Primary Care Pharmacist Edition

Autumn 2015

insight

pda
the pharmacists' defence association

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

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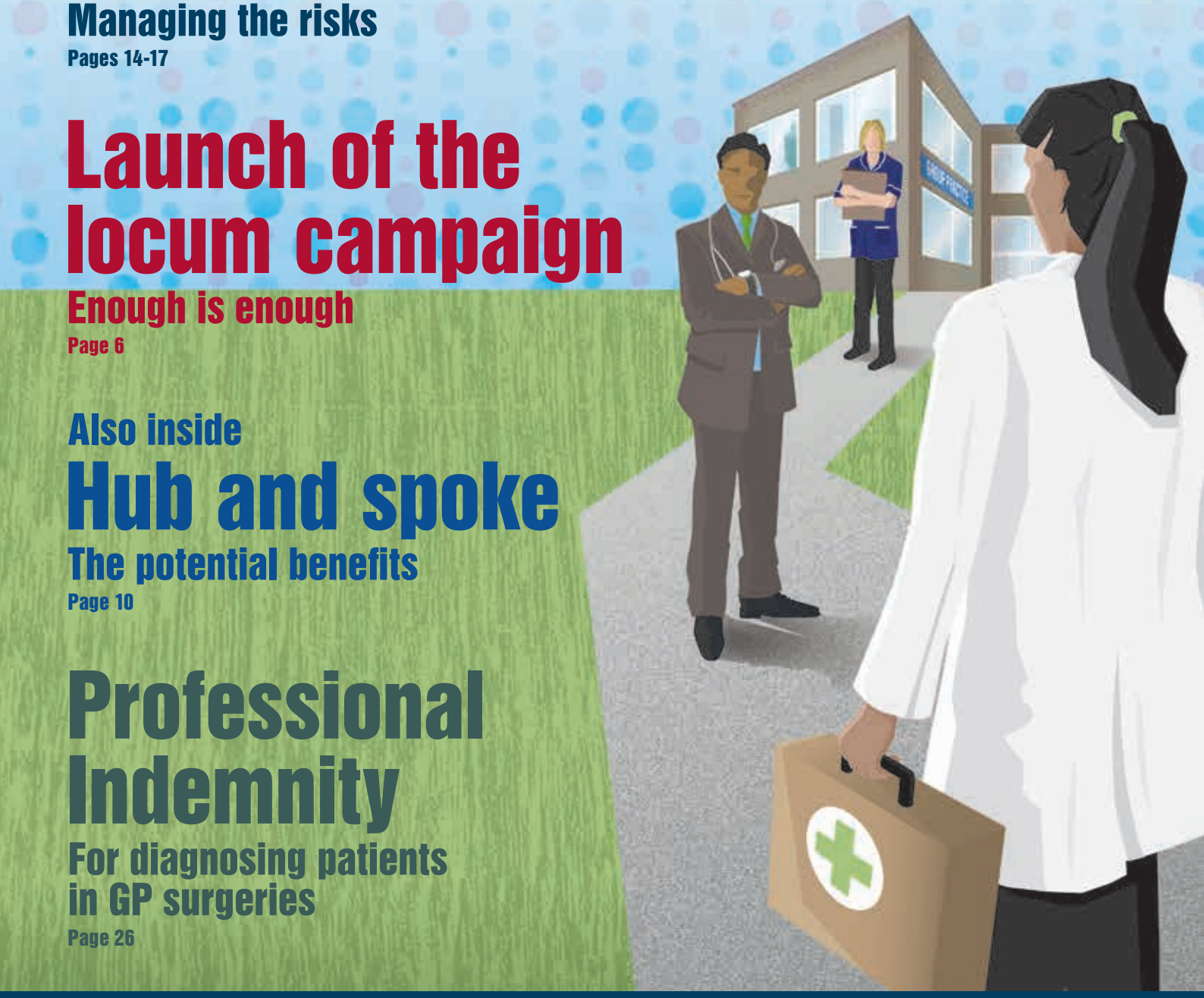

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The Campaign to support locums

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 locuming and 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. That pharmacists in much larger numbers than ever before are now to be encouraged to work in GP surgeries is a welcome development and one that has been driven by the capacity shortages in the GP service.

Primary care pharmacists will be very familiar with the GP surgery based role as they will have already been involved in this area of activity for many years. However, if the new GP practice trial, recently expanded to involve more than 375 pharmacists, is successful, it could create somewhere in the region of 4,000 new roles for pharmacists who want to develop their clinical expertise.

This is good news for all pharmacists, whether they would like to develop a GP surgery based role, or whether they work in one of the other sectors of pharmacy and seek an improved relationship with the GP surgery.

This will also go some considerable way in addressing some of the supply and demand issues currently being faced by the profession.

As with all of these new developments however, there are risks along the way – but without risk, no progress can be made. **The features on pages 14 to 17 and 26 and 27 seek to explore the various issues to look out for and they are especially relevant to primary care pharmacists.** There is no doubt that we are entering a new era for pharmacy practice and I urge all primary care pharmacists to consider the implications of some of these beneficial changes upon their current roles.

Mark Koziol, M.R.Pharm.S.

News...

Sanctions guidance from the GPhC

Earlier this year, the GPhC consulted on its ideas regarding the guidance for the Statutory Committee's 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.

Meeting of the EPhEU Executive in Dusseldorf

This Association represents the interests of employed pharmacists from the different member states of the European Union. The PDA is the UK member organisation representative and has also had a seat on the Pan European Executive board which recently met in Dusseldorf.

The seat on the Executive gives PDA access to EU Health officials in Brussels and in particular it enables the PDA to be able to feed in issues and concerns based upon its UK experiences. The latest meeting was held in Dusseldorf on September 30th.

Members of the EPhEU Executive Committee at the FIP Congress in Dusseldorf

In continental Europe, the majority of the countries only allow pharmacies to be owned by pharmacists. This means that the large corporatisation of the pharmacy profession as seen in the UK simply does not exist in many of the EU member countries. EU officials are therefore very interested to learn about the impact of corporatisation of pharmacy practice in the UK and the large number of defence episodes that the PDA is involved in where pharmacists are trying to put professionalism and the safety of patients ahead of the requirements of some of their employers whose focus is upon making profit, often through cutting costs. In particular, they are interested to learn about the vagaries of the commoditisation of services such as the targeting of MURs.

Boots 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 within 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 célèbre', however, was that the Boots/BPA agreement specifically excluded the right to negotiate on terms and conditions. The PDA Union 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 PDA Union'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 incoherent 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. Deregulation should happen in some areas and regulation should focus more effectively in others. Barriers between professions should be removed and new roles created.

