Spring 2015

insight

pda
the pharmacists' defence association

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

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Patient safety must always come ahead of making profit.

As a Defence Association, in the last few years we have handled tens of thousands of defence episodes involving our members and the majority of these are employment disputes.

The root cause of a significant proportion of these conflicts is a simple one; it is the fact that the corporate focus is upon retailing and profit and these aims often clash with the professional and patient centred concerns of pharmacists.

The experience of handling so many of these cases across the spectrum of pharmacy has led us to loudly and consistently articulate that we believe the professionalism of pharmacists is under attack resulting in a diminution of patient safety.

For more than a decade, the PDA has argued that the best way to protect patients is to underpin pharmacists professional autonomy and this view is at least in principle, shared in both government and regulatory circles.

The Francis Inquiry into the Mid Staffs hospital shone a spotlight on what can happen when organisational objectives are placed ahead of patient safety. It identified case after case where healthcare professionals had reported concerns about patient safety to management, but their concerns had either been suppressed, or the staff members who had raised concerns ended up being disadvantaged for getting in the way of organisational objectives. Ultimately, the employer created culture was not conducive to patient safety and one consequence of this was that it led to fatalities.

The resultant national scandal concluded with far reaching recommendations being made, including proposals that focussed upon the importance of the Duty of Candour and also the need to raise and act upon concerns.

The GPhC as the pharmacy regulator has sought to pick up on these themes in its recent attempt to rewrite the sanctions guidance for the disciplinary committees. These are the 'sanctions' that committees are urged to impose upon pharmacists that fall foul of the professional standards. As the feature on page 10 identifies, they seek to place all of the responsibility for delivering the thrust of the Francis report (and much more besides) onto the shoulders of individual pharmacists and not upon their (often non-pharmacist) line managers or employers.

In the wake of Francis, the government changed the law making it a criminal offence for any NHS body to fail in respect of its Duty of Candour to Patients. It took a stick to encourage NHS employers to foster a culture which supported healthcare professionals in raising concerns about patient safety.

In pharmacy, the GPhC's proposals have the effect of focussing all of the sanctions upon individual pharmacists. Non-pharmacist managers who are often integral to supporting the delivery of pharmacy services and who often dictate the operational culture, continue to be unregulated.

We find this an astounding and worrying paradox; can it be that the GPhC has not understood one of the central lessons from Francis?

Our extensive experience at the PDA has led us to believe that the problems identified by Robert Francis QC at the Mid Staffs hospital are also plaguing community pharmacy. Here, the professionalism of pharmacists is under attack from a targeted retailing agenda and as a consequence there is a diminution of patient safety.

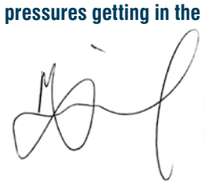
If anyone was in any doubt as to how hard it can be for a pharmacist to follow the recommendations of Robert Francis QC, they should read the feature on page 26 which describes what happened to one Boots pharmacist who fought a difficult battle against considerable resistance to try and ensure professional standards and patient safety were a priority in his pharmacy. In the end, the pharmacist was left with no alternative but to walk away from his job after blowing the whistle and suffering at the hands of his employer.

After winning his employment tribunal, this pharmacist will receive a financial settlement and is now working elsewhere with a clear conscience; however we know only too well that challenging an employer in this way is an extraordinarily high price for any pharmacist to pay, so as to protect patient safety – employers also know this.

The new GPhC approach to raising concerns in the workplace places pharmacists in a difficult position, for if they fail to do so, they may face severe regulatory consequences. Pharmacists finding themselves torn between the GPhC regulations and the organisational culture of their employer are urged to read the feature on page 21.

In the meantime, Boots pharmacists can be assured that the case which relates to their colleague (page 26) will be shared with Robert Francis QC, the Commons Health Select Committee, the GPhC and the Professional Standards Authority.

We must ensure that pharmacists can protect patient safety without corporate retailing pressures getting in the way.



Mark Koziol,
M.R.Pharm.S.

News...

PDA News from Northern Ireland

Following on from the launch of PDA Road Map in Scotland and England, numerous meetings have also been held and activities have been undertaken in both Wales and Northern Ireland.

Currently, the greatest progress is being made in Northern Ireland where a PDA official, now sits as a formal representative on the 'Medicines Optimisations Policy Group' and is a steering group member of "Making it better through pharmacy in the community", both groups being facilitated by the Chief Pharmaceutical Officer. Additionally, PDA acts in an advisory capacity to the NI "Pharmacy Forum'.

Increasingly, the PDA's Road Map concept which sees caseloads of patients on long term conditions being referred to group practices of pharmacists who then take responsibility for the delivery of their pharmaceutical care is gaining support.

"Great changes in healthcare provision are being encouraged by the government in Northern Ireland as it tries to get the healthcare service to work in a smarter, more integrated and patient focussed way. The governments 'Transforming Your Care' policy initiative has wide implications for all healthcare professions and represents a great opportunity for pharmacy. We are lucky, because we happen to have a well-developed and detailed Road Map policy which ticks many of the boxes and which we can plug straight into these discussions."

Said Harry Harron, the PDA's Northern Ireland Representative.

A senior official of the NI General Practitioners Committee told the PDA recently that he believed PDAs Road Map proposals would provide more capacity for GP's enabling them to concentrate on preventing unnecessary A&E attendances and hospital admissions.

In particular, he also agreed that the support provided by group practices of pharmacists and the focus upon a more integrated pharmacy/ GP patient journey would provide wide ranging benefits that would go way beyond just a more efficient use of medicines.

In separate meetings with Health and Social Care Board officials, discussions about operating through federations which also involved GPs were held.

Members are asked to keep a look out for the imminent publication of the specific PDA Road Map vision for Northern Ireland.

Progress with Prescription for Excellence in Scotland

Ever since many concepts of the PDA's Road Map appeared within the Scottish Governments new Prescription for Excellence Policy (PfE), it has been important to keep up the momentum on progress.

In 2014, the Scottish Government established a stakeholder reference group whose role was to provide ongoing input into the Scottish Government to support the PfE Action plan. Alongside other representative organisations, the PDA was given a seat on that reference group and through its representative has been providing input through this group. While the process of developing PfE through formal structures is underway, the process of lobbying continues.

It is important to ensure that everyone understands the exciting opportunities offered by the prospect of pharmacists being able to offer pharmaceutical care through the establishment of independent group practices which can operate clinically, free from the influence of target driven corporate retailing pressure. To further these aims, PDA officials met with representatives of ALLIANCE, which is the national third sector body which involves a range of health and social care organisations in Scotland. ALLIANCE was keen to learn of the views of the PDA and shared the PDA's enthusiasm for the possibilities offered by PfE.

In a separate initiative, following a meeting of the Scottish Health and Sport Committee which was held in the Scottish Parliament to consider the Prescription for Excellence Policy in 2014, the PDA met with the Convener and the Clerk to this influential Committee.

The purpose of this meeting was to indicate the extent to which PDA supported the PfE policy and also to give suggestions on how the delivery of pharmaceutical care might best be approached. Most importantly, when this committee met in 2014, it appeared interested in learning whether there was any difference (when considering future policy) in thinking of the profession as the operator of pharmacies or as a group of individual pharmacists.

The PDA was keen to address this question specifically and provided the Convener with some compelling narrative on the benefits of both approaches.

The Convener indicated that in future, the PDA should be invited to provide evidence directly to the committee when it sat in formal evidence gathering session.

Government proposals on decriminalisation of dispensing errors released for consultation

Many pharmacists will recall the shock they felt when pharmacist Elizabeth Lee was given a suspended prison sentence for making a dispensing error. Ultimately, the PDA was able to successfully overturn this judgement in the Royal Court of Appeal in 2009.

The PDA's case succeeded because it managed to secure a new and favourable interpretation of Section 85.5 of the Medicines Act which meant that from that day on, only those pharmacists who owned a pharmacy business could be prosecuted for applying the wrong label onto dispensed medicines. Since most pharmacists are employee's or locums, this took more than 90% of all pharmacists out of the firing line in relation to that offence.

It still left pharmacists exposed to prosecutions from other sections of the Act (such as Section 64) which covered the dispensing of the wrong substance. Because of that, since the Elizabeth Lee case, the profession has been eagerly awaiting a change in the law.

There has never been a question of pharmacists trying to avoid the consequences of their actions. If any pharmacists act in a way that is reckless or grossly negligent, then there is agreement within the profession that they should face the full consequences of the criminal law. Provisions in the law already exist to accomplish this.

