for many years, having their bookings cancelled for no other reason than that they are inexperienced locums prepared to work for less, has been found. The poor treatment of locums is part of a much wider concern in community pharmacy where the is a significant cut in overall staffing levels, a drop in standards and a consequent reduction in patient safety.

Locums are increasingly receiving poor treatment at the hands of some employers: it’s about time that something was done about it!

• Have you had your locum rates reduced or travelling expenses cancelled?
• Been forced to work with staffing levels that represent a risk to public safety?
• Had your bookings cancelled because a cheaper locum could be found?

Locums are the victims of poor treatment at the hands of some employers and they are being pressurised to hit unachievable targets. In some instances employees, for example requiring locums to work through their lunch hour or beyond the normal closing time of the pharmacy for no pay or they are being pressured to hit unachievable targets. In other instances employers have unilaterally decided to withdraw the payment of travelling expenses.

The PDA has also received many complaints of locums who have built up a relationship with a specific pharmacy, with the local patients and GP surgeries for many years, having their bookings cancelled for no other reason than that they are inexperienced locums prepared to work for less, has been found. The poor treatment of locums is part of a much wider concern in community pharmacy where the is a significant cut in overall staffing levels, a drop in standards and a consequent reduction in patient safety.

Locums are increasingly receiving poor treatment at the hands of some employers: it’s about time that something was done about it!

• Have you had your locum rates reduced or travelling expenses cancelled?
• Been forced to work with staffing levels that represent a risk to public safety?
• Had your bookings cancelled because a cheaper locum could be found?

Locums are the victims of poor treatment at the hands of some employers and they are being pressurised to hit unachievable targets. In some instances employees, for example requiring locums to work through their lunch hour or beyond the normal closing time of the pharmacy for no pay or they are being pressured to hit unachievable targets. In other instances employers have unilaterally decided to withdraw the payment of travelling expenses.

The PDA has also received many complaints of locums who have built up a relationship with a specific pharmacy, with the local patients and GP surgeries for many years, having their bookings cancelled for no other reason than that they are inexperienced locums prepared to work for less, has been found. The poor treatment of locums is part of a much wider concern in community pharmacy where the is a significant cut in overall staffing levels, a drop in standards and a consequent reduction in patient safety.

Locums are increasingly receiving poor treatment at the hands of some employers: it’s about time that something was done about it!

• Have you had your locum rates reduced or travelling expenses cancelled?
• Been forced to work with staffing levels that represent a risk to public safety?
• Had your bookings cancelled because a cheaper locum could be found?

Locums are the victims of poor treatment at the hands of some employers and they are being pressurised to hit unachievable targets. In some instances employees, for example requiring locums to work through their lunch hour or beyond the normal closing time of the pharmacy for no pay or they are being pressured to hit unachievable targets. In other instances employers have unilaterally decided to withdraw the payment of travelling expenses.

The PDA has also received many complaints of locums who have built up a relationship with a specific pharmacy, with the local patients and GP surgeries for many years, having their bookings cancelled for no other reason than that they are inexperienced locums prepared to work for less, has been found. The poor treatment of locums is part of a much wider concern in community pharmacy where the is a significant cut in overall staffing levels, a drop in standards and a consequent reduction in patient safety.

Locums are increasingly receiving poor treatment at the hands of some employers: it’s about time that something was done about it!

• Have you had your locum rates reduced or travelling expenses cancelled?
• Been forced to work with staffing levels that represent a risk to public safety?
• Had your bookings cancelled because a cheaper locum could be found?

Locums are the victims of poor treatment at the hands of some employers and they are being pressurised to hit unachievable targets. In some instances employees, for example requiring locums to work through their lunch hour or beyond the normal closing time of the pharmacy for no pay or they are being pressured to hit unachievable targets. In other instances employers have unilaterally decided to withdraw the payment of travelling expenses.

The PDA has also received many complaints of locums who have built up a relationship with a specific pharmacy, with the local patients and GP surgeries for many years, having their bookings cancelled for no other reason than that they are inexperienced locums prepared to work for less, has been found. The poor treatment of locums is part of a much wider concern in community pharmacy where the is a significant cut in overall staffing levels, a drop in standards and a consequent reduction in patient safety.
PDA complains to NHS England over funding of Locum training for National Flu Vaccination PGD

The Head of Primary Care Policy and Contracts, NHS England, responsible for the negotiation on funding for the new National Patient Group Directions (PGD) for Influenza Vaccinations, acknowledged, following PDA’s correspondence laying out its members’ concerns, that she had “been prompted by the [PDA] email to look into the arrangements for locums in pharmacy, in a little more detail”.

The PDA wrote to NHS England, following complaints from Locum members that in order to take part in the vaccination service they would have to self-fund the training or risk being overlooked for bookings.

The PDA accepted that the concept of providing national recognition of the competence framework to be able to provide the service is a good one and should be beneficial to patients and the individual pharmacist, particularly Locums who often find themselves needing accreditation by more than one CCG to provide services under PGDs.

In the letter, PDA focussed on the fact that contractors are paid a fee for providing the service and an add-on premium for training in the PGD competencies and none of this is being used to train Locums.

John Murphy, General Secretary of the PDA Union pointed out in his correspondence, “Locums fulfil a very important role in keeping a continuous service available to the public where regular employees are not available for a variety of reasons. In addition, they are also a vital emergency resource in times of crisis such as epidemics.”

He went on to state “NHS England obviously believes that the training is important enough to fund (and so does the PDA). However, the funding is given ONLY to contractors as part of a service fee and on many occasions the service will be provided by pharmacists who have had to shoulder the burden of the training cost themselves.”

He expressed surprise that funds were not allocated directly to CGGs or nationally commissioned training providers specifically for training all interested pharmacists, whether employed or self-employed.