The PDA 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 PDA 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!

professional standards authority

BPSA Prereg Conference series *sponsored by PDA*

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 receive further briefings about a range of work place orientated patient safety issues relating to pharmacy.

Aiming High and Finishing First

Each year the PDA sponsors and administers both of the British Pharmaceutical Students (BPSA) day conferences; one in the autumn and one in the spring, designed to support preregistration pharmacist graduates through their training year.

The first event, took place at the Pharmacy Show on Sunday 18th October. This gave delegates some interactive skill development in listening and building rapport, how to handle conflict and to give and receive feedback. The sessions achieved a great acceptance score from the delegates.

"It's a very interactive way of learning" said Harry Harron, the PDA Student Services Manager, ***"and we are very pleased with the delegates' reaction to the quality of the event."*** However, he added, ***"We now start planning for part two of the programme which we will hold in the spring.***

The next stage of the programme is equally as worthwhile".

The second day of the programme 'Finishing First' is designed to help graduates prepare for the registration assessment and life as a practising pharmacist. The conferences will include a short mock assessment, and ways to risk manage common pitfalls encountered by newly registered pharmacists.

Having had considerable experience in understanding the issues trainees face in their training year, BPSA and the PDA can identify with the pressures preregistration graduates can find themselves under; and both organisations know that they can do with all the support they can get!

"They have come too far to trip up at the finishing line now," said Mr Harron.

He urged preregistration pharmacists to make a note of the following dates and to look out for registration details on **www.conferenceevent.com**.

Date 2016	City	Venue
13th March	Glasgow	Radisson Blue, Argyle Street
10th April	Manchester	Manchester Conference Centre, Sackville Street
17th April	Birmingham	Aston University, Aston Triangle
24th April	London	UCL, School of Pharmacy, Brunswick Sq

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 GP's. In September 2015, 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.

Launch of the campaign to support locums

Comments received from locums

Employing only a locum to cover a very busy pharmacy which should normally have two members of staff (1,000 items+ per day). The lack of staff created by cost cutting measures leads to an increase in dispensing errors.

Being left alone without any staff other than work experience students.

They regularly have me working with not enough trained staff for the work load expected, including staff who can't dispense and don't know the computer system. This means you may have to regularly double check prescriptions which you have labelled and dispensed yourself.

I work in a busy dispensary with approx. 40 daily methadone patients and a busy needle exchange scheme but the company has only provided me with two untrained teenage part time staff.

Patient safety issues frequently emerge when members of staff either go on annual leave or leave their jobs, and the employer does not organise staffing cover to compensate for this, leading to acute and chronic understaffing respectively.

With no staff at all. I dispense and check the prescriptions around 500 items a day without any help. Carry out NHS health checks, MURS, NMS, EHC and others services on top of my job.

I am an employed pharmacist and am experiencing the same problems as locum pharmacist. My main help – the Pre reg trainee is taken away from my branch and moved to cover staffing levels at other branches).

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?**

PDA locum members have been reporting that some employers, aware that there is an abundance of pharmacists at this time, have been taking advantage of the situation. In some instances, this has resulted in a reduction in the hourly rates of locum pay, in others, employers have placed unreasonable demands, 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 pressurised to hit unachievable targets. In other instances employers have unilaterally decided to withdraw the payment of travelling expenses.

The PDA has also received many reports 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 because an inexperienced locum prepared to work for less, has been found. The poor treatment of locums is part of a much wider concern in community pharmacy where some employers are driving down costs and exhibiting unprofessional behaviours for purely profit driven reasons. In many instances this leads to a significant cut in overall staffing levels, a drop in standards and a consequent reduction in patient safety.

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 involved in unprofessional behaviours and which ones are not. As well as seeking examples of where cost cutting has decreased patient safety, locums are asked to provide examples of good employer behaviour so that these can be publicised.

Depending on the outcome of the information gathering exercise, a first step to secure improvements is likely to result in an engagement with both

the employers and the GPhC so as 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 by 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 exceptionally valuable resource for any pharmacy proprietor and are worth their weight in gold. They should be treated with the respect that they deserve but some employers instead, sensing that the supply and demand dynamics are currently favourable have decided to take a short term view and make life for locums difficult thinking that this will improve their profitability.

Ultimately, this cost cutting approach affects both the quality and quantity of staff and also the morale in pharmacies and when it starts to impact upon the safety of patients, then it's time to call a halt to these activities.

We have seen these kinds of poor behaviours from some employers before, they are cyclical but in the end those employers involved always come to regret their short term actions when they realise that they have harmed their brands and reputations. Like the canaries in mines, locums often experience the first signs of ill wind in pharmacy employment trends; inevitably the employers who treat locums poorly will also try to impose unacceptable conditions upon their employees. The problem of cost cutting employers should not be seen as one that is solely specific to locum pharmacists."

Already more than 2000 locums have participated in these initial surveys at the time of going to press.

Some of the comments provide an indication of the depth of feeling within the locum community and a selection is provided alongside this article.

All locum pharmacists are urged to get involved and to pass on the information about this campaign to their friends so that they too can lend their support.

The initial locum campaign launch survey is available on **www.the-pda.org**

Comments received from locums

Usually if a member of staff is absent they are not replaced. When there are only 2 members of staff you have lost 50% this is dangerous.

Most of the time you are working simultaneously as a pharmacist, a technician and an over the counter staff member. You routinely self-check and this leads to errors.

I am mostly self-checking!!! This is against the employers Standard Operating Procedures!!!!!

My dispensary staff have been replaced with apprentices.

Putting up signs saying how fast the dispensing process is and I am expected to keep to that speed even if I am working with untrained staff and a 15 item prescription has arrived. I still have to deliver 2 MUR's per day.

Been subtly told / either put up with it or not be booked again.

In 9 hr shifts large multiple complaining of pharmacist having toilet breaks.