Where it becomes clear that no gross negligence has occurred, but it is down to a simple human error, then other healthcare professionals are referred to their regulator. However currently, in such situations pharmacists are the only healthcare professionals to be exposed to a criminal offence through simply making a dispensing error whether it is damaging to a patient or not.

> ***"The time when pharmacists are treated in the same way as other healthcare professionals is long overdue"***

The effect of this is toxic and not in the patients interest, for in the event of a dispensing error, pharmacists may be reluctant to complete an error log. The prospect of criminal prosecution has blighted pharmacy practice and has restricted the good learning that could come from subsequent analysis.

The time when pharmacists are treated in the same way as other healthcare professionals is long overdue; the spectre of criminal sanctions for inadvertent dispensing errors has to be removed.

The journey has been long, frustrating and arduous

For the last six years the government has been trying to secure a change in the law so as to prevent a pharmacist making an inadvertent dispensing error from being prosecuted by the courts. This has not been easy as a change in the law can sometimes lead to unintended consequences.

The government's first effort was aimed at the Crown Prosecution Service and an attempt was made to establish an arrangement with the CPS where the police, instead of prosecuting pharmacists would leave the job of discipline for dispensing errors to the Pharmacy Regulator. This did not deliver the required results.

The next attempt was a proposal to change the law giving pharmacists a 'Due Diligence Defence'. However, the analysis provided by PDA Counsel was that this would have actually made matters even worse as pharmacists would never be able to prove that they had acted with 'Due Diligence' by showing that they had done all they possibly could to avoid an error from occurring, for had they done, then no such error would have ever occurred. The 'Due Diligence' approach would have deprived them of any possibility of mounting a defence. This ill-conceived plan was eventually withdrawn despite making some considerable progress through parliament.

The latest effort

The Medicines Legislation and Pharmacy Regulation Rebalancing programme board which was convened nearly two years ago has been working on further proposals. The PDA met with the Chairman of the Board in 2014 for two specific reasons, firstly to explain to him exactly what the implications of the Elizabeth Lee case were on labelling offences (Section 85.5) and secondly to discuss the Rebalancing Boards draft proposals on the Section 63 and 64 amendments.

The PDA expressed the view that although after the (Section 85.5) Lee case most pharmacists were now out of the firing line it still left those pharmacists who were owners exposed and asked that his board addressed that outstanding issue. He explained that this would not be handled by his board, because it was a section of the Act that was the responsibility of another branch of the government (the MHRA).

The PDA had already explained its position on Section 85.5 at previous meetings with the MHRA and consequently he was asked to use his influence (there was afterall a representative from MHRA on the Rebalancing Board) to press for further change.

Disaster

In late 2014 however, it was announced that the MHRA had managed to consolidate section 85.5 of the Act, into the Human Medicines Regulations. The effect of the new wording used now meant that the hard earned interpretation secured in the Elizabeth Lee case was now altogether lost. Currently, all pharmacists are yet again exposed to prosecutions from labelling offences. The PDA has been told that the MHRA would now try and repair the situation and the PDA has asked for a timetable.

In February of 2015, the work of the Rebalancing Committee relating to decriminalisation was released for consultation. That fresh proposals on changes to the law have finally been released is a welcome development. As on previous occasions, the PDA will now be looking objectively at the detail of the proposals and consulting with leading Counsel to establish whether they will provide pharmacists with what they have been waiting for – a meaningful and effective defence to a criminal prosecution in the event that they are involved in the commission of an inadvertent dispensing error.

> ***Members will be provided with an analysis once this assessment is completed.***

PDA Union questions NHS Maternity Policy

The PDA Union is at the centre of a potential claim which could alter the accrued holiday pay for women whilst on Maternity Leave.

In a recent case, the PDA Union was made aware that the Maternity Policy for NHS Commissioning Support Units states that bank holiday leave is not accrued whilst on paid or unpaid maternity leave.

This emerged when a PDA member whose entitlement as laid out in the staff handbook was 27 days annual leave and 8 days 'General Public Holidays', sought confirmation that her accrual was 35 days, as she understood it to be her contractual right.

When she was told that public holidays were not accrued she challenged her employer with the support of the PDA Union. She argued that she was being treated less favourably than her colleagues were because of her maternity. Her grievance was rejected and in the employer's opinion the decision was not discriminatory because:

- Bank holidays should be taken as they fall and as other staff take bank holidays as they fall she is not being treated differently.
- The statutory minimum leave requirements for staff, as the Working Time Directives apply in the UK of 28 days (prorate for part-time) does not differentiate between annual leave and public holidays.
- All NHS staff have a minimum of 27 days leave plus public holidays and therefore with the exception of staff who are on maternity leave for the full 'leave year' they would potentially have at least one bank holiday in the year therefore lifting them above the statutory minimum of 28 days.

The employer conceded that she could accrue one of the public holidays which would take her up to the statutory 28 days but would concede no more.

Counsel has advised the PDAU that there are legal precedents to suggest that public holidays should be included in the contractual entitlement to accrue when on maternity leave. And on the issue of taking bank holidays 'as they fall', even if the employer is correct that the member was required to take them at that point, and did so on the proscribed days during her maternity leave, arguably she was treated less favourably in such circumstances. Whereas those otherwise at work would get the day off the employee was already off work on maternity leave. For each public holiday she either lost a day of maternity leave or a day of leave for the public holiday.

The member lodged a claim in the Employment Tribunal for unlawful deductions of pay and entitlement and sex discrimination, as she has been disadvantaged whilst on maternity leave.

This is a complex case on the intersect of contract law, domestic statute and European directives. The PDAU expect the claim to be defended vigorously as there will be many employees in the NHS and other organisations that may lodge similar claims seeking these 8 days if this is successful.

THE PDA union
strength in numbers

A New Constitution for the PDAU and new opportunities for YOU

In 2011 when the PDA Union attained Independent status, it acquired the right to seek to represent members within an organisation to negotiate their terms and conditions collectively.

There are certain criteria to meet and hurdles to jump before a union can aspire to exercising these rights because laws have been introduced by successive governments to make union recognition more difficult. However, the PDAU must gear up for the future to take advantage of any developments and to structure its services amidst growing demand for collective bargaining.

A New Union Structure

The Executive has authorised that a new structure, the basis on which the union will be able to expand to meet future needs, be put to the membership by ballot according to the rules.

Currently the union organises itself into national sector Membership Groups. The sectors represented are Locum, Community Employees, Hospital Employees, Primary Care & Specialist and Student & Preregistration Graduates. Each group nominates a representative to sit on the National Executive.

The new structure will have a geographical Region as its democratic building block. Each of four Regions in total shall elect a committee comprising a proportionate balance of members from each sector within the region with the exception of Student & Preregistration members. Each Regional Committee will in turn elect a representative to the National Executive. It is important that the pharmacists of tomorrow, students and preregistration graduates, have a representative voice on the National Executive, so it is proposed that this population will form an elected National Membership Group, which will provide a delegate to the National Executive directly. Alongside these changes the Union will also ensure, that a strong sectoral representative process to the National Executive will still exist.

A New Opportunity To Work For The PDA Union

An appointed Regional Union Official will support each Region. The role of the Official will be to; provide the main contact with the Union HQ through the Assistant General Secretary; act as the secretary for the new Regional Committees; predominantly provide or arrange representation for members who are in dispute with their employers within their respective regions, and drive and support collective representation on NHS and CCGs' staff-side committees.

The size of the Region and the density of the membership will dictate the number of days per month each Regional Official will be required. PDA is inviting applicants who would like to fulfil this role on a 'contract for services' basis (as opposed to an employment contract) for between four to six days per month initially and increasing in time on the expansion of the Union. The geographical location of the applicant is important and they must demonstrate that they have relatively easy access to all parts of the Region by road or public transport.

To find out more go to the union web site **www.the-pdaunion.org** or contact **kayleigh.mapstone@the-pda.org**

Professor Linda Strand working with the PDA

The definition of Pharmaceutical care is; *"A patient centred practice in which the practitioner assumes responsibility for patients medicines related needs and is held accountable for that commitment".*

In short, instead of a pharmacist sending a patient back to their prescriber if a problem with a prescription is identified, under the pharmaceutical care model of practice the pharmacist would take charge and make the necessary changes. Such a prospect would require access to patient records, patient registration, a much greater integration of the pharmacist within the primary healthcare team, and a re-engineered and much more clinically driven form of practice.

These principles lie at the very heart of the PDA's Road Map vision.