Although NHS England agreed with the notion that the makeup of the pharmacy workforce had some unique features and that despite pressures on the employment market there are still a third of those community pharmacists registered with the GPhC that perform locums, they likened the situation to that of Locum GPs who are expected to self-fund their own training. This may be the case, and mostly, Locum pharmacists make their own CPD arrangements, but the PDA believes this situation is different in so much as there is a payment being made to contractors specifically for ‘training’ which is being used largely for employees rather than all of those providing the service.

The PDA’s suggestion that funds for training would be more equitably applied if allocated through CGGs rather than individual pharmacy contractors also found no favour with NHS England, because of the way it “had positioned the service” which is “an advanced service which the pharmacies will have to claim for as an accredited service”.

The PDA believes that this is an excellent example as to why the pharmacy contract is outdated. This arrangement, in the same way as MURs, is a ‘commoditised’ service, the funding for which will benefit contractors through the generation of fee payments whilst individual pharmacists will be required to deliver it over and above their current workload and will not be rewarded for their professional contribution. Furthermore, in many cases (where Locums are involved) will they even have their training reimbursed by contractors despite the fact that the contractors have received the money to do so.

John Murphy reflected, “I don’t think that the NHS even considered the issue of Locum involvement and our intervention has pricked a few consciences. We urged NHS England that in future, where they are introducing a service that requires the expertise of an individual pharmacist, to fund the training in a more equitable way. I also requested that where such discussions take place we should be given the opportunity to contribute given the breadth and depth of our pharmacist membership.”

Albeit that it is a ‘done deal’ and in reality, NHS England cannot change anything now, there was a ray of hope when its response ended with “I don’t think that the NHS even considered the issue of Locum involvement and our intervention has pricked a few consciences. We urged NHS England that in future, where they are introducing a service that requires the expertise of an individual pharmacist, to fund the training in a more equitable way. I also requested that where such discussions take place we should be given the opportunity to contribute given the breadth and depth of our pharmacist membership.”

In the RPS 2015 new member survey, 82% of members say they joined because of professional development. Pharmacy and the roles of pharmacists are ever evolving access to resources supporting your professional development ensures you keep up to date and develop skills and knowledge to deliver new services and effective care.

The RPS Faculty helps you identify strengths and areas for improvement, providing a structure for development. If you’ve been awarded with Faculty post nominals, you can gain professional recognition by submitting a portfolio. You will be awarded with Faculty post nominals, receive a professional development plan to focus your learning, and gain access to increased opportunities through the Faculty network.

We’ve asked our members to tell us how they’ve benefited from the Faculty:

Jonathan Burton MrFPGS MrPharmS community pharmacist

“My Faculty Professional Development Plan confirmed much of what I’d learned about my own standards/scope of practice whilst building my portfolio. But it also clarified, through the eyes of objective assessors, my strengths and weaknesses and threw up plenty for me to think about. It’s a long time since I’ve had anything like a 5 year pharmacy plan in my head, not on a personal level anyway, but the whole Faculty process has really got me thinking about how I want to develop my career!”

Cathy Gesson MrFPGS MrPharmS NIHR Clinical Research Fellow, Luton and Dunstable University Hospital

“I have had a varied clinical career. However, I felt a need to measure myself against best practice. I wanted to know:

• Am I good enough / what does good look like?
• How could I measure that?
• Do I have ‘gaps’ / where should I develop?

Longer term it has given me a clear framework and development goal, from Advanced Stage II to Master!”

Greg Lawton FRPhS MrPharmS, Consultant

“One of the greatest benefits of the Faculty is identification of opportunities for further development. The RPS have set out a framework against which to assess one’s own practice, such as research and evaluation and education, training and development. Through doing so it kindles the fires of ambition and interest. I was delighted to discover the range of additional professional opportunities and means to contribute to its development. There are opportunities suited to different skill sets which allow Faculty members to give something back - contributing to ongoing growth and development.”

Find out more about how the Faculty can support your professional development at: www.rpharms.com/ Faculty
Potential benefits of hub and spoke medicines assembly

In March of 2014, the PDA submitted its response to the NHS Call to Action which aimed to improve health and patient care through community pharmacy. Novel solutions to medicines assembly and service provision

In the detail of its response the PDA argued that the pharmacy contract should identify the payments that would be made for the supply of medicines and those for the provision of services and these should be contracted for separately. Such an approach could have the benefit of stimulating the development and the provision of a whole new range of services and it would also potentially have the effect of introducing innovation in the area of medicines procurement and assembly in a way that could produce a WIN WIN for patients, the NHS, the tax payer and the profession.

The profession is rightly proud of its achievements in the community setting in so far as they relate to the supply of medicines. Pharmacists fully understand the important and often laborious work that goes on behind the scenes to ensure that the medicines provided to the public are safe and supplied in accordance with the intentions of the prescriber.

Every day, lifesaving interventions are undertaken by pharmacists across the country which are either not understood or valued by the public, of where the pharmacy service is fully understood and valued by the public, pharmacists should recognise that there is a belief amongst the public that;

• The pharmacist is far too busy in the dispensary to provide a convenient source of advice.
• The value of the community pharmacy transaction is measured by the speed with which the public can collect their medicine.

There is no doubt that community pharmacy is working very hard but is it working smart?

The current situation is unsustainable and one that all pharmacists must address.

How might hub and spoke assembly work?

Currently, medicines procurement, assembly and accuracy checking absorbs the vast majority of the time of the community pharmacist.

Imagine however, if the procurement, assembly and accuracy checking could be done in a central location (the hub) with dispensed medicines then being distributed to the local pharmacy (the spoke). This would leave the local community pharmacy to concentrate on the more professionally valuable parts of the operation – the clinical check upon receipt of the prescription and the patient counselling upon the medicine being handed out to the patient after it has been returned to the pharmacy from the hub.