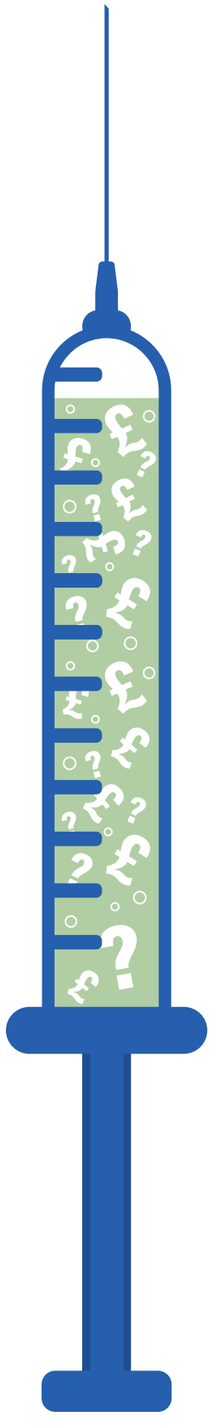
I have worked a 12 hour shift with only 15 mins to sit down it was that busy. I was then reprimanded for not doing any MURs by manager, who emailed me while she was on holiday.

The situation re patient safety was that bad that I called the Head Office to speak to the Clinical Governance pharmacist to be told that she would only have time if death was involved.

Where I have raised the issue of patient safety, I have been told that I should have thought of that before up taking the shift.

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 that 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 CCGs 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 this 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 CCGs 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 "***We will determine this [funding] for service development on a case-by-case basis dependent on how we decide to commission any future services of this nature."***...and thanked PDA for its offer of involvement going forward.

ROYAL PHARMACEUTICAL SOCIETY

ROYAL PHARMACEUTICAL SOCIETY FACULTY

The RPS Faculty: Your professional development

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 ensure that 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 qualified for at least two years, 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 MFRPSII MRPharmS, community pharmacist

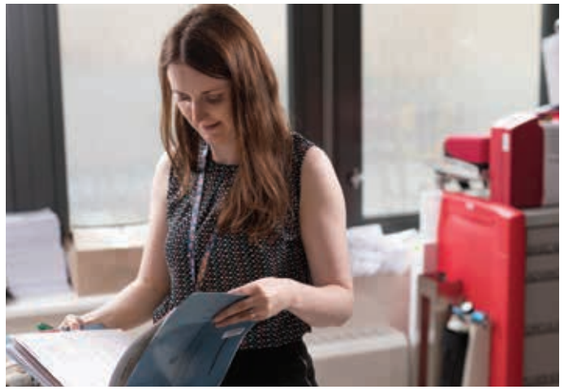
"My Faculty Professional Development Plan confirmed much of what I'd learned about my own standards/scope of practice whilst building my portfolio. But it also clarified, through the eyes of objective assessors, my strengths and weaknesses and threw up plenty for me to think about. It's a long time since 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 Geeson MFRPSII 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?

The Faculty was the catalyst for me undertaking my MSc and this led to my increased understanding of the importance of research, but also to the self-awareness of my passion for it!



By reflecting on my practice and undertaking the MSc I feel that I have increased my potential to contribute at patient level and strategically, but it has also led to a career change (into research) that I never anticipated.

Longer term it has given me a clear framework and development goal, from Advanced Stage II to Mastery."

Greg Lawton FFRPS 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 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.

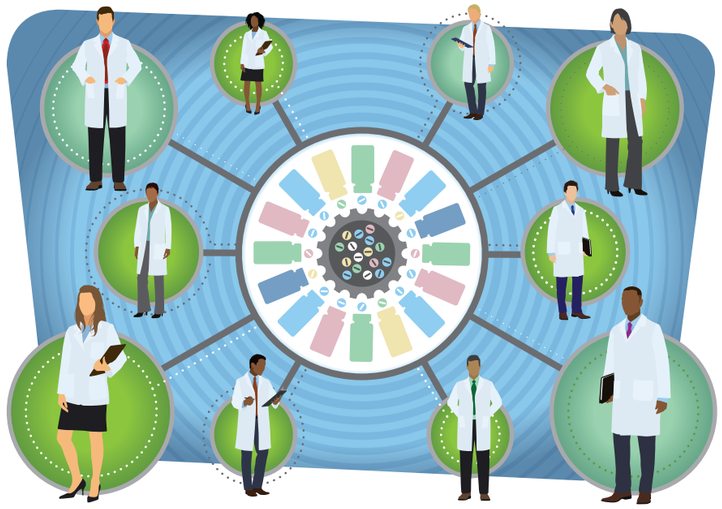
I was delighted to discover the range of additional professional opportunities and means to contribute to its development. There are opportunities suited to different skill sets which allow Faculty members to give something back - contributing to ongoing growth and development."

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 delivery 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 made where queries, interactions and clinical errors are quietly resolved by pharmacists who are involved in clinical checks on prescriptions and long may that continue. However, this is not always how pharmacists are perceived by the public.

Focus groups involving members of the public deliver some uncomfortable insights. Although these can only provide a snapshot view and there are always those exceptionally good examples 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;

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

- 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 when the medicine is 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 repeats, 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 pharmacists. 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 provision elements

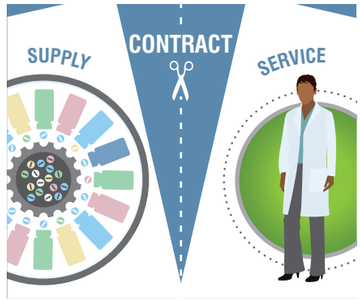
Splitting the pharmacy contract into the elements of supply and services is a fundamental element of the proposal. Already some of the central hub models in the UK have shown that they can reduce the cost of the supply, but this leads to a reduction in pharmacy staffing levels. The purpose of moving 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 made primarily for the supply would leave 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 product 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 MUR's, 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 be maximised as 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, but 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 are 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 it 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 systems 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 and has already commenced its engagement with the community pharmacy representative organisations.

‘If I only had a brain’

In 2004, Lord Fraser of Carmile, 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 he was the artificial “person” with no brain and speaks and acts for its once-upon-a-time sovereign, the real person. This means that the real person can almost abrogate responsibilities and leave it to their Straw Man to do their bidding. The scarecrow identified the straw man’s persona for Dorothy in the words of the famous song;

I’d unravel every riddle
for any individ’le,
In trouble or in pain.
With the thoughts I’d be thinkin’
I could be another Lincoln
If I only had a brain.

The PDA has unfortunately dealt with many Straw Men (as Lord Fraser put it) who 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 Pharmacist. 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 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.

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). The Superintendents stated they had no knowledge of these orders and were unaware of the ultimate destination of the medicines. As a consequence of this activity, a number of Superintendents found themselves in difficulty with the GPhC after complaints were made and learned a harsh lesson that ignorance of what is happening in the pharmacy is no excuse or defence to Fitness to Practise proceedings.