One of the architects of this concept of pharmaceutical care is Professor Linda Strand from Minnesota, USA. Her model of care has been operationalised and is already delivering transformational change to more than one million patients in the USA.

Professor Strand is supporting the PDA as it seeks to turn its Road Map vision into an operational model of practice here in the UK.

In the last few months, Linda has spent considerable time at the PDA office and has accompanied PDA officials in meetings with numerous CCG's in England and with representatives of the Scottish Government as the PDA seeks to support the Scottish Governments "Prescription for Excellence" programme.

Pharmacists who would like to see the Linda Strand lecture at the recent PDA Conference may do so by using the following link: **www.the-pda.org/linda-strand**

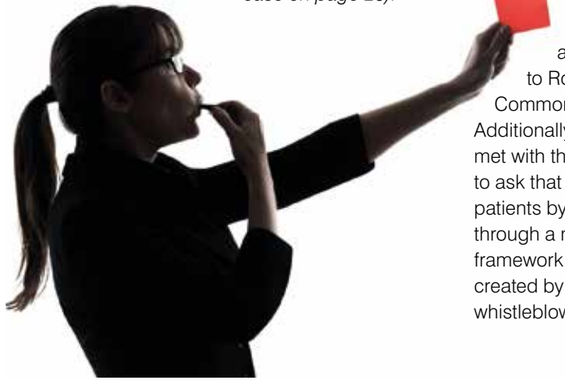
PDA lobbies to remove the impediments to Whistleblowing in Community Pharmacy

Whistleblowing became a significant public interest policy issue for the government after the publication of the Francis Inquiry. This identified that employees had been reporting their concerns about patient safety and critical incidents to management, but that these had not been taken seriously.

Since the end of 2014, NHS bodies have had a statutory duty imposed upon them which now criminalises those NHS employers that fail to exercise their Duty of Candour or fail to act upon any patient safety concerns raised by staff. This change dramatically improves the prospects for healthcare professionals who refer concerns to their employers because they must now take them seriously.

However, these changes do not (as yet) apply to community pharmacy. The PDA has concerns because numerous defence episodes it handles demonstrate how pharmacists are discouraged from raising concerns and whistleblowing because of their poor treatment after raising patient safety issues.

Occasionally, examples of such cases come into the public domain because they have been the subject of Employment Tribunals *(see Boots case on page 25)*.



Consequently, the PDA has serious doubts about whether the culture required to encourage the raising of concerns and in particular to protect whistleblowers currently exists in community pharmacy.

This matter represents a risk to the public. ***"It is necessary and important to ensure that pharmacists who report concerns about patient safety are protected from any employer retribution."*** says Mark Pitt, Director of Defence Services at the PDA.

The government agrees and this was demonstrated recently when the Commons Health Select Committee looked in detail at whistleblowing and concluded that; ***"the failure to protect whistleblowers remains a 'stain' on the reputation of the NHS."*** These are serious concerns and following on from the Francis Inquiry into the Mid Staffs Hospital, Robert Francis QC was tasked by the government to examine the issue of impediments to whistleblowing.

The PDA is keen to focus attention on the problems faced by community pharmacists when seeking to raise patient safety concerns.

Consequently, the PDA has sent a dossier containing the transcript of the recent Boots Employment Tribunal and other relevant material to Robert Francis QC, and to the Commons Health Select Committee. Additionally, senior PDA officials have met with the GPhC sharing this material, to ask that they take action to protect patients by supporting pharmacists through a more focussed regulatory framework that removes the impediments created by some employers to whistleblowing in community pharmacy.

Undercover Story – Covert Surveillance

In one recent case a pharmacist working for one of the large multiples found that CCTV cameras had been turned on him without his knowledge or permission.

One day the pharmacist noticed several covert CCTV cameras had been installed in the dispensary. None of the staff knew anything about them and after contacting head office to ask about this, the pharmacist was told they had not been installed by the employer. The PDA member was perplexed and decided to cover the cameras up until it could be established who had installed them and why.

It is important to note that an employer cannot just install covert surveillance to spy on staff and check their levels of work. The relevant guidance from the Information Commissioners Office states "monitoring through covert means should only be carried out for the detection and prevention of criminal activity or equivalent malpractice" and that consent from the police should then be obtained.

The company subsequently confirmed that it had installed the cameras to covertly observe how the pharmacy was functioning as they had concerns about how quickly the telephone was being answered. The pharmacist was then accused of tampering with the camera and put through a disciplinary process.

This case is still ongoing and the PDA will report on the outcome in the next edition of Insight.

Remote supervision – *Here we go again!*

They are asking employers and pharmacy technicians for their opinions but why are they not inviting the opinions of pharmacist employees and locums?

The Government has never been able to explain the rationale behind its thinking satisfactorily, but the plan to operate a pharmacy in the absence of a pharmacist has never been far from its thinking.

Having consistently tried and failed to win the arguments and therefore change the legislation in parliament with the support of the profession since 2006, the Department of Health now plans to have this poisoned chalice managed by the Rebalancing of Medicines Legislation and Pharmacy Regulation programme board.

One of its remits is to remove the pharmacy supervision arrangements from statute and transfer them to the pharmacy regulator – the GPhC.

Judging by the fact that the government intention has been to enable a pharmacy to operate in the absence of a pharmacist for many years, it is perhaps safe to assume that when this is transferred from statute to regulation, that the GPhC will receive considerable encouragement from the government so as to deliver upon its long standing ambitions. This is of concern to many within the profession.

There is no doubt that the current supervision rules need to be updated, however, the PDA has always maintained that the new rules on supervision and also enhanced roles for pharmacy technicians must seek to make the pharmacist more accessible to the public in the community pharmacy and not less so by dint of not being in the pharmacy at all.

Safety of the public

The PDA has consistently argued that operating a pharmacy in the absence of a pharmacist will impact upon the safety of the public, will be damaging to the profession and it will also harm the unique feature of the community pharmacy which is currently the place that provides easiest access to a healthcare professional for hours that are often longer than those of a GP surgery.

The added concern is that the two hour absence provided for under the

current RP regulations so as to enable pharmacists to deliver new services out in the community has since 2009, demonstrated how any 'permitted' absences will be widely abused.

Currently, in many instances they are not being used for the purposes for which they were intended. In many instances, the 'two hours permitted absence' has been used instead by certain pharmacy employers to operate their pharmacies for two hours before the arrival of a pharmacist by requiring their RP to retrospectively sign on upon arrival.

They do not pay the pharmacist for this time, as they argue that it is not really work. This demonstrates how a permitted absence designed with the intention of benefitting patients, will simply be used instead to improve profits by reducing operational costs.

Last summer, the head of Pharmacy at the Department of Health (DoH) attended a pharmacy technicians conference and invited them to describe a list of scenario's where they believe the current supervision regulations are affecting the delivery of pharmacy services. These are to be used by the DoH to consider how the supervision arrangements should be changed – perhaps this could be done by allowing pharmacy technicians to undertake more roles.

Since then, the Company Chemists Association have also offered their views to DoH officials on scenario's where they believe that remote supervision would be beneficial.

The current supervision rules need updating, but these must make the pharmacist more accessible to the public in the community pharmacy and not less so.

These views are now to be considered by the Rebalancing Programme Board as they consider what changes to the supervision rules should be undertaken. The Programme Board in considering supervision is inviting opinions from pharmacy technicians (many of whom are keen to develop their roles) and also from large multiple employers (some of whom already reduce their operational costs through the two hour absence rules). However, the PDA is not aware of them inviting the opinions of those who will be most affected by any changes; the community employee and locum pharmacists and this is a real concern.

The PDA is keen to ensure that it is not only the views of those who potentially stand to gain through the diminution of the pharmacists role in the pharmacy that are being considered by the programme board.

When the idea of remote supervision was first put by the government in 2006, it argued that the benefits of pharmacists being able to leave the pharmacy and deliver a range of new and professionally fulfilling services to the public out in the wider community outweighed the risks of not having pharmacists available in the community pharmacy.

The PDA has consistently argued that operating a pharmacy in the absence of a pharmacist will impact upon the safety of the public

Indeed, the government argued (back then), that unless pharmacists could develop these new services, then this would likely damage the profession over the long term. However now, nearly a decade later, there are more pharmacists available than anyone dreamed about when this risk vs benefit analysis may have been undertaken in 2006.

Within a couple of years, there's likely to be several thousands of pharmacists looking for employment. Consequently, the opportunities out in the community can now very easily be delivered by pharmacists, without the need for the pharmacy to be left with no pharmacist on the premises.