With the vast majority of prescriptions in the UK being repeated, the reduction in the operational costs of the pharmacy, if it kept far fewer medicines in stock, could be considerable.

Under the current system dispensing is undertaken by humans and this is good to a point but in a very busy pharmacy with many interruptions, dispensing errors occur which lead to patient harm. These also result in employment disciplinary action, regulatory sanctions and sometimes even criminal proceedings for the supervising pharmacist. Added to this is the workload and stress that is suffered by pharmacists through having to dispense and check ever increasing numbers of prescriptions, with ever decreasing numbers of staff. Often, they know that they are unable to spend time with the patients deserving of their attention.

The potential impact of robotics on the accuracy of the dispensing operation could be highly beneficial. Trials in the UK and elsewhere have shown that these are vastly more accurate than dispensing by humans.

If the central hub and spoke system were to proceed, a considerable amount of time could potentially be released enabling pharmacists to concentrate more upon patient facing roles and to directly improve the patient journey. Beyond that, the pharmacist could do much more to help alleviate some of the stress being placed upon the NHS in the current primary care system such as helping to alleviate the GP capacity crisis.

Splitting the pharmacy contract for the supply and service elements

Splitting the pharmacy contract into the elements of supply and services is a fundamental element of the proposal. Already some of the central hub models in the UK have shown that they can reduce the cost of the supply, but this leads to a reduction in pharmacy staffing levels. The purpose of moving to the hub and spoke system must not be about cutting the cost of the community pharmacy service and reducing the staffing levels; it must be about investing the savings made to ensure that community pharmacists can contribute far more in alleviating some of the pressures on the NHS.

Leaving the contract as it is, with contractual payments mainly provided for the supply of medicines, would not be fair to the community pharmacy service vulnerable to a significant reduction in the global sum following a cost of service inquiry. Splitting into two contracts would mean that the true cost of the streamlined procurement and assembly function could be reflected in the contractual payments for supply. It would also mean that the remainder of the global sum could be protected by focussing upon the services contract.

The additional benefits

A split contract could create business opportunities for those wishing to develop procurement efficiencies and assembly. Large scale robotic dispensing and bar code checking systems which could not work on a smaller local community pharmacy scale could be developed on a larger scale by a consortium of independent pharmacists with the profits being retained in pharmacy.

Largely freed from the process of procurement and medicines assembly, the contractual payments for service provision would enable community pharmacists to concentrate on changing how they are often perceived by the public, from that of supplier of products to consumers to that of a healthcare professional enjoying a clinical relationship with patients. Indeed, this element of the contract could be used to fund a second pharmacist in the pharmacy to enable a much more ambitious and comprehensive service offering to be developed. Innovations such as access to the patient’s records should become a core component of pharmacy practice and with a second pharmacist; this prospect would become much more realistic.

Under the present system every time a new service is announced, such as MURs, NMS and more recently flu vaccinations, the collective cheer is very quickly extinguished by the harsh reality that pharmacists at the coal face just don’t have the time to deliver any more new roles as they struggle to deliver the current service.

Within such a framework, the potential for community pharmacy to support patients to get the most from their medicines could lead where this would be the essence of the services element of the contract. Another advantage is that it could enable a pharmacy service to be provided in areas where there was a big demand for services or where there are health inequalities, where the prescription volume would be low.

Issues to manage

No significant changes, such as the suggestion to split the pharmacy contract and also to operate a hub and spoke system are without their potential challenges; these would need to be addressed prior to moving ahead.

• Who would take professional responsibility for any accuracy errors that occurred at the dispensing hub if the pharmacist at the local pharmacy handed a fully final checked bagged item to a patient?
• What would happen to extremely high volume pharmacies that are positioned in areas where their prospects for service provision were limited?
• How could it be ensured that the pharmacy network was not harmed?
• How would the changes be seen by the public?

These and other issues would need to be discussed by the representative bodies and regulators prior to moving ahead. Above all, it would be necessary to ensure that the pharmacy network was not damaged but instead was invigorated as this would ultimately be beneficial to patients. If this could be achieved, then the changes could lead to a new and much more rewarding era for pharmacy.

These changes are now on the horizon

As it stands currently, the only hub and spoke models that are legally permitted are those where both the hub and the spoke are owned by the same pharmacy business. However, the Department of Health has recently explained that it is now looking into relaxing the law prohibiting companies from operating the model unless they own both the hub and the pharmacy. This would allow all pharmacies, rather than just the large multiples to use the system. At a recent conference, the Chief Pharmacist for England called for the law to be lifted as soon as possible.

The stage could now be set to make changes. The challenge for community pharmacy is whether it waits to react to forthcoming government proposals – or whether it steps forward with an imaginative and perhaps radical plan that can deliver the paradigm shift that the public, the NHS and community pharmacy so desperately need.

The PDA will be playing its part in making sure that it already commenced its engagement with the community pharmacy representative organisations.
If I only had a brain

In 2004, Lord Fraser of Carmyle, a long standing Chairman of the RPSGB Statutory Committee (the equivalent of today’s GPhC Fitness to Practise Committee), criticised Locums for allowing themselves to be used as ‘Straw’ Superintendent Pharmacists.

In interpreting what he meant by a ‘Straw Man’, one is drawn to the film The Wizard of Oz.

This classic film story was based upon the New World Order that was unfolding in America after the stock-market crash and bankruptcy of the United States (1929 – 33).

The masses’ behaviours and experiences are represented by Dorothy, the Tin Man, the Cowardly Lion, the Straw Man and Toto the dog. The people are meek and naive like Dorothy. They work so hard that work turns them into stiff robots like the Tin Man (TIN representing Tax Identification Number). The Lion is the “king of the jungle”. We all have lion characteristics, yet we don’t even know it – because we are often too afraid to stand up for what is right.