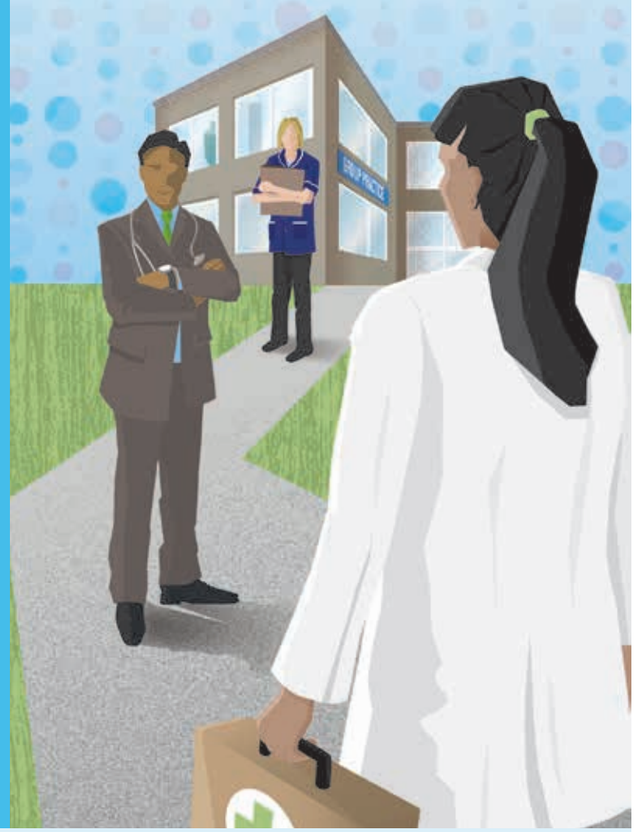
The risks of being a locum Superintendent Pharmacist are very high and even higher if performing the duties on a part-time or remote basis. A GPhC document **‘Guidance for owners and superintendent pharmacists and pharmacy professionals in positions of authority’** will help pharmacists to understand the roles and responsibilities. It is an essential read.

If asked to take up the responsibility, pharmacists should refer to these documents, and involve the PDA pharmacist advisory team in the decision making process (there may be some indemnity consequences). Pharmacists must make a diligent assessment as to whether or not they can reasonably and ably carry out the responsibilities.

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.

By John Murphy
PDA Director

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



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.

The history of pharmacists working in GP surgeries

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 PCO troubleshooters to support problem surgeries.

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 focal point where learning experiences could be shared and examples of good and poor practice could be disseminated.

Independent Prescribing for pharmacists

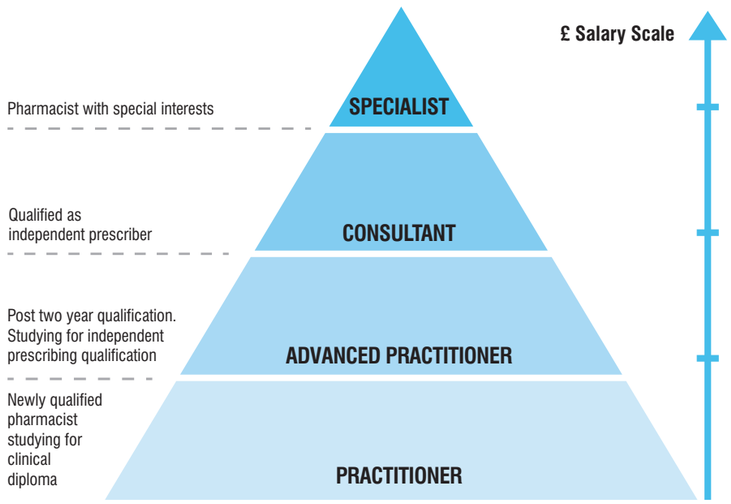
When independent prescribing for pharmacists was introduced, this provided an opportunity to expand a more advanced hierarchy so as to facilitate the development of specialisation within the discipline. Those pharmacists who wanted to stay involved in the relatively less risky 'administrative' roles such as switching programmes, 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.

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' (PWSI).

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.



GPs 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, in the many multidisciplinary meetings that have been held in England so far to discuss these proposals, already GPs 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. ▶

The biggest risk is that a pharmacist could end up working in an area where they *"don't know what they don't know"*

One would be forgiven for thinking that pharmacists would be involved in all of the roles described, ranging from basic tasks such as administering formulary management and managing repeat prescriptions through to the highly skilled management of and prescribing for long term conditions and all points in between. There is however an important dividing line between predominantly administrative and the predominantly clinical roles in terms of exposure to risk. Participating pharmacists and surgery based teams who will be managing the scheme must discuss and agree how to manage each role. It is vital that pharmacists do not end up working under a hastily developed system which pushes them to work beyond their areas of competence.

The biggest risk is that a pharmacist could end up working in an area where they "don't know what they don't know".

The fact that there is an entry level and an advanced level role makes sense and will help the creation of a risk management pyramid which can be used to match the skills required with the level of clinical responsibility and the commensurate salary. Roles that appear on the current list should be graded into those that can only be carried out by higher level practitioners (i.e. those with relevant post qualification experience, independent prescribing qualifications and operating at band 8 – consultant level) and those roles that could be carried out by either consultant level practitioners or by the less experienced advanced practitioners. There could even be roles that do not yet appear on the initial list being considered, such as pharmaceutical care being delivered by pharmacists who have caseloads of patients on long term conditions referred to them by the GP. Such a role is defined in the PDA Road Map. These pharmacists may deliver these pharmaceutical care services on an independent basis (as part of a group practice of pharmacists) in residential and care homes, hospices, the homes of patients and even on a sessional basis in community pharmacies. These could be pharmacist specialists. The skills escalator shown on the previous page is a simple but useful device that can be used to assist with this exercise.

The lack of expertise in the starting specification

It is a concern to see that the government has specified that the GP surgery role is band a 7 role and that some supervision would be provided by a band 8 pharmacist. It is suspected that this specification was driven more by 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 practice. 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 additionally have independent prescribing qualifications.

Despite the skills and experience required for some of the roles required, pharmacists from all backgrounds and all levels of experience are being encouraged to apply. Although the broad background specification could be beneficial to pharmacists wishing to expand their practice, there is concern from a risk management perspective about the lack of focus upon the levels of experience required, which may hamper development of the practice.

If this GP surgery based scheme is to be a long term success, then NHS England must invite pharmacists with demonstrable skills experience and competence to join this scheme. Additionally, it must clarify from the start which roles band 7 pharmacists with more limited experience can realistically be expected to undertake and which of the roles should be reserved for the more experienced band 8 pharmacists.