There is no longer any need to introduce the risks associated with operating pharmacies without pharmacists. The question that needs to be asked is why the government is still attempting to introduce risks to the public by continuing to proceed with its policy on remote supervision, when these risks are now entirely unnecessary.

To assist the Rebalancing Programme Board with their work, alongside the examples provided by the Association of Pharmacy Technicians, who at best represent a few hundred members mainly from the hospital sector and also those of the representatives of large employers, it is important that they also receive the views of front line employee and locum pharmacists. The PDA therefore appeals to members to contribute their views as these will then be passed to the programme board.

We ask that members provide us with their views on how they think enabling a pharmacy to operate in the absence of a pharmacist (even for relatively short periods of time), could impact upon patient safety and upon their ability to provide a comprehensive service from a community pharmacy.

It is important that these views are framed as operational workplace impact scenario's. We provide a few examples of areas that may be affected by a pharmacist absence;

- Workplace patient safety
- Staff performance
- Pharmacy's positioning as an accessible healthcare provider
- Managing interactions around OTC medicines
- The sales of P medicines
- Involvement in Public Health initiatives
- Handling emergency presentations
- The supply of medicines and advice
- Proactive handling of unexpected and opportunistic patient presentations
- Interpretation of PMR's and summary care records
- Clinical checks on prescriptions
- Interactions with patients both at the point of prescription receipt and handing out.

Contributions from members can be made on **www.the-pda.org/supervision**

As the work of the Rebalancing Programme Board proceeds, members will be asked to assist in further phases of this work.

Whatever happened to P-Meds on self-selection?

Many pharmacists will recall that at the end of 2012, the GPhC consultation which was considering the standards that it would use to regulate community pharmacy managed to surreptitiously slip in their idea that P medicines should be available on self-selection.

The idea was conditional upon the GPhC securing additional powers and establishing further measures, nevertheless, it caused considerable alarm within the profession.

At meetings, the PDA expressed its concerns to GPhC officials in clear terms, and several other representative bodies added their concerns urging the GPhC to reconsider its mistaken stance. Even some of the government's Chief Pharmacists joined the debate asking the regulator not to ignore the concerns being expressed.

The PDA organised a series of meetings around the UK which were attended by many pharmacists, it commissioned a substantial report itemising the reasons why the current position on P medicines should be maintained and it launched a petition which has thus far secured the support of nearly 6,000 individuals.

Undoubtedly, after all of this activity, pharmacists will be wondering what has happened – has the threat gone away? Or is it still looming?

The answer is that the threat has not gone away and this is very much still 'on the GPhC radar'. However, the GPhC will now hold a consultation on the matter – something that it previously appeared not inclined to do. This consultation, when it comes however, will not just be about P-Meds on self-selection, it will be part of the much wider consultation that deals with the outcomes of the work of Rebalancing Medicines Legislation and Pharmacy Regulation programme board (Decriminalisation, remote supervision and skill mix). This may eventually occur in 2016 and only then if the new government pursues the same policies.

The PDA will therefore publish its substantive P-Meds report and will advise pharmacists as to how to engage further with the PDA's petition and the GPhC's consultation when it is the most appropriate time.

To sign the P-Meds petition go to www.the-pda.org

To strike off *or* not to strike off?

Currently, the Pharmacy Regulator – the GPhC issues guidance to the disciplinary committees as to what kind of sanctions they should impose upon pharmacists appearing in front of them. At the end of 2014, the GPhC instigated a consultation to review the scope of the areas for which guidance is issued and the sanctions that should be considered.

The areas upon which feedback was sought included Dishonesty, Sexual Misconduct, Duty of Candour, Raising Concerns and Aggravating and Mitigating factors.

The PDA defends pharmacists in the majority of the GPhC's disciplinary hearings, it experiences all of these matters and has offered detailed responses, a short report follows.

Dishonesty

The PDA believes the GPhC has struggled with how it handles dishonesty for some time. Dishonesty covers a very wide range of matters and yet the committees appeared not to be taking account of the degree of dishonesty, nor were they keen to take account of any mitigating factors. Pharmacists where in many cases simply being struck off for all forms of dishonesty. This is the equivalent of executing a thief whether this is for the petty theft of an apple or for grand larceny. In particular, the PDA is concerned that the committees have been unprepared to factor in the effect of the corporate encouragement of behaviours that would not satisfy their standards, but which are created by the profit driven culture of their employer. The targeting culture imposed by certain pharmacy employers often places pharmacists in near impossible situations. One example is that in the run up to Christmas, in an attempt to bolster sales, some pharmacists were deliberately told by their employers not to close their pharmacies on Sunday at a time which complies with the Sunday trading hours legislation and that senior management would take responsibility for any subsequent discovery.

> *This is the equivalent of executing a thief whether this is for the petty theft of an apple or for grand larceny*

Duty of Candour

That patients have a right to be told the truth about an incident that may have detrimentally impacted upon the standard of their care was one of the key findings of the Francis Inquiry into the Mid Staffs Hospital Trust. The GPhC now wants to introduce clearer penalties to be used by the committees in cases where pharmacists have failed to exercise what is called the Duty of Candour. Whilst the PDA agrees that this duty is very important, it is improper that the GPhC is seeking to place all of the responsibility upon individual pharmacists and none upon non-pharmacist line managers or employers.

The Francis Report found that healthcare staff often attempt to comply with this duty, but that it can be suppressed by the management and the organisational culture of the employer. No matter how well meaning, without the support of the employer, the Duty of Candour becomes that much more difficult for pharmacists to exercise.

As NHS bodies, hospitals now have a statutory duty which criminalises those that fail to notify errors that cause harm to patients. This does not yet apply to community pharmacy. Employer organisations and non-regulated line managers have a significant role to play in the delivery of healthcare services and often have an involvement when something goes wrong, therefore they surely must also have a responsibility to participate in the Duty of Candour, but currently, this is not the case in community pharmacy. This discrepancy poses a significant threat to patient safety especially if pharmacists are line managed by non-regulated personnel.

The PDA experiences situations where employee pharmacists and locums are told by their employer not to make any contact with patients nor to make any inquiries in the event of a dispensing error. They are told to stay out of the process because the employer will make contact with the patient. Often however, when such contact is made by Head Office, it is done very belatedly and in a style which does not focus upon a Duty of Candour, but upon mitigating a civil claim in compensation. We believe that this is because the employer fears that in allowing the pharmacist to make contact with the patient, the pharmacist may damage the employer's brand. Or alternatively, that in talking with the patient or the GP, the pharmacist may draw attention to flawed systems and processes within the employers' organisation. This could cause more compensation to be paid to that patient in the event of a civil liability claim being pursued or worse still (for an employer) that the employer ends up being referred to a regulator.

> *It is improper that the GPhC is seeking to place all of the responsibility upon individual pharmacists and none upon non-pharmacist line managers or employers.*

In such situations, pharmacists are in a conflict between their professional Duty of Candour and their employer's instruction not to make contact with the patient or other.

The PDA has recommended that non-pharmacists such as hospital or area managers or company directors should be regulated by the GPhC and should have a Duty of Candour placed upon them as this would deal with a major cause of dilution of the public interest in pharmacy.

Whilst the PDA fully supports the Duty of Candour in principle, it believes that the current pharmacist focussed approach being taken by the GPhC will not get to the root of the problem.

Raising Concerns

The GPhC wants committees to take very seriously a finding that a pharmacist has failed to raise concerns about the workplace.

The PDA argues that an environment and culture must first exist in pharmacy where individuals are supported by employers in raising concerns about standards of care and risks to patients. Currently, in many cases, such a supportive environment does not exist especially in community pharmacy where there is an overtly commercial environment. The PDA member experience shows that not only are pharmacists not being supported in raising concerns, but they actually face substantial barriers to discourage them from doing so, such as;

- Being berated by line managers for not being team players because they refuse to operate in an unsafe pharmacy environment.
- Being downgraded in salary reviews after raising safety serious concerns.
- Having their promotional prospects adversely affected after raising concerns.
- Having their capability unfairly questioned after raising concerns.

Some pharmacy employers see a pharmacist who is prepared to work in woefully inadequate conditions as someone having a positive employee attribute and they consider this a valuable employee characteristic.

Even if pharmacists do make a stand, the concerns that they raise are often disputed by more senior managers and are not resolved.

Recently, a damning verdict written by a judge after the PDA successfully supported a member at an Employment Tribunal against Boots shone a light upon similar issues ***(See page 25)***.