The Straw Man was the fictitious entity American citizens were given to enable the government to chase their debt during the great depression.

The allegory of the Straw Man was that the real person can act as Superintendent Pharmacists in inappropriate situations. They give the business the credibility of a ‘front man’ on whom the (often non-pharmacist) owner can lay the responsibility if things go wrong from a professional or statutory perspective. The owner cannot suffer sanctions through the GPhC but the gullible Straw Man, who allows the use of their almost ‘fictitious’ persona can and will.

Typically, Locum pharmacists are asked by owners to be their part-time Superintendent Pharmacists. Frequently they are told that it is a position that will not carry too much responsibility and that it can be performed partially and even remotely. Often pharmacists feel obliged to acquiesce if pressure is applied.

These responsibilities cannot be enacted remotely. In one case the Superintendent scrutinised the RP register after closing time following completion of his own locum engagements. Following an investigation by the GPhC, the entries were found to be forged by the non-registrant owner of the pharmacy.

This is an absolute offence and a Superintendent can suffer sanctions through the GPhC but the owner of the pharmacy cannot suffer sanctions. Furthermore, should the owner to account if practices are not acceptable. The owner cannot suffer sanctions through the GPhC but the gullible Straw Man, who allows the use of their almost ‘fictitious’ persona can and will.

Problems are not just confined to small independent pharmacies. In another case, a pharmacy group operating as a number of separate companies required a Superintendent for each pharmacy. Orders for restricted medicines were placed by the group’s head office (purportedly on behalf of the pharmacies). These responsibilities cannot be enacted remotely. In one case the Superintendent scrutinised the RP register after closing time following completion of his own locum engagements. Following an investigation by the GPhC, the entries were found to be forged by the non-registrant owner of the pharmacy. This is an absolute offence and a Superintendent is responsible under legislation to ensure that an RP register is legally kept up to date which in turn can be used as an audit trail for patient safety purposes.

Being the Straw Man is not a tenable position because Superintendent Pharmacists will need to hold the owner to account if practices are not acceptable. Furthermore, should anything go wrong, it will be the Superintendent who will be held responsible and generally not the non-pharmacist owner.

Derek had the perfect prescription for protecting his finances in the event of long-term sick leave.

Thank goodness for PG Mutual’s income protection cover

Whether you’re a doctor, nurse, or pharmacy staff, an income protection plan from PG Mutual ensures that you receive a regular monthly income for an affordable, monthly cost if you find yourself on sick leave.

As a PDA member, you are entitled to a discount on PG Mutual’s Income Protection Plan: 15% OFF your first two years’ cover*

Just visit www.pgmutual.co.uk/Quotation, and enter your discount code ‘PDA’.

By John Murphy
PDA Director

---

*For full Terms & Conditions, visit www.pgmutual.co.uk. Offer ends 31.12.2015. PG Mutual is the trading name of Pharmaceutical & General Provident Society Ltd. Registered office: N Parkway, Portman Wood, St Albans, Hertfordshire AL2 1BN, incorporated in the United Kingdom under the Friendly Societies Act 1992, Registered Number 462F. Authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority, Firm Reference Number 110023.
Historically, these pharmacists and the development of the discipline of ‘Primary Care Pharmacy’ (PCP) were supported by the National Prescribing Centre (NPC) which employed senior pharmacists. It developed a considerable expertise in the primary care pharmacy discipline. It provided training material, organised ongoing CPD and enabled peer review through the support and encouragement of PCP networks. It provided a local point where learning experiences could be shared and examples of good and poor practice could be disseminated.

When independent prescriber for pharmacists

When independent prescribing for pharmacists was introduced, this provided an opportunity to expand a more advanced hierarchy so as to facilitate the development of specialisation within the discipline. Those pharmacists who wanted to stay involved in the relatively less risky ‘administrative’ roles such as switching programmers, formulary work or even managing repeat dispensing could do so. Those with higher diplomas or independent prescribing qualifications could participate in some of the most advanced forms of clinical pharmacy practice in both primary and secondary care, or move from one sector to the other with little impediment.

In July of 2015 NHS England, prompted largely by a crisis in GP retention and recruitment and a move towards seven day doctor cover, announced that it would help with the GP capacity crisis by providing £15 million to part fund 250 pharmacist posts to work within GP surgeries. This investment has been substantially increased recently to include at least a further 125 pharmacists due to a strong demand for the initiative. Similar arrangements have also been put in place in Northern Ireland where it is hoped that around 60 pharmacists will join the scheme. Added to this is the ongoing work in Scotland with Scottish Government’s Prescription for Excellence Programme. Since then, the PDA has received many enquiries from members about the risks associated with working in these new roles.

This feature seeks to provide some clarification that will not only be relevant to those working under this new NHS England initiative but possibly also to pharmacists working in Scotland and Northern Ireland.

Independent prescribing for pharmacists

Since the very outset, the PDA has provided professional indemnity protection for pharmacists involved at all levels of Primary Care work and as a result, it has been able to develop a suite of different indemnity protection cover levels which aim to match the levels of specialisation and risk associated with a specific role.

Pharmacists working in GP surgeries – what are the risk management considerations?

In one way or another, pharmacists have been working alongside GP’s in their surgeries for several decades and there is a lot of experience within the profession as to what these roles entail.

There are those pharmacists whose pharmacy is located in a GP surgery which results in a close working arrangement.

There are those pharmacists who enjoy a role first developed in the early 1990’s, the ‘practice based’ pharmacist. Here pharmacists worked on surgery based priorities and these roles grew over time as part of an iterative process. Initially these started out as a more administrative role, such as helping the surgery to avoid being a prescribing outlier but ultimately, they evolved into patient facing clinical roles.