Considering the issue of local supervision

The NHS England scheme envisages that one band 8 pharmacist will supervise the work of several band 7 pharmacists and this suggests local supervision. This approach is to be welcomed in principle, but it must not occur in a local vacuum with different standards being developed throughout the country as this could lead to a disparate service with problems for patients and pharmacists alike.

A national standard will have to be developed and supervisory pharmacists will need to find a way of keeping in touch with best practice nationally.

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.

What is the accountability for local supervision?

Questions over training provision.

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 NPC to provide the training programme for this new scheme. Perhaps the reason for this was because the NPC 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 and self-directed study. There is 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 knowledge to be able to apply it to a real life complex patient facing situation. Paradoxically, pharmacists who have very considerable experience of working in a GP surgery capacity and having achieved advanced qualifications are being told that their attendance on the basic training course described is mandatory – even though their skills and competence level is considerably ahead of the level at which the training is being pitched. It would appear that the training provision is an area that currently requires some attention.

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

Caution over tensions between cost saving and clinical roles

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. One 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 part of a historic Primary Care pharmacist role with which many GPs are already 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 role 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 degrees; as such the first few years of this new service will be vital as they are likely to lay down the formative foundations going forward.

Developing a peer access group

Whether applying for a band 7 or band 8 pharmacist role, and regardless of relevant experience, it is vital for pharmacists involved in this new scheme to keep in regular contact. It has to be remembered that this initial scheme is intended to be just the beginning, it is hoped that GP surgery based work could form the basis of the role for many thousands of pharmacists in the future. The lessons learned and shared from all of the operational experiences of pharmacists involved in this new scheme will form a vital component of its successful development on a larger scale going forward. All participants are urged to take advantage of as many industry initiatives as they can and attend events that will be made available in the coming months.

In turn, the PDA will disseminate any initial risk management assessments and member experiences for the benefit of all pharmacists.

Setting up a GP surgery based group

If you are a pharmacist that is currently on the NHS England training programme, or are preparing to work as a pharmacist in the new GP surgery based project in Northern Ireland, or 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 GP surgery based pharmacist group being established by 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 the PDA website www.the-pda.org

Internet Pharmacy

Out of sight – out of mind?

As the public becomes more and more comfortable with making online purchases, there has been an inevitable increase in the number of online pharmacy services. There are approximately 500 distance selling pharmacy websites registered with the GPhC. The number could actually be even higher, since the GPhC only operates a voluntary internet pharmacy logo scheme, and it is the MHRA with whom anyone selling medicines via a website, needs to be registered with.

Whilst such services can provide certain benefits such as convenience, there are also some obvious dangers and risks to patient safety, beyond those to do with counterfeit medicines. This is reflected in the increase in the number of enquiries to the PDA team from pharmacists seeking advice and support.

There are many different arrangements that exist where there is no face-to-face contact with the patient, and in April 2015 the GPhC issued **"Guidance for registered pharmacies providing pharmacy services at a distance, including on the internet"**.

The scope of it covers (but is not limited to) the electronic prescription service, delivery services to patients in their own homes or nursing homes, mail order services, internet services including those linked to online prescribing, and "hub and spoke" arrangements. Each of these different arrangements present their own risks, but this article will focus on the concerns about the safety of patients when prescription only medicines are obtained online using prescribers associated with the pharmacy.

Examples of medicines that can be easily obtained online include:

- analgesics including codeine, dihydrocodeine & cocodamol 30/500,
- azithromycin to treat Chlamydia
- salbutamol inhalers
- sildenafil
- orlistat
- contraception and emergency contraception
- norithisterone
- varenicline
- chloroquine, mefloquine
- finasteride for hair loss

To obtain prescription only medicines via an online GPhC registered pharmacy, a legally valid prescription must be obtained, which can either be paper or electronic. Many websites offer a service whereby customers complete an online questionnaire, before a prescriber authorises a prescription based on the information provided. The prescriber will either be a UK GMC registered doctor, an EU registered doctor or an independent non medical prescriber working on a self employed or employed basis for the Internet Pharmacy. Online forms ask standard questions based on a protocol to determine if the medicine requested is suitable, as well as seek confirmation as to whether the patient would like their GP to be informed. Payment is then taken before the item is shipped to the customer. There seems to be no great difficulty in obtaining medicines online including substances that can be misused such as opiate analgesics.

When the PDA has asked members to provide the SOPs relating to this mechanism of supply, the pharmacist advisory team have been dismayed by the lack of rigour that seems to have been applied by some Internet Pharmacies. Principle 1 of the GPhC guidance mentioned above states that there should be governance arrangements to safeguard the health, safety and wellbeing of patients and the public.

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 on-line 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 multiple 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 or 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 abrogate their professional responsibilities because of the challenges that remote interactions present.

The PDA is aware of a vulnerable teenager who impersonated family members in order to obtain multiple supplies of dihydrocodeine over the internet from GPhC registered pharmacies. The steps put in place by the pharmacies to prevent such abuse of the system were inadequate. In another case a patient presented to their GP in a desperate state stating that they had been buying large amounts of dihydrocodeine from online pharmacies. The patient reported taking very large doses and was in significant financial difficulty as a consequence.

The PDA advises members working as the RP or superintendent for online pharmacies associated with a prescribing service, to check that the business is registered with an appropriate regulator, such as the Care Quality Commission. The CQC is a public body of the Department of Health established in 2009 to regulate and inspect that various care services provide to people. The GPhC and the CQC work together, to promote safe and high quality care.

Pharmacist prescribers are urged to be particularly vigilant when issuing prescriptions via the internet for painkillers, such as codeine, dihydrocodeine and cocodamol 30/500. Members, who are currently prescribing via the internet or plan to do so, are urged to contact the PDA to check that they are covered for this activity.

There is a proliferation of websites linked to GPhC registered online pharmacies offering to supply opiate painkillers, which suggests this is a profitable and growing business area. The PDA is aware of one internet pharmacy where the non-pharmacist owner refused to allow the pharmacist to strengthen patient safety protocols on the grounds that it would drastically cut painkilling medicine sales. Some websites charge over £100 for a supply of dihydrocodeine.

Internet pharmacy is a fast growing area and the PDA is in a good position to understand the risks such activity presents. Our pharmacists and lawyers are handling a number of serious cases involving members and provide the following guidance. →

PDA Guidance to online pharmacist prescribers

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 such 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 and 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 medicines 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

INSPIRATION, COURAGE AND YOUNG LEADERSHIP – REGISTRATION ASSESSMENT 2015

A motivational story about some hidden stars

Bagui, was a Pre-Registration Trainee Pharmacist last year at The University Hospitals of Leicester NHS Trust.