If pharmacists raise concerns then this can lead to career limiting consequences, especially at a time when they can be easily replaced. Unsurprisingly, many pharmacists who have families to look after feel they have little alternative other than to muddle on as best as they can.

The PDA has warned the GPhC that unless there is a culture and an environment in which employers genuinely address concerns raised by pharmacists, then the GPhC proposals will provide no benefits to patients whatsoever other than to produce a record of unaddressed concerns. Nothing contained in the GPhC's proposal to deal with raising concerns appears to be linked to placing a requirement upon employers to resolve the issues being raised. This is pivotal to resolving the problem.

General comments

The GPhC believes that focussing its guidance so that it impacts primarily upon practicing pharmacists will have the greatest beneficial impact upon patients. This belief is manifestly misplaced and is tantamount to telling the passengers of a high speed train what their destination must be and that failure to reach it will result in expulsion from the train, whilst failing to say anything to the train driver.

PDA believes that regulation should be used to protect patients by creating a culture that underpins the professionalism of pharmacists. It must be used to encourage employers to create the kind of environment where such professionalism can flourish. What is happening instead is that there is an ever growing regulatory focus upon the actions of pharmacists on the one hand but there is a lack of regulation of non-pharmacist employers on the other. This is creating an impossible NO WIN situation for pharmacists and patients alike. For pharmacists, the current approach by the GPhC represents increasing risks to their patients, their continued registration, their livelihoods and their mental health.

This is a matter of the utmost strategic importance and it is a matter that the PDA has urged the GPhC to consider very seriously.

The full PDA response to the consultation can be found on www.the-pda.org/sanctions

Two heads are better than one

PDA SEEKS TO SECURE A SECOND PHARMACIST IN EVERY PHARMACY

The Pharmacy Contract Global Sum is shrinking in real terms. Employers are seeking ways to control their salary bills by reducing the number of hours for pharmacist cover and then either reinvesting it in support staff or making savings. Furthermore, there is fear in many quarters that Government is promulgating 'skill-mix' strategies, and encouraging the deskilling of the dispensing operation simply to justify the reduced income that pharmacy can expect despite the increase in volume, year on year.

To suggest that the skill-mix can be better utilised to release more pharmacist time, is true to an extent, but in the PDA's view it is an over-simplification and fails to recognise the pharmacist's contribution to patient safety.

Support staff play a crucial role as part of the healthcare team in a pharmacy but their skills and training must not be over-exaggerated and they should not be used as substitutes for pharmacists.

The PDA, is therefore seeking to promote a case that;
improved patient safety, improved health outcomes and increased economic benefits can be achieved by employing more pharmacists in pharmacies, not less.

The suggestions therefore that each pharmacy should have more than one pharmacist available to oversee the dispensing operation, and more dedicated resource to deal with OTC advice and Public Health counselling will no doubt be met with disdain in some quarters but before they object, the objectors should consider the following;

- The process of dispensing and the means of distribution (delivery drivers as an example) is becoming less, not more, safe. In the PDA's experience, the number of serious incidents and deaths caused by dispensing and delivery errors is at an all time high.
- The availability of 'Summary Care' records require the application of highly developed clinical skills that only a pharmacist can perform. If their use is applied diligently, this will have enormous benefits for patients, but it will put the pharmacist under more scrutiny should they miss a critical drug reaction. Taking short-cuts because of time pressures will be little mitigation if the pharmacist could have saved a life but failed to.
- Pharmacists have historically been the only group of health care professionals freely accessible to the public through the community pharmacy network yet they are spending less, not more, face-to-face time with patients because of excessive workloads. Too much of this activity is now delegated to support staff with less expertise. Patients are deriving reduced value from these interactions and should expect more. Pharmacists with specific expertise could prevent damage to health caused through the excessive and inappropriate taking of OTC medication, and at the same time be the filter for patients with conditions more worthy of an in-depth investigation by their GP.
- Pharmacists can remove significant pressure from the financially strapped NHS if utilised properly and integrated into the health system coherently through the effective treatment of minor ailments. A role that can only be delivered effectively if pharmacists are more able to engage in patient facing interactions.
- The excessive outflow of pharmacy graduates already point to supply outstripping demand in an industry increasingly being controlled by non-pharmacists seeking to maximise profitability by reducing head count and taking short-cuts which damage patient safety.

PDA Project Group

The PDA has set up a project group to identify the benefits of funding more than one pharmacist per pharmacy. Its remit is to

1. Identify missed opportunities for patient care due to there being insufficient pharmacist time in community pharmacies to perform a more comprehensive role.
2. To seek out the evidence and identify further research needed.
3. To establish the cost and health outcome benefits that may be derived by increasing the number of pharmacists in community pharmacies.

The PDA made proposals in its Pharmacy Road Map for Community Pharmacy to embrace a strategic career pathway. Making a case for a dispensary based and a patient facing pharmacist is an opportunity to create that structure and to stake a claim for specialist roles in traditional areas of practice which will demonstrate the advantageous health outcomes to be gained in using more pharmacists more appropriately in a community setting.

This project is an extension of the PDA's mission to enhance current and develop new roles for its members.

Summary Care Records

Potentially a transformation in pharmacy practice

In recent years, as advances in medicines manufacture were made, original pack dispensing has become the norm and the traditional 'mixing the medicines' role has become obsolete.

Today, the medicines assembly function is being seen by the government as a technical and not a professional role and it has even argued that a pharmacist need not be on the premises as such technical activities can be undertaken by technicians and be supervised remotely by pharmacists.

However, the PDA has consistently argued that in addition to the vital public health and the accessible advice roles performed by pharmacists in a community pharmacy, a vital professional role of the pharmacist which is irreplaceable is the clinical check on the prescription. Importantly, such a check can establish whether the prescribed medicines are safe or appropriate for the patient, or whether there has been a prescribing error.

The pharmacist may detect harmful interactions with other prescribed medicines or those purchased over the counter, or identify dosages that may not be optimal and change them. Such a clinical check can also establish whether a patient understands how best to use their medicines. It involves an interaction with the patient, with their carer and often with the GP. In the most complex situations, this interaction is undertaken at prescription receipt and when the patient returns for their medicine. In a hospital setting, the interaction with patients is undertaken on the wards, in a community pharmacy however, this role is performed in the pharmacy where the prescription is presented by the patient and where the public come for the advice.

The demographic changes in Society has seen many more elderly patients being cared for by the NHS and this trend is set to increase dramatically. Increasingly, pharmacists are seeing prescriptions being presented for patients on polypharmacy regimes and suffering with multiple conditions.

This places a much greater burden upon the vital clinical check performed by pharmacists. Currently, this valuable check is under threat; the sheer volume of prescriptions being dispensed and the reduction of staffing levels by employers have resulted in pharmacists often working flat out just to get the medicines dispensed and leaving little time to dwell upon the clinical issues.

The biggest hurdle, in terms of being able to undertake a quality clinical check, is that there has been the lack of any access to patient information other than the pharmacy PMR. This is in stark contrast to hospital pharmacy where patients drug charts can usually be found on the wards.

With pharmacists being able to access the patients Summary Care Record, this may be set to change. Pharmacists could transform their current role, by concentrating their efforts in an area which is neither technical nor mechanical but one which is entirely professional, requiring the specialist input of a pharmacist. The good news is that community pharmacists may not be too far away from seeing such a possibility become reality.

The Summary Care Record trial

Since 2014, 125 community pharmacies throughout the UK have been invited to participate in a trial whereby they were given access the Summary Care Records (SCR) of patients. The purpose of this trial was to establish three things;

1. Whether use of the SCR improved patient safety
2. What would the optimal operational model would look like
3. Whether the use of the SCR in community pharmacy could be of benefit to relieving the stress on other parts of the NHS.

The 125 sample size is small, but despite this and even though the trial has not yet concluded, according to those pharmacists involved, already some very positive evidence is being generated.

In a large proportion of the encounters where the Summary Care Records was accessed potential harm was avoided, with a significant proportion of these being episodes where a prescribing error was identified and prevented. One member told the PDA that having accessed the SCR to make a relatively innocuous inquiry, he identified and was able to prevent a potentially life threatening allergic reaction. Access to the SCR has clearly improved patient safety.

Currently, the SCR is also being used in situations where a vital piece of the jigsaw is missing. Little surprise then that in the vast majority of encounters where the SCR was accessed, pharmacists subsequently did not need to send the patients back to the GP as they were able to resolve the issue within the pharmacy. At its most basic level, SCR use by pharmacists would reduce the pressure on GPs and this is before other, more sophisticated nuances of SCR use are exploited.