There are also those pharmacists who are directly employed by or contracted to work through a third party for local NHS primary care organisations; the Clinical Commissioning Group or Health Board. Pharmacists in these roles may well have also been involved in some GP surgery based work, but largely, they sought to deliver the organisational priorities of the primary care organisation.

Typically, at senior levels their work involved strategic activity, but some would be involved in formulary work, switching programmes, development of patient group directions and a lot more besides. This work could extend to being part of a multidisciplinary team including working in virtual wards to decide upon how to manage the most complex of patients; some of these pharmacists also act as PCD troubleshooters to support problem surgeries.

Over time, these developments clarified how pharmacists could start off in this area of work in the first place; they created a structured career framework which enabled pharmacists to develop their roles. All of this was supported by a banded skills and salary escalator which linked salary to higher levels of skill, responsibility and service provision. The growth of primary care pharmacy and ultimately specialisation enjoyed a gradual and orderly development.

Today, some of the pharmacists involved undertake these roles in a full time capacity; many however have portfolio careers with a range of different challenges working for several different employers. The majority of these pharmacists are involved in a mix of activities, ranging from administrative to patient facing roles, whilst others have advanced clinical roles and they are working as ‘pharmacists with special interests’ (PWIS).

Indemnity protection for pharmacists working in GP surgeries

Since the very outset, the PDA has provided professional indemnity protection for pharmacists involved at all levels of Primary Care work and as a result, it has been able to develop a suite of different indemnity protection cover levels which aim to match the levels of specialisation and risk associated with a specific role.

GP’s have made it clear that pharmacists involved in this scheme will need to shoulder the burden of the indemnity insurance themselves.

The PDA has a lot of experience in the development and understanding of primary care pharmacy. Over time, underwriters became fully aware of what works and what can go wrong. Wider healthcare underwriting experience means that the underwriters are confident that the risks associated with any new healthcare discipline can usually be identified and managed by following a well ordered, iterative and essentially ‘managed’ process.

However, the recent £15 million funding announcement has created a new and completely different dynamic with none of the hallmarks of the measured and informed approach described above. Within the detail of the plan (or more worryingly, lack of detail) emerge a number of factors that give cause for concern from a risk and indemnity point of view. Indeed, even the many multidisciplinary triadings that have been held in England so far to discuss these proposals, already GP’s have made it clear that pharmacists involved in this scheme will need to shoulder the burden of the indemnity insurance themselves as they do not wish for them to be covered by the surgery indemnity arrangements.

Those pharmacists seeking to participate in this new scheme are urged to observe a number of risk management principles so as to develop their activities in a way that minimises the risks of harm to patients and the risk of liability to themselves.

The importance of role clarification

It appears that it was neither the role nor the intention of the NHS Alliance or the RPS to assess the risk profile when they drew up a list of diverse and seemingly disconnected activities that could be a part of the £15 million allocation.

Financial Report

£ Salary Scale

Pharmacist with special interests

Qualified as independent prescriber

Post two year qualification, studying for independent prescribing qualification

Newly qualified pharmacist studying for clinical diploma

ADVANCED PRACTITIONER

CONSULTANT

SPECIALIST

PRACTITIONER
One would be forgiven for thinking that pharmacists would be involved in all of the roles described, ranging from basic tasks such as administering formulated management and managing repeat prescriptions through to the highly skilled management of patients on long term conditions and prescription. These pharmacists may deliver these services to patients in different settings, such as community pharmacies, hospices, and care homes. Thus, the lack of expertise in the starting specification can be a concern. It is a concern to see that the government has specified that the GP surgery role is band 7 role and that some supervision would be provided by a band 8 pharmacist. It is suspected that the level of clinical responsibility and the competence level is considerably cost, but it creates a starting point where the entry level (advanced practitioner pharmacist) would need at least a clinical diploma with at least two years post qualification experience. In the view of the PDA this should be a senior level band 7 at the very least. The most challenging of the clinical roles on the list are suitable for band 8 pharmacists who as well as having considerably more experience have the opportunity to join this scheme. Band 8 pharmacists with these supervisory responsibilities under the current scheme specification will additionally need to establish exactly what the scope of their responsibilities will be. Furthermore, they will also need to understand the extent of their accountability for the activities of the band 7 pharmacists that they will be supervising.

A focus upon training provision

Historically, training for primary care pharmacists was provided by the National Prescribing Centre – NHS England however have not asked the NFC to provide the training programme for this new scheme. Perhaps the reason for this was because the NFC was integrated with NICE in 2012. Instead, NHS England and Health Education England have asked the Centre for Postgraduate Pharmacy Education to provide training for 375 pharmacists who will now be funded as part of the recently expanded scheme in England. Each intake of 30 trainees will start with a four day ‘boot camp’ with sessions on leadership, medicines optimisation in practice, consultation skills and medical examination techniques. This will be supplemented by on line learning and self-directed learning. There will be little focus upon therapeutics which will be an important skill required. The proposition that pharmacists can be taught medical examination techniques in a limited session within a four day training ‘boot camp’ may sound attractive but it is overly ambitious and cannot provide pharmacists who may have no prior experience of this area with enough

Feedback to the PDA from members across the UK is that there are two schools of thought as to the work that pharmacists in GP surgeries may be involved in. There is that pharmacists will be primarily focussed on cutting the costs of medicines use and otherwise on a cost cutting agenda. This is to an extent shared by the Board of the Primary Care pharmacist role with which many GPs are familiar. In Northern Ireland there is already a debate about the GP based pharmacists being primarily involved in cost cutting and their band 6 pharmacists are being considered for this role. The other approach is that these new roles pharmacists will be taking some work from GP’s and undertaking a range of patient facing clinical roles. In practice the second of these views must prevail as pharmacy will only have a sustainable future in the GP surgery if pharmacists can develop clinical relationships with patients in their own right. The reality is that GP surgery based pharmacists will be involved in both areas to differing

Questions over training provision.