She, like many hopeful registrants was taken aback at the difficulty of the recent registration examination, so she decided to launch her own campaign. This is a story about how an individual found the courage and energy to mobilise and organise the workforce to deliver to the authorities a well constructed dossier on the experiences of her peer group during the examination, and to make sure that those responsible for setting the examination knew of their feelings and concerns in no uncertain terms.

The overall registration examination results this year were the worst in living memory with only a 70% success rate. These results once again showed a considerable disparity in the success rates in favour of Hospital prereg compared to those of their Community colleagues.

"The training year really gave me an opportunity to transition from being a University student to a Pharmacy clinician." Bagui said enthusiastically but when she reflected on the June 2015 assessment she described it as: ***"By far and away, one of the most challenging exams I have ever sat in my academic life. I came out of the exam thinking I had very little hope of passing, after having thoroughly revised consistently throughout the year, using a variety of different resources and calculation papers. I felt so forlorn because not only were the questions unusual in comparison to other years, but the level of difficulty encountered in relation to the timeframe for the completion of the assessment seemed incredibly unfair."***

Having had conversations with many other preregistration graduates, she soon realised that her feelings were almost unanimously experienced by her colleagues. So only a few hours after sitting the exam, she decided to focus her energy in to doing something about it.

She sought support from her tutor and engaged her preregistration work colleagues to educe their opinions on the best way forward to approach this situation. She elicited the help and mentoring of Mr Altaf Vaiya, a pre-registration tutor who supported hundreds of pre-registration trainees throughout the year via a WhatsApp revision group and she encouraged her preregistration colleagues to persuade their tutors to give the campaign some credibility.

The group set up an initial online survey to establish whether it was worth taking the matter any further. In their own time, they designed the key questions and shared the questionnaire far and wide via the many professional forums, WhatsApp groups, Facebook and other social media groups to get maximum coverage.

"It obviously hit a nerve," said Bagui ***"We were blown away by the response. 841 returns in 48 hours. – better than any other survey on this topic I believe; I guess that we asked the right questions, which we thought through very thoroughly and hit the right social media groups."***

The hard work was only just beginning; the newly formulated team of preregistration 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 but 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 the concerns with the GPhC at their next meetings."***

The PDA Director John Murphy confirmed that he had written to the GPhC commending the report to them and asked 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. Vaiya in pharmacy"***, he said.

If you want to read more of the report please follow the link **www.the-pda.org/registrationassessment**

Conflicts of Interest and the Public Interest

An article published recently by the Daily Telegraph threw a spotlight on pharmacists dealing with the pharmaceutical industry. The paper investigated declarations of conflicts of interest for individuals working with Clinical Commissioning Groups (CCGs).

The newspaper submitted requests under the Freedom of Information Act to establish what direct and indirect, financial and other interests in pharmaceutical companies members of the CCG and their advisors have.

The news piece stated that health officials from across England attended a luxury trip hosted by a pharmaceutical company lobbying to get its products used by the NHS. It alleged that senior staff attended a two-day meeting in Germany in July 2015 after being invited by an NHS health official who was being paid thousands of pounds by several drug companies. The organiser suggested to an undercover reporter that one day after the trip, pharmacists had switched to recommend the pharmaceutical company's products. This revelation raised concerns regarding the independence of NHS advisors.

CCGs are subject to Freedom of Information requests as they are public bodies. Some pharmacists who carry out private consultancy work outside of the CCG may have concerns about what information needs to be disclosed and may have recently been approached by their employer to declare conflicts. Our understanding is that if the private consultancy work is for pharmaceutical companies, this will have to be declared.

Each CCG must make arrangements to ensure that employees declare any interest which may lead to a conflict with the interests of the CCG and the public for whom they commission services in relation to a decision to be made by the CCG.

What are the potential conflicts?

Conflicts referred to may be:

- Direct pecuniary interests (such as where an individual may benefit financially from a decision made by the CCG)
- Indirect pecuniary interest (such as where a relative may benefit financially from a decision made by the CCG)
- Conflicts of loyalty (such as loyalties to another employer, a professional body, society or special interest group)

Pharmacists are required to name each pharmaceutical or medical device company with which they have engaged e.g. sat on an advisory board or received training. It is not sufficient to say a number of companies have been advised. A declaration must be made of any interest likely to lead to a conflict or potential conflict as soon as the individual becomes aware of it and within 28 days according to some CSU policies the PDA has reviewed. If there is any doubt as to whether or not a conflict of interest could arise or is relevant, a declaration of the interest should be made.

The Information Commissioner has previously ruled that where individuals hold sufficiently senior roles within an organisation, there is a public interest in their interests being disclosed. It is difficult to argue against the view that there is a strong public interest in knowing whether individuals with influence over CCG prescribing policy have connections to pharmaceutical companies.

Advice to members

The PDA understands that some pharmacists may feel that they should not have to disclose some information and may wish to challenge the freedom of information request. Some requests may seem onerous or intrusive for example declaring every occasion work was undertaken and the fees generated from the same.

If this is the case, the PDA's advice would be to raise all concerns to the FOI officer for the CSU to avoid any dispute and allegations of concealment. To date, the PDA is aware of and is assisting a number of individuals who have been suspended by their employers during investigations by the NHS Counter fraud Unit into their conduct.

Breaches of such policies are treated as serious and could lead to disciplinary sanctions, up to and including dismissal. Due to the widespread press interest and political sensitivity, investigations are likely to be thorough and may take some time to complete. It is also possible that the GPhC will take an interest and may instigate its own investigations if it considers the Standards of Conduct, Ethics and Performance have been breached.

If you are a member and require any advice during any investigation process, please contact the PDA team on enquiries@the-pda.org

» 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.

Under the new rules, you will be able to:-

- Manage your tax liability more efficiently, through varying your level of income.
- Make better arrangements for ill health, by maximising your income over a smaller period if your life expectancy is shortened.
- Leave more to your spouse, dependents, children and estate by cascading the value of your pension fund more efficiently.
- 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.

» The threat

Before Pension Freedom came in to 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 outliving 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:

- 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**.

PDA members can view our podcast and download a free Pension Rule Change Factsheet 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.