The trial will be evaluated once it has concluded later in the year. Nonetheless it is already possible to see how the use of the SCR could transform community pharmacy practice and provide pharmacists with just the tool that they have needed to be able to do justice to the vitally important task of the performing the clinical check.

How to use the Summary Care Record

Already, discussions have commenced as to how best to use the SCR. In a recent Chemist and Druggist article *(Feb 2nd page 345)*. It was argued that the SCR could help pharmacists when they are making an emergency supply. It could be used when they are undertaking an MUR, or where there is an obvious query or concern.

There is no doubt that such incidental reliance upon the SCR may be of benefit, but if community pharmacy is to undergo a paradigm shift in service provision, one in which the professional skills of the pharmacist can be more fully utilised for the benefit of patients and the wider NHS, then the reliance upon the SCR must drive roles that go way beyond just the clinical check of the prescription. The use of SCR must become a core component of practice and not an incidental one, seeking only to improve the existing supply service.

A more comprehensive reliance upon SCR would allow pharmacists to optimise the medicines being taken by patients by enabling them to consider the whole patient and not just the whole prescription or the whole single condition for which the prescription was prescribed.

Beyond that, a more comprehensive use of the SCR could allow pharmacists to get on top of the medicines waste issue, to tackle ADRs and even help to avoid unnecessary hospital admissions.

Furthermore, if used as part of a service which was integrated with other members of the primary healthcare team, it could create much more capacity for GPs enabling them to see more patients with acute conditions because they could refer case loads of their patients with longer term conditions to pharmacists.

To drive such benefits, pharmacists would need to be routinely accessing SCR's with the majority of patient presentations and seeking out opportunities to optimise medicines use.

Undoubtedly, this would take much longer than does the current dispensing service and would necessitate a significant re-engineering of community pharmacy practice. One consequence would be the need to re-evaluate skill mix in the community pharmacy requiring the presence of more clinical expertise and probably more than one pharmacist in the pharmacy *(see feature on page 12)*.

One of these pharmacists could be focussed upon this new and much more clinical role and the other would be able to devote more time on the opportunistic advice, public health and medicines sales role. This vision would alter the experience of patients collecting their medicines from a community pharmacy and this is an opportunity that would require the profession to manage in the most effective way. It would also require the NHS and the government to work with pharmacy so as to deliver an imaginative and compelling patient facing information dissemination exercise so as to explain the benefits of the new approach.

Exploiting the opportunities

The wholesale development of community pharmacy in the way described would be of benefit to patients, to the profession and to the wider NHS and would surely be a goal worth striving for. The big question for pharmacy is whether it is able to move its focus away from simply being a supplier to consumers (that of a retailer) to that of a healthcare professional enjoying a clinical relationship with patients.

"In the UK, community pharmacists are seen as shop keepers and do not even have access to the diagnosis upon which the prescription has been based. What a waste of professional expertise and what a reflection on our governmental systems, that purely for historical reasons, necessary change has not been driven forward."

Hugh McGavock
Professor of prescribing science
(ex member of CSM)

Not only is community pharmacy disadvantaged by its retailing image, but it has reached the point where unless it is a large multinational conglomerate, it struggles to maintain its viability. If community pharmacy (as opposed to retailing or supermarketeering) wants to carve itself a more viable long term future, then it must take the healthcare professional route and major upon the development of clinical relationships with patients. The PDA believes that the emergence of the SCR provides an excellent opportunity to do just that.

Patient safety:
Dangers of Delivery

The home delivery of medication to patients is often used as a carrot to entice the public into taking up repeat prescription schemes. And whilst these schemes can often provide an invaluable service to housebound patients, frequently the main driving force is to increase the market share of dispensing business.

The unintended consequence of providing such a desirable, convenient service is that it appeases consumer expectation and acts to accentuate their belief that medicines are no more than a normal item of commerce, and are to be treated much the same as a pizza delivery. The PDA has first hand experience as to how this desire to provide a value added customer service offering to patients can lead and has led to catastrophic circumstances.

We have identified two PDA case studies which pharmacists may find of interest with the consequent leanings.

CASE STUDY: **ONE**

A pharmacist received a call from the patient's daughter stating that the wrong dosette tray had been delivered the previous week and that the patient had taken incorrect medication. The patient was admitted to hospital and unfortunately died a few days later.

On investigation, the labels, generated some weeks ahead of the date of supply, when retrieved, clearly bore the signature of the pharmacist, and had been accurately checked in accordance with the prescription.

At the time, the bag seemed to have been discarded by carers who were involved in the administration of medication to the patient at his home.

The employer's investigation concluded, erroneously as it turned out, that the wrong bag labels had been interchanged for two different patients. Surprisingly the outer packaging was eventually located in the patients house and it became apparent that the medication had been correctly checked and bagged, and that the correct bag label had been applied but that the driver had made a mistake at the point of delivery. By then however, many months had elapsed.

The Coroner's inquest determined that the post mortem did not link the error to the death. The main purpose of an inquest is to establish how, why, when and where a death occurred. It is not usually a contentious environment and there is no prosecution or defence, nevertheless it can be a highly traumatic experience to have to come face to face with the recently bereaved family and have to explain your involvement.

The experience for the pharmacist in this particular case was sufficiently traumatic for her to resign from her employment and to consider her future in pharmacy.

It remains unexplained as to why the other patient, says he received the correct medication when he was contacted by the pharmacy.

CASE STUDY: **TWO**

The PDA was initially contacted by a pharmacist seeking help because his employer was conducting a formal investigation into his involvement in a dispensing incident.

The suspicion was raised when a carer had called at the pharmacy to enquire as to why the expected delivery had not yet arrived. The record revealed that the receipt of the medication had been signed for as delivered. On closer inspection the signatures for all ten deliveries that afternoon appeared to be the same, and it was evident that the driver had taken upon himself to sign on behalf of patients because of a shortage of time. ➔

CASE STUDY: **TWO** cont...

This was in breach of the procedure laid out in the SOPs. The internal investigation established that a technician had packed the items and applied the incorrect bag label, which the driver had then delivered to the address indicated on the label.

Fortunately there was no harm to the patient, and with the involvement of the PDA the allegations into the pharmacist's conduct, made totally accountable by his employer as the RP, were dropped. This particular incident had occurred over a Christmas period and at a time when the usual delivery driver had left and had not been permanently replaced, which meant that a driver had been "loaned" by another branch.

Public holidays are notoriously more difficult periods and pharmacies are typically stretched to the limit. Being mindful of this and having a heightened awareness could be enough to minimise the risk of incidents arising.

On this occasion the pharmacist was rightfully absolved of responsibility, but the PDA are involved with cases on a daily basis, where pharmacists are disciplined for being in breach of SOPs, and not conducting a check on the bag label which is applied prior to delivery could easily fall under that description.

WHAT ARE THE LEARNING POINTS?

Many pharmacies are heavily burdened by the preparation of monitored dosage supply and delivery systems with insufficient levels of staffing, which means that labels are often generated many days or weeks in advance.

The PDA has long advised pharmacists not to be party to any pre-labeling which inevitably increases the risk of errors. However, if a pharmacist believes that they have no option, or is 'parachuted in' to a process that is already in train, there needs to be a system in place that allows for a clear audit trail for the complete chain of supply.

Ask yourself when was the last time you sat down to look at the SOPs for such prescriptions and are they even applicable to your pharmacy? When was the last time you discussed these with your delivery driver? Are there provisions for what to do if patients are unable to sign for medication? Do patients know they are expected to sign for receipt? What does the driver do if no one is in? Do you see the delivery record once it is returned? Where is it kept?

- ➔ Many patients who are having medication delivered are also having the same medication administered to them by carers employed to do so, and who have a duty of care in making basic checks but who are often untrained. Every opportunity must be taken for a collaborative approach between GPs, pharmacists, carers and patients.
- ➔ Do not make an assumption that because you are informed that you have made an error, that you are responsible for it. Take the appropriate responsibility when you have all the facts. Obtain the evidence for your-self and do not necessarily rely on those that have made the allegation until you are sure. It is often very difficult to piece together exactly what has happened after a significant event has occurred, which is why PDA always advises pharmacists to be proactive about gathering together every source of evidence and information that is available as soon as possible after the event becomes apparent. It can be very difficult for locum pharmacists to obtain information about an incident that they have little involvement in remedying and they are often told by the employer that certain information has to be withheld from a confidentiality/ governance perspective.
- ➔ If you are involved in an incident, from both a professional and a civil liability viewpoint, you are entitled to know everything about that incident. You have a professional responsibility to investigate where you went wrong and why, so as you can apply risk management strategies in future. You are also personally liable should a claim for compensation be made against you and you should be expected to collect the evidence in the event that there is one. You have the right, as the person who is being made accountable for an error and who is bound by the same duty of confidentiality as the employer, to see the relevant information – which may include the patient details. You should not take 'no' for an answer when you request such detail and the superintendent pharmacist should be contacted if there are any difficulties.