Setting up a GP surgery based group

If you are a pharmacist that is currently involved in the NPSH England training programme, or are preparing to work as a pharmacist in the new GP surgery based project in Northern Ireland, or are seeking to get involved in the Prescription for Excellence programme in Scotland or even if you are already an established GP surgery based pharmacist, then why not register your details with the PDA. In so doing you may be able to assist with the PDA research programme into GP surgery based work and you will receive information based upon the activities and employment experiences of your colleagues as soon as it becomes available.

To do so – go to the PDA website www.the-pda.org
The remote nature of an online pharmacy consultation has clear disadvantages due to the lack of personal contact with the patient...

It appears that some pharmacists are simply signing on as the Responsible Pharmacist with no real understanding of what safeguarding mechanisms are in place or whether they are fit for purpose.

In the event of an adverse incident arising from the supply of a prescription only medicine (POM) obtained via an online pharmacy website, responsibility may be jointly shared between the prescriber and the pharmacist involved in the transaction, particularly as many Internet Pharmacies produce their own protocols for the prescriber. The PDA is aware of one patient who used an online pharmacy to obtain supplies of dihydrocodeine without their GP being aware and subsequently died of dihydrocodeine toxicity.

The remote nature of an online pharmacy consultation has clear disadvantages due to the lack of personal contact with the patient. In a face to face discussion, much can be gleaned from body language, the patient’s appearance and demeanour and what is said and not said. This is something that cannot be replicated remotely using questionnaires. Internet pharmacy services place a much greater reliance on the patient providing accurate information which cannot readily be verified. Whilst patients seeking the service have a responsibility to be truthful, this does not mean that pharmacists can arrogate their professional responsibilities because of the challenges that remote interactions present.

The PDA is aware of a vulnerable teenager who imported family members in order to obtain multiple supplies of dihydrocodeine over the internet from GPhC registered pharmacies. The teenager put in place by the pharmacies to prevent such abuse of the system were inadequate. In another case a patient presented to the pharmacy with an online prescription for multiple doses and was in significant financial difficulty as a consequence.

When dealing with requests via the internet for codeine, dihydrocodeine, cocodamol 30/500 or other medicines liable to misuse, pharmacists should ensure that:
- They are confident of the patient’s identity, GP details and home address and should take steps necessary to know the purchaser is legitimate.
- Patients without a GP or unwilling to provide GP details should be signposted to an alternative medical service or no prescription should be issued.
- The purchase history is checked and repeat requests are carefully reviewed.
- Patient consent is obtained for the GP to be informed of any medications prescribed if consent is refused, no prescription should be issued.
- If consent is given, then the GP must be notified.
- Check whether your indemnity insurance covers such activities.

If you work in an internet pharmacy associated with prescribing services, please contact the PDA for advice by sending an email to enquiries@the-pda.org
The hard work was only just beginning. The newly formulated team of pre-registration graduates worked collaboratively with each other, through social media and conference phone calls, and working hard together into the late nights to analyse each question and to compile the results of the survey. The results were very telling. 97% of respondents felt prepared for the assessment (having used the recommended resources and GPhC syllabus) when they started the examination. 96% felt either disappointed or very disappointed with their performance at the end of the examination.

“I was downhearted with the reaction I got from the RPS and the GPhC” said Bagui. “The PDA were genuinely very supportive however, and they made me feel listened to without being judgemental. They also acknowledged the tremendous effort, determination and hard work that we had put into this report and reassured us that they would follow up with those who made the comments.”

The PDA Director John Murphy confirmed that he had written to the GPhC commending the report to them and asking the matter to be put on the agenda for the next PDA / GPhC meeting. He also said how impressed he was with the initiative Bagui’s group had shown and how her and her colleagues’ actions should inspire others. “We need more people like Bagui and Mr. Vaitya in pharmacy”, he said.

If you want to read more of the report please follow the link: www.the-pda.org/registrationassessment
Pension freedom – the shackles are off, what now?

Pension freedom came into effect on 6th April 2015, giving everyone over the age of 55 more choice over the way they use their pensions.

Six months on, it’s become a lot clearer how the new rules actually work in practice, and therefore how PDA members can make the most of the opportunities and manage the risks.

The wealthiest you’ll ever be

In case you are not aware, from April this year, you are now able to access your entire pension fund (excluding public sector final salary schemes), with no restrictions, from the age of 55.

By removing the need to buy an annuity it is thought people will have far greater incentive to save for their retirement in the knowledge that they will have full control of their money when they get there.

On one hand this represents a major opportunity to use your money the way you want, when you want. On the other as the onus and responsibility lies solely with you, get it wrong and you could conceivably run out of money in retirement.

What is the opportunity?

From the age of 55 you can now use your various income streams, pensions and investment vehicles strategically to release the appropriate income at the appropriate time throughout your retirement. It is all about using your money in the most effective and efficient manner.

For most people, decisions are made as you begin your retirement. However, under the new rules, you will have flexibility to take advantage of opportunities at any point after the age of 55, even if you are still working.

The threat

Before Pension Freedom came into affect you were forced to purchase an annuity with the money in your pension; this provided you with a guaranteed income for the remainder of your life. With pension freedom, that requirement has been removed, and you now have control over the level of income that you take from your pension plans, the major threat that many people will face is the risk of running out of money. It will be important that you understand all of the benefits and risks associated with any action that you choose and consider the likelihood that you could run out of income.