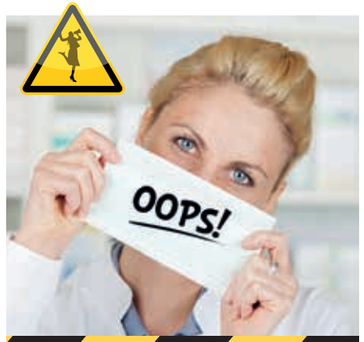
For advice on any of the issues raised in this article, contact Lloyd & Whyte on **01823 250750** or through their website at **www.lloydwhyte.com**

Workplace banter – *Don't cross the line*

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 behaviour at work. 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 refer to 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 was allegedly said or done. Now pharmacy employers are using the Standards of Conduct, Ethics and Performance produced by the GPhC in disciplinary letters.



Of the 7 Key Principles it is Principle 3, **"show respect for others"** and sometimes Principles 6 and 7 **"be honest and trustworthy"** and **"take responsibility for your working practices"** that become engaged when it comes to the issue of workplace 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...

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 colleagues, 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 and standard 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.*

Approximately 9% of complaints to the GPhC last year related to the issue of behaviour...

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 seniority and vulnerability of those on the receiving end of it, the number of colleagues involved and whether there are any aggravated 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 revolve 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.

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.

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.

Professional Indemnity arrangements for Pharmacists working in GP surgeries

Pharmacists have been working in GP surgeries for many years. Recently, however, there has been a groundswell of activity relating to the rapid expansion of pharmacist roles in this area of practise;

- **In England a substantial investment was announced which will fund over 375 pharmacists (see pages 14-17)**
- **In Northern Ireland more than 60 pharmacists are being funded**
- **In Scotland, the Scottish Government's Prescription for Excellence policy could result in many 100's of pharmacists working as pharmaceutical care specialists.**

As a consequence, the PDA has received many requests for information about the necessary Professional Indemnity insurance arrangements. This feature discusses some of the issues currently under consideration.

THE BACKGROUND TO GP SURGERY INDEMNITY

That healthcare professionals other than doctors have been asked to work in GP surgeries on the basis that they would be lessening the burden on GP's is not a new development. Initially, these were nurses and more recently physicians assistants. The thinking behind their surgery appointment was that they would be involved in supplementary roles that were compatible with their levels of competence. For example, a nurse taking the blood of a patient or checking blood pressure, or a physicians assistant weighing a patient. However, because of the pressures placed upon GPs, gradually, these members of staff found themselves in a front line diagnostic role triaging and even treating patients. In many instances they are being pushed to the very boundaries and, in some cases, beyond their level of expertise and this may be detrimental to patients.

For these new groups of healthcare staff, this transition represents a significant shift in the complexity of their role and also their exposure to liability. These are important lessons for pharmacy.

THE COSTS OF MIS-DIAGNOSIS CLAIMS ARE EXPENSIVE

Mis-diagnosis claims are much more costly than claims caused by a typical pharmacy dispensing error. That is why the average GP's indemnity insurance costs are in the region of £6,000 per annum. A trend has developed where the GP insurers, rather than suffer a claim are seeking to pass liability claims directly onto someone else – this would be the nurses or physicians assistants who stepped up to the plate to help out. The Royal College of Nursing became so concerned about GP practices shifting their expensive liability claims onto their employee nurse practitioners, that they have withdrawn their indemnity scheme for nurses working under a contract of employment in a GP surgery altogether. The consequence of these developments is that if the individual nurse practitioner or physician assistant seeks to take out an indemnity insurance policy in their own right with another insurance provider because they are required to do so by the GP surgery, their indemnity insurance premium is in the region of £2,500 per annum.

CONCERNS FOR PHARMACY

In many of the multidisciplinary meetings that have been held in England to discuss these scheme proposals, GP's have made it clear that pharmacists will need their own personal indemnity insurance, as they would not be covered via the surgery. The nursing experience clearly has implications for pharmacists preparing to work in GP surgeries under the new scheme.

The training package for pharmacists in England developed by the CPPE includes a few hours of medical examination techniques, undoubtedly participating pharmacists will be expected to diagnose.

The PDA and its underwriters have reservations about the adequacy of the training for an activity that is so risk laden. There are other factors that are also currently under consideration by underwriters; the extent of the training and a lack of emphasis on therapeutics, the starting point specification is for pharmacists with band 7 status (and ideally it should be higher) and pharmacists with little experience are also being considered for these roles.

The worry is that pharmacists working in GP surgeries, if they are not properly prepared, may become exposed to many negligence claims if they diagnose patients on a larger scale. These issues can also result in regulatory consequences.

CURRENT ROLES IN GP SURGERIES

The PDA recognises that pharmacists have, in one way or another, been involved in diagnosis in GP surgeries for a long time. Much of this diagnosis (as opposed to prescribing) has been on a supplementary basis. For example, the GP may have already diagnosed the condition e.g. asthma and the pharmacist is subsequently involved in reviewing the patient's asthma. Based upon his/her knowledge and through reliance on guidelines, the pharmacist identifies a change in the severity of the condition and because they are an independent prescriber, they prescribe a new treatment regime. This is done with, or without a further referral to the doctor who initiated the diagnosis.

Another example may be where a senior pharmacist with special interests (PWSI) has developed a detailed expertise (for instance) in dermatology and such is their level of expertise that, often junior doctors in a hospital may turn to that pharmacist for assistance in diagnosing.

It is recognised that these roles have always been undertaken by pharmacists and they are not the cause for any concern for underwriters. These pharmacists are either working in a supplementary diagnosis capacity, where the diagnosis has already been undertaken elsewhere or are working entirely within their area of specialisation and higher levels of competence. Alternatively, their activities and their interaction with the doctors is moderated by a written protocol.

WHY UNDERWRITERS ARE CONCERNED WITH SOME OF THE NEW ACTIVITIES

Underwriters are concerned that pharmacists will find themselves in unfamiliar diagnosis territory once working in the surgery, just like the nurse practitioners and physicians assistants.

Unsurprisingly, amongst many pharmacists there is a belief that they are experienced in diagnosis because of counter-prescribing in a community pharmacy. However, the dynamics involved are fundamentally different to those seen in a GP surgery. A pharmacist may respond to symptoms from a member of the public walking into a community pharmacy setting and make a counter-recommendation based on the belief that the patient is suffering from a minor ailment. However, that setting and a more retail orientated relationship creates an altogether different burden in terms of expectation and in turn, exposure to liability. Should a patient fall seriously ill or worse, because the community pharmacist did not have access to some of the information needed to identify the signs of a very serious underlying condition, then they would be able to rely upon the fact that this was an unplanned interaction in a setting with no access to clinical notes or detailed patient history and that this was a first line intervention. Although it was responsibly informed by accepted protocols (WWHAM questions etc.), it is likely to have been made with an unnamed and anonymous patient. Furthermore, the pharmacist is likely to have ended the interaction by advising the patient that they should see their GP if symptoms persist. Clearly, the pharmacist owes an important duty of care to the patient, but it is highly unlikely that the pharmacist in this instance could ever be called in to a subsequent liability action, inquest or regulatory proceeding as they would have acted within a number of limitations associated with the community pharmacy setting.