At least the pizza delivery boy wouldn't deliver the items unless someone is there to take them in.

In addition to PDA experiences, there was story that made the headlines last year (Mail Online, 8th January 2014) about a toddler who was thought to have ingested medication that had been posted through the letter box. A 21 month old child was caught by his father retrieving Trajenta tablets from the door mat. The Trajenta had been delivered to an incorrect address and the child was about to ingest them. Fortunately it seems that the child did not actually swallow any of the antidiabetic and no harm was caused. It was a straightforward delivery error, which could have and should have been averted.

At least the Pizza delivery boy wouldn't deliver the items unless someone is there to take them in. A lesson to be learned for all of us!

"Pizza makes me think that anything is possible" said Henry Rollins, musician, writer, journalist, publisher, actor, television and radio host.

The campaign to cap the numbers of Pharmacy Graduates

In 2012, the PDA instigated a series of Conferences around the UK to focus on the problems looming on the horizon regarding the over production of pharmacy graduates.

This enabled the PDA to develop a two track approach to the problem of oversupply of pharmacists;

- Controlling the numbers of undergraduates so as to reduce the over-supply on the one hand
- Developing new roles for pharmacists so as to increase the demand for pharmacists on the other

The detailed outcome can be found at **www.the-pda.org/seven-point-plan**

Ultimately, this activity and garnering the involvement of other bodies in pharmacy led to the research which was undertaken by the Centre for Workforce Intelligence. This showed what everyone already knew, that a crisis in pharmacy student numbers needed to be urgently addressed.

With the backing of a coalition of pharmacy bodies a consultation was undertaken by the Higher Education Funding Council (HEFCE) and a recommendation was put to the University Minister to introduce a cap on pharmacy student numbers. The previous Universities Minister appeared sympathetic and it looked like the requested changes would take place.

A new Universities Minister was appointed and to everyone's surprise, he concluded that despite all these recommendations, no cap should be applied.

A new campaign has been instigated and in the last three months several PDA officials and PDA members have lobbied key members of parliament.

On November 27th 2014 a question was put to the new Universities Minister in the House of Commons and he provided his response in December.

Q *"To ask the Secretary of State for Business, Innovation and Skills, for what reasons the cap on the number of dental and medical students has not been extended to cover pharmacy students."*

A *"Pharmacy students are funded in the same way as chemistry, biology and other science subjects which will not be subject to a student number control at HEFCE funded institutions in 2015/16. Medicine and dentistry attract a much larger amount of HEFCE grant funding than science subjects like pharmacy. Therefore it would not be appropriate to cap pharmacy student numbers."*
Greg Clark

The PDA is keen to keep up the pressure and seeks members help by asking them to lobby their own local MP. There are many arguments that members could use and MPs are currently in listening mode due to the forthcoming General Election. We provide some of the arguments that may be of use;

1. Universities teaching Medicine and Dentistry do attract a higher HEFCE grant than is the case for each pharmacy graduate, but the Pharmacy Pre-reg year attracts an additional £20,000 per graduate of government funding (DoH).
2. Many pharmacy courses are being provided to undergraduates as part of a broader health faculty where pharmacy, medical and other healthcare undergraduates attend many of their lectures together.
3. Pharmacy is not a science subject in the same way as is Chemistry or Biology, the vast majority of pharmacy graduates work in healthcare roles and in patient facing situations.
4. The Centre for Workforce Intelligence has estimated that if the current approach continues, there will be thousands of pharmacy graduates who will never qualify as pharmacists because there are not enough pre-registration training posts. This is not only a waste of tax payer's money, but this surplus will bring the Higher Education system into disrepute.
5. Rarely have all of the pharmacy bodies been so aligned, they all agree that pharmacy student numbers should be capped. This is also the position of the Department of Health.
6. One of the most important roles of a pharmacist is to ensure that an employer's profit driven demands do not stand in the way of patient safety. The tension between these two, often conflicting forces, has hitherto been managed by pharmacists often in the face of intense pressure from employers. Already the emerging oversupply is challenging this healthy tension because some unscrupulous employers are taking advantage of the ease with which they can get replacements that will do their bidding. This represents a diminution in the safety of the public.
7. Unemployment in pharmacy will make it increasingly difficult to attract high calibre undergraduates to Pharmacy Schools. This will damage the patient interest since the complex challenges placed by medicines upon Society generally means that pharmacy needs to employ high calibre individuals if it is to meet these challenges.

The PDA will continue to press for changes to the current policy and will seek to exploit the manifesto pledges being made by the various political parties.

Hang 'Em High....er

Are the GPhC getting tougher?

BACKGROUND

Readers will be depressingly familiar with the well trodden route to the GPhC Fitness to Practise Committees that pharmacists accused of Medicines Use Review (MUR) irregularities, face. The journey starts with an employee pharmacist, usually working for one of the big multiples, who is unable to cope with management demands to meet MUR targets. The pharmacist either falls behind with completing the necessary paperwork or reports figures for completed MURs that cannot be subsequently verified. The company disciplinary machinery finds the pharmacist guilty of gross misconduct and they are summarily dismissed. The employer makes a complaint to the GPhC who commence their own investigation.

At the hearing, the pharmacist will face allegations of acting dishonestly due to fraudulent MUR claims being made and sometimes because of initial denials of responsibility. For all healthcare professionals, a finding of dishonesty lies at the top end of the spectrum of gravity of misconduct, with removal from the register being a real possibility. Committee members tend to focus on the pharmacists' actions and pay little attention to the corporate pressure and target culture that feature frequently in mitigation. In the past pharmacists found guilty of acting dishonestly by making fraudulent claims for MURs, have tended to receive a period of suspension not exceeding 12 months, rather than being struck off the register for at least 5 years.

RECENT DEVELOPMENTS

More recently though, the Fitness to Practise Committees appear to be taking a much tougher approach towards pharmacists accused of dishonest behaviour and in particular those facing MUR allegations. One pharmacist reported to the GPhC by a pharmacy multiple was struck off the register recently by a Fitness to Practise Committee for making false MUR claims, even though earlier cases based on similar facts had led to pharmacists being suspended.

In trying to explain his misconduct, this pharmacist stated that the pressure to meet targets was relentless via email, telephone calls and visits. The pressure, he said, took the form of area managers ringing him on a daily basis, asking how many MURs he had done and from area managers who maintained league tables, using these to embarrass people. He said there were continuous emails describing the number of MURs done in each store in the area and threats that he would be put on a Performance Improvement Plan and even face dismissal if targets were not met.

A large proportion of pharmacists working in community pharmacy will be familiar with the sort of pressure described above. However the Committee did not believe him after hearing from a senior company manager who gave evidence that the picture painted by the pharmacist was simply not correct. The manager said that the company approach was to examine with the member of staff concerned what those performance issues are, identify causes and problems, consider support and training to ease the pressure and even consider increasing staff. The Committee chose to believe the manager and discounted any undue pressure as a factor. Unfortunately the pharmacist only conceded late in the day that he had claimed for MURs that he had not in fact done. The Committee felt that this was an admission that should have been made much earlier on and saw this as evidence of failing to take responsibility and lacking insight.

A MESSAGE TO THE PROFESSION

On the issue of MUR pressure the Chairman gave a stark message to the profession before directing the removal of the pharmacist:

"The exercise of professional integrity requires sometimes that a pharmacist must stand up and be counted. If pressures of work prevent the proper discharge of professional responsibilities, the professional owes a duty to his patients and to his profession to voice that concern, uncomfortable though it might be to do so. A professional does not engage in dishonesty, despite personal provocation or the consequences for himself and even for his continued employment in a particular appointment"

LESSONS TO BE LEARNT

Judging by recent developments, the GPhC are taking a tougher line with pharmacists involved in fraudulent MUR claims. Committees seem unwilling to hold employers to account for their part in creating a culture where pharmacists feel they have no option but to resort to misconduct to meet unreasonable targets to keep their jobs. Had this pharmacist contacted the PDA at an earlier stage, we believe that he would have avoided being removed from the register. The PDA has an effective and tested strategy for dealing with MUR pressure and pharmacists should seek prompt advice. As the Chairman says, the GPhC will have no sympathy for those that do not raise concerns.