The traditional route of Annuity purchase has not disappeared completely, they will just be one of the tools you may consider when and if the time is right and your circumstances warrant it.

Pension income can also be subject to tax charges, so careful planning with your income, can mean that you could pay less tax that you otherwise might.

The responsibility of what you do with your money now lies squarely with you and outsourcing your retirement fund is a very real risk without appropriate planning.

Your options and grasping the opportunity

Planning is key, and seeking advice will be crucial to maximising the opportunity that the new rules offer you. The sheer scope of the implications and the impact on people’s retirement funds is not to be underestimated. Because of this it is important to explore all the options, gain as much insight as you can and seek professional financial advice.

Good quality independent financial advice will help you:

- Help your family with life’s more expensive necessities, like University fees, house deposit or general financial support, by withdrawing lump sums.

The options are seemingly endless. However, you will need to consider the tax implications and effects any actions will have on the long-term value of your retirement fund.

- Gain a clear understanding of the new rules.
- Assess and review your assets and income streams.
- Explore and identify your objectives from 55 and throughout retirement.
- Explore how you can use your assets in the most effective and efficient manner.
- Understand the income and inheritance tax implications.
- Review your situation as your retirement unfolds.

Exciting yet daunting

The flexibility offers far greater scope than before, but is far more dependent on specialist knowledge to unlock the potential. This freedom may initially appear daunting, particularly in contrast to the more traditional and restricted model, but specialist financial advice can open up a far more expansive and tailored solution than the old annuity route could ever hope to provide.

Everyone will have a decision to make at some point and as the appointed provider of financial advice for the PDA, we’re here to help.

For retirement advice or to book a review, call 01823 250750 or visit www.lloydwhyte.com/pdapensionfreedom.

Enjoying Pension Freedom

Michael’s keen eye for detail has served him well, as a pharmacist and a photographer.

Under pension freedom, however, his vision of retirement is not quite as precise as it used to be.

With online guidance and face to face advice, we’re helping PDA members like Michael get a clearer picture on how to adapt their plans and make the most of the new opportunities.

Watch the podcast and download a free Pension Rule Change Fact sheet at www.lloydwhyte.com/pdapensionfreedom

Author Profile

Daniel James (DipPFS) is Director of Client Services at Lloyd & Whyte, who are the appointed independent financial advisers of the PDA.

For advice on any of the issues raised in this article, contact Lloyd & Whyte on 01823 250750 or through their website at www.lloydwhyte.com

Regulations

Lloyd & Whyte (Financial Services) Ltd is authorised and regulated by the Financial Conduct Authority.

Lloyd & Whyte (Financial Services) Ltd is authorised and regulated by the Financial Conduct Authority. Calls may be recorded for use in quality management, training and support.

Lloyd & Whyte (Financial Services) Ltd is authorised and regulated by the Financial Conduct Authority. Calls may be recorded for use in quality management, training and support.

www.the-pda.org
Don’t cross the line

Workplace banter

Behaving appropriately in the workplace will undoubtedly be something that as healthcare professionals and managers, pharmacists are likely to feel that they do already. It may come as a surprise to pharmacists to learn therefore, that a significantly high volume of PDA enquiries relate to issues involving workplace behaviour. These may relate to concerns over the impropriety of colleagues, managers and even members themselves. Over the years the PDA has dealt with thousands of grievance and disciplinary hearings ranging from fairly innocuous matters to those which involve inappropriate workplace behaviour that is clearly unacceptable and meets the definition of bullying, harassment, discrimination and victimisation.

Pharmacists need to be particularly mindful of the importance of behaving appropriately in the workplace to protect their future employment as an employee or locum; notwithstanding the potential involvement of the police for serious issues such as harassment and of course the involvement of the GPhC for a breach of standards. A few years ago, the PDA would not have seen many complaints regarding poor behaviour in the workplace leading to Employment Tribunals or fitness to practice proceedings at the GPhC. Now, however this is a growing trend. There could be a number of reasons for this, with colleagues being more aware that they can report matters and employers taking a tougher stance for instance. Whatever the reason, the PDA has noticed over the last 12 months in particular, a tendency for employers to set GPhC standards in letters setting out disciplinary offences.

Employers generally refer to unacceptable standards of behaviour in the workplace as an allegation before setting out exactly what it is that has allegedly said or done. Now pharmacy employers are using the Standards of Conduct, Ethics and Performance produced by the GPhC in disciplinary letters.

The absence of a reference to the GPhC standards is not an indication that a regulatory complaint will not be made by an employer or indeed a colleague; however if employers go to the trouble of including the GPhC standards in their correspondence, pharmacists can almost be certain that this is the path that their matter will take. It is therefore imperative that pharmacists ensure they defend themselves against unreasonable, malicious or vexatious complaints from colleagues alleging that they have been victims of inappropriate behaviour. It is very important for pharmacists to display insight and apologise where it is clear that their behaviour has fallen below acceptable standards which may constitute misconduct.

Misconduct in the regulatory context, is not defined in statute but found in case law from Judgments made in the High Court. Essentially, it needs to be more than a breach of duty owed or failure to comply with the standards of behaviour expected of a pharmacist and it must be serious. The conduct should be conduct which other pharmacists, members of the profession would regard as “deplorable” and falling significantly short of accepted standards of behaviour.

In the workplace, pharmacists are expected to have self control and set the tone for behaviour. In various cases the PDA has dealt with, members have unfortunately lost sight of this and either set a standard that is unacceptable or allowed themselves to be drawn into an existing culture where they were not the instigator of inappropriate behaviour or even conversations but participated in them nonetheless. The attitude of both employers and the GPhC has been unforgiving, holding pharmacists accountable as highly educated individuals with professional standards to adhere to, and answerable to the public.