In the summer of 2015, the PDA became involved in the first pharmacist mis-diagnosis claim involving the death of a patient which arose from a consultation in a GP surgery

The GP surgery setting changes that balance dramatically.

The very same pharmacist, talking to the very same patient, but this time from within a GP surgery setting, would have a significantly higher expectation placed upon them and could not rely upon the limitations within which their advice could have been measured in a community pharmacy. In a GP surgery, the patient may well have already been to a community pharmacy and seen their condition worsen. The patient (and ultimately their lawyer) would not see themselves as an anonymous consumer wishing to make a purchase but as a patient who requires a clinical intervention from a medical professional fully connected to that patients medical circumstances. They attend surgery where they are known because they are registered and they will have made an appointment. The pharmacist would have full access to the medical history and would likely consult with the patient in the quiet of a private consultation room. They would have use of medical technology and could examine the patient, referring to others in the surgery if the situation was not clear. The pharmacist could even accompany the patient to the GP's room next door so as to get a more expert view if in doubt.

In the summer of 2015, the PDA became involved in the first pharmacist mis-diagnosis claim involving the death of a patient which arose from a consultation in a GP surgery. The pharmacist considered the patient to have only had a minor ailment and issued the treatment accordingly but the patient was actually suffering from a serious underlying condition.

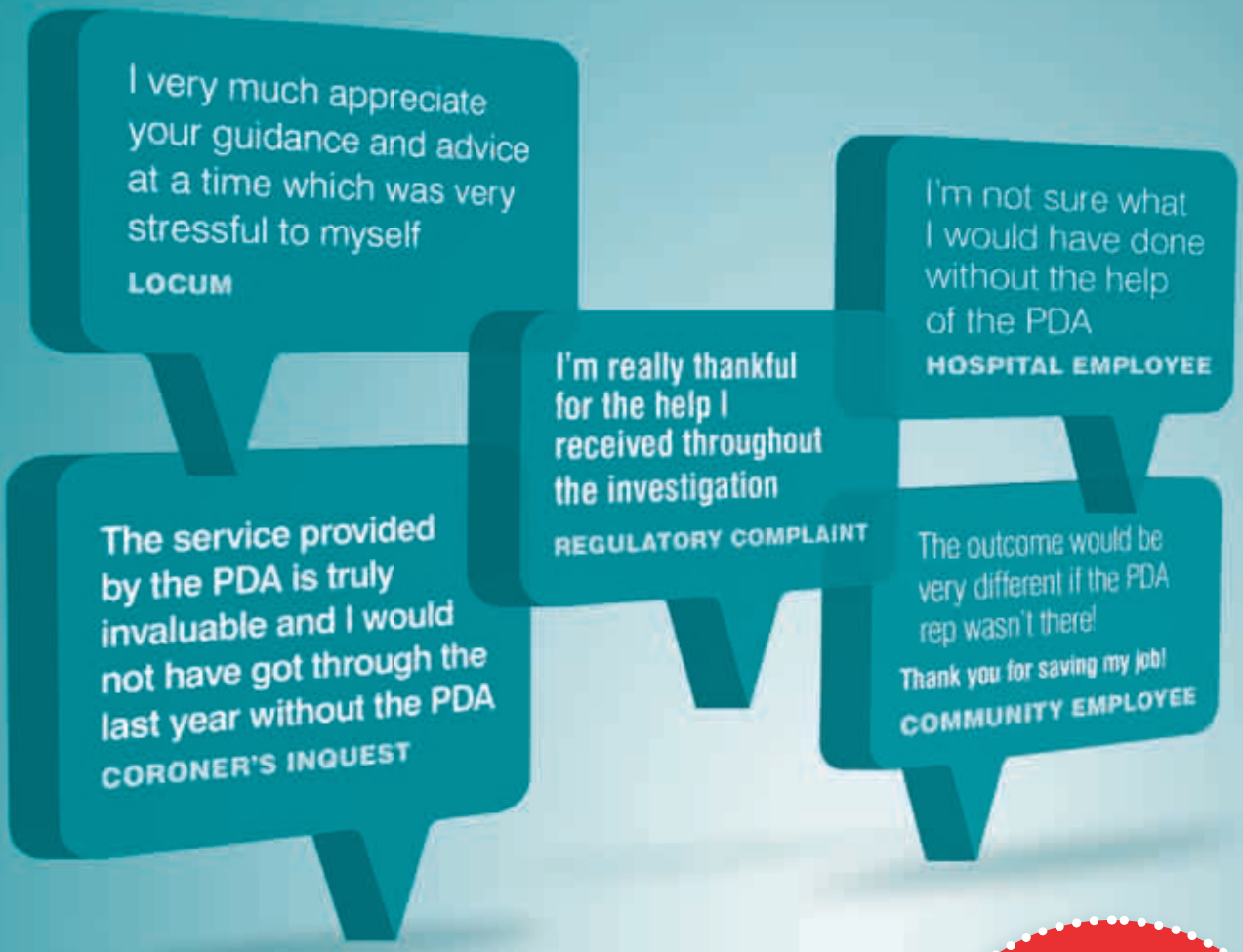
As a consequence of all these factors, the PDA is currently in dialogue with its underwriters as they are undertaking an urgent review of the new risks of liability for practice based pharmacists involved in diagnosis. There is a strong likelihood that the premiums required for protection against the risks of mis-diagnosis will be considerably higher than the premiums that pharmacists have previously been used to.

DISCUSSIONS WITH THE GOVERNMENT

The PDA is aware that other pharmacist insurance providers are also uneasy about these matters. In a recent meeting to discuss this subject between officials of the PDA and the NPA, it was agreed that they would jointly meet with NHS England to discuss their concerns. The worry is, that in the rush to get pharmacists into GP surgeries, not enough thought was given to risk management nor the indemnity insurance arrangements and ultimately the impact that the costs of such insurance for pharmacists might have on the scheme. The PDA is determined to negotiate the necessary insurance solutions in good time for the launch of the new initiative. Those members who intend to participate in GP surgery work and, in particular, those with a potential exposure to diagnosis should make themselves known to the PDA as they will be kept abreast of developments.

WHY JOIN US?

Every day our members tell us...



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