Behaviour can be reprehensible but fall short of being serious misconduct and therefore short of meeting the test of impairment when deciding a pharmacist’s fitness to practice. Like the GPhC, employers appear to be using the test of impairment when assessing if disciplinary allegations should result in warnings or dismissals. Consideration is given by employers to whether the conduct or behaviour of a pharmacist; a. presents an actual or potential risk to patients or the public, b. has brought or might bring the profession into disrepute, c. has breached one of the fundamental principles of the profession or d. shows that the integrity of the pharmacist can no longer be relied upon.

It is not necessary to engage all four grounds and usually with allegations of inappropriate behaviour in the workplace it is only b) and c) that are applicable. Pharmacists may now be wondering what behaviours are appropriate in the work environment. When does “banter” “light hearted humour” become misconduct? What is demeaning conduct that falls short of deplorable and therefore not serious misconduct? The table below sets out some examples of behaviour that has been determined by employers and the GPhC to be unacceptable. Consideration is given to the length of the period of behaviour, the seriousness and vulnerability of those on the receiving end of it, the number of colleagues involved and whether there are any aggravating factors such as sexual gratification or violence involved. When applying sanctions, thought is given to whether regret has been expressed and an apology given with proper insight shown. Also considered is the likelihood of the behaviour being repeated and whether there was a real intention to cause offence.

The question of whether matters have been put right is also given weight. Most employers will set out examples of good and bad or positive and negative behaviours in their employee handbooks and grievance policies. With the possibility of a pharmacist being disciplined at work and referred to the GPhC even if it is not justified, pharmacists are urged to revisit these documents which essentially resolve around treating colleagues politely and considerately.

Approximately 9% of complaints to the GPhC last year related to the issue of behaviour. It is worth bearing in mind that any responses pharmacists give to their employer in investigation and disciplinary meetings may be furnished to the GPhC as evidence when a complaint is made; it is therefore important that pharmacists establish the details of complaints at an early stage so they are clear what allegations are being faced.

SEXUALISED BEHAVIOUR

Inappropriate sexual comments, innuendo of an inappropriate sexual nature. Using sexual parlance, for example asking colleagues if they have recently “got their leg over” commenting on the state of your own or someone else’s genitalia. Kissing staff, or attempting to, asking them to feel your abs, offering staff Rohypnol, slapping bottoms, whispering in a colleague’s ear, showing pornographic images on a mobile phone.

AGGRESSIVE VIOLENT BEHAVIOUR

Shaking, pushing staff, making physical gestures of an inappropriate nature, shouting at staff, using foul and abusive language. Teasing staff with name calling, referring to them as ‘stupid or thick’. Using social media to publicly humiliate colleagues. Throwing objects in the confines of the pharmacy.

ADVICE TO PHARMACISTS

Having knowledge of employer’s policies and refreshing personal awareness of the GPhC Professional Standards will assist pharmacists in any investigations into these types of allegation. When pharmacists become aware of complaints, it is important to seek PDA advice at an early stage to avoid compromising their position. Pharmacists who find themselves working in an environment where pharmacy staff demonstrate some of the behaviours described above should avoid getting drawn in. The GPhC expect Responsible Pharmacists in such situations to take appropriate action to restore and maintain a professional working environment.

It can be also very easy for some employers to get carried away with investigations by treating matters as if they were the GPhC Disciplinary Committee and making reference to an individual’s fitness to practise. This is, in fact, well outside the scope of what an employer should determine and disciplining managers, in any event, generally lack knowledge and competence in this area.
In October 2014, the General Pharmaceutical Council and the Pharmaceutical Council and the
In October 2014, the General

This is known as the professional ‘duty of candour’ and it requires pharmacists to inform the patient (or, where

A PDA member received a letter from the

A PDA member received a letter from the

The letter to the patient included the following paragraph, anonymised for the purposes of this article:

For example, the following are anonymised examples of stock phrases used in letters to

In another example, a member employed by a large multiple contacted the PDA because he had been treated in an extremely rude and condescending manner by a non-pharmacist store manager, who blamed the pharmacist for being rude to a patient who received a dispensing error.

The letter to the patient included the

it is not appropriate for us to

the risk of patient

Misleading template responses increase the risk of patient complaints and a referral to the GPhC

PDA Advice

It is recognised that “Head Office” have a role to play in communicating with patients, however, pharmacists must actively involve themselves in the investigation of errors or complaints involving them. This includes participating in safety reviews, making sure all relevant factors are documented in the error report and pharmacists should insist on approving any correspondence that will be sent to the patient to ensure it is correct and that any assurances given have been or can be complied with. Unfortunately, pharmacists cannot always rely upon their employer to get it right.

By following the above advice pharmacists will be in a better position to comply with their ‘Duty of Candour’ and reduce the risk of patients being misled.

If you have been involved in an error or complaint and have concerns about how this was handled by your employer, please contact the PDA for advice by sending an email to enquiries@the-pda.org
WHY JOIN US?
Every day our members tell us...

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

✓ More than 4,000 cases handled last year alone
✓ More than £1,000,000 compensation secured from employers who have treated pharmacists unfairly or illegally
✓ £500,000 worth of Legal Defence Costs Insurance
✓ £5,000,000 worth of Professional Indemnity Insurance
✓ Union membership option available

Visit our website: www.the-pda.org
Call us: 0121 694 7000

OVER 25,000 MEMBERS
Have you joined yet?

WHY JOIN US?
Every day our members tell us...

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

✓ More than 4,000 cases handled last year alone
✓ More than £1,000,000 compensation secured from employers who have treated pharmacists unfairly or illegally
✓ £500,000 worth of Legal Defence Costs Insurance
✓ £5,000,000 worth of Professional Indemnity Insurance
✓ Union membership option available

Visit our website: www.the-pda.org
Call us: 0121 694 7000