Blowing the whistle... making it count!

Whistle blowing has been a hot topic in the press for a while now. This is driven partly by the aftermath of the public inquiry into the Mid Staffordshire NHS Foundation Trust conducted by Robert Francis QC and partly from a number of scandals affecting care homes.

Whistle blowing, in the context of pharmacy, is usually defined as disclosing information (a protected disclosure) in good faith usually to an employer, which in the reasonable belief of the worker tends to show that the health and safety of any individual has been, is being or is likely to be endangered. For example raising concerns about staffing levels, the working environment, an unsafe workload or indeed any other matter which may adversely impact upon patient safety can all fall into the category of whistle blowing in pharmacy. There are other types of protected disclosure, but in this article we focus on common issues faced by pharmacists at work.

Community pharmacy employers may have thought they had escaped scrutiny in this area, but a recent case brought by a pharmacist against Boots ***(See page 25)*** shines a spotlight on this powerful piece of legislation and highlights the poor treatment of one whistleblower who worked for the largest pharmacy multiple in the UK.

This article describes how pharmacists should respond if they are concerned about patient safety at work. Done for the right reasons, whistle blowing is a commendable act and for employees at least, there is a robust legal framework in place to protect individuals from being disadvantaged as a result. Whistle blowing can be a powerful catalyst for improving patient safety and the PDA believe that this piece of legislation is under used in community pharmacy and one that is widely misunderstood by employers.

To protect whistle blowers, employees have legal safeguards from being subjected to any detriment by any act, or any deliberate failure to act, by the employer on the ground that a protected disclosure has been made. In community pharmacy examples of detriments could include being criticised for closing the pharmacy, being put onto a performance improvement plan unfairly or being downgraded at salary review as a consequence of whistle blowing. Other examples include being overlooked for promotion or being moved out of the pharmacy.

Pharmacists may be concerned that there does need to be a clear link between the whistle-blowing act and being subjected to a detriment. This is not necessarily the case as the burden of proof shifts to the employer. In practical terms once a tribunal accepts that a protected disclosure has been made and a detriment suffered, it is down to the employer to prove that the worker was not subjected to the detriment on the grounds of making a protected disclosure. Nor does the detriment need to be a major one; what is important is that any complaint to an Employment Tribunal must be made within three months of the detriment itself. The other piece of good news is that a claim can be brought whilst the pharmacist remains in employment, there is no need to resign and further statutory protection kicks in once a complaint is made to a tribunal.

Pharmacists can remain in their job after making a whistle blowing claim and the PDA is currently dealing with such a case in another pharmacy multiple.

The PDA urges any member who is contemplating blowing the whistle to contact us for advice at the earliest opportunity. We can also assist members who have already made a protected disclosure and feel they are now suffering at the hands of their employer.

KEY POINTS TO REMEMBER

- Pharmacists are encouraged and expected to raise patient safety concerns by the GPhC, and the profession
- Concerns should be raised in writing and set out what the health & safety issues are, as well as the potential consequences for patient safety
- Keep a written record of discussions and interactions with company managers
- Raise a grievance which attracts the right of union representation
- The time limits for bringing a claim are very strict and normally this must be done within 3 months of suffering a detriment
- Take advice from the PDA Union at an early stage.
- Consider reporting concerns to the GPhC if your employer is not taking them seriously

Flexible Pensions – What Pharmacists Need to Know

From April 2015, a lot of the restrictions on what you can do with your pension pots will be lifted. Widely regarded as a positive step, everyone will soon have a lot more freedom to do as they please come retirement.

It doesn't matter whether this will affect you tomorrow or in 40 years, what is really important is to understand the implications and how you can best take advantage of the situation.

In order to help, here's a summary for PDA members on what's changed, how this affects your pension and the most common risks involved.

An Independent Financial Adviser's opinion

As an advocate for objective-based financial planning, I've welcomed these changes. More freedom makes it that much easier to build a financial plan around what matters to you.

Still, this is my opinion as a professional financial adviser. I spend my day studying the financial world in order to make sense of it, so I'm also aware that complete freedom of choice might be overwhelming to the majority of people. Particularly those who don't spend as much time looking at spreadsheets, graphs and indexes as I do.

The traditional restrictions

Pension funds have traditionally been used to buy an annuity at retirement. This way, a saver could secure an income for the rest of their life.

Wealthier savers were permitted to leave the pension fund invested and draw an income from the growth– an option called "income drawdown". However, limits did apply.

To be eligible for Flexible Drawdown, you currently have to meet a minimum level of 'secure income' before drawing an income directly from your pension.

Secure income is defined as:

- State pension and social security benefits
- Occupational pensions
- Private pension annuities

The minimum level used to be £20,000, which is why the majority of people had to purchase a private pension annuity. However, this threshold was reduced to £12,000 for the current (2014/15) tax year and will be removed entirely from April 2015.

This means you can use Flexible Drawdown on a fund of any size, without needing to arrange a secure income.

What this means for retirees

Income (or Flexible) Drawdown isn't anything new. However, the requirement to provide a 'secure' income meant these were only accessible to those with larger pension funds.

While this means a lot of pharmacists would be eligible, they would still have had to use a sizeable portion of their personal pension fund to purchase a secure income.

From April 2015, you will have access to your entire pension fund, with no restrictions, from the age of 55. Although, there will be tax implications to bear in mind.

The Wealthiest You'll Ever Be

From the age of 55, you will probably have direct access to more cash than you ever have in your life time. You'll probably be the wealthiest you've ever been. Or ever will be, for that matter.

Once you retire, your wealth is going to diminish over time. The traditional restrictions were designed to ensure you didn't run out of money. Now that this is gone, this responsibility is yours.

Outliving your retirement fund is a very real risk.

What about Final Salary Schemes?

Final Salary schemes are exempt from the rule change. At your retirement date, you will begin to receive your benefits over time with the option of a cash lump sum.

However, it is likely there will be ways to transfer benefits to a personal pension and cash that in.

In the majority of cases, it would not be beneficial to sacrifice the long term benefits of a Final Salary Pension for a lump sum in the short term. Final Salary Pensions offers generous benefits that would be hard to find elsewhere.

If you are being advised to transfer, make sure the source of advice is a pension transfer specialist.

It's daunting

The flexibility offered is certainly daunting. A lot of my clients who are approaching retirement had always expected to purchase an annuity. They were comfortable with this.

Now, being asked to consider other options is quite intimidating.

However, I expect to see a host of innovative new products emerging in the coming years.

And, while annuities still play a big part of catering for retirement, it will definitely pay to consider your options.

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.

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**

Undergraduate FtP under scrutiny?

By Joy Wingfield
Professor of Pharmacy Law and Ethics

Most readers of this article will not be undergraduates, but imagine for a moment that you still are. Imagine……. in your wilder youth, you got involved in an arson attempt at the local school resulting in a "police caution". You didn't declare this when you started your MPharm course but now it has come to light. *Will you be able to continue your course? Will you be able to get on the register at the end of your training?*

There are no guaranteed answers to these questions. The PDA handles cases where late disclosure of a caution has resulted in the student being removed from the course; in another, no action was taken. Much depends on the context of the offence, the level of insight shown by a student and what are known as "aggravating" or "mitigating" factors.

Examples of undergraduate behaviours that might attract University FtP hearings

- Criminal conviction, caution or similar relating to theft, fraud, possession of illegal substances
- Drug or alcohol misuse, including driving with excess alcohol
- Aggressive, violent or threatening behaviour
- Persistent inappropriate attitude or behaviour such as lack of commitment to academic work, poor time management, neglect of administrative tasks
- Cheating or plagiarising – cheating or passing off other's works as one's own
- Dishonesty or fraud, including dishonesty outside the professional role
- Unprofessional behaviour or attitudes such as bullying, harassment, rudeness
- Health concerns and lack of insight or management of those concerns

Courses for medical and nursing students have long included fitness to practise (FTP) requirements. Following the Shipman inquiry about a doctor who had deliberately caused the death of hundreds of his patients, all health professions were required to bring in similar FTP processes. So, in 2009 a student code of conduct and associated FTP procedures were introduced to pharmacy undergraduates.

The student code of conduct

In essence, the code requires pharmacy students to conduct themselves professionally as soon as they enter their degree course. This applies both on and off campus. The code is not explicit about requiring undergraduates to pro-actively report misdemeanours but it is, however, perhaps implicit in phrases such as "tell your university if there is anything that could impair your ability to study".

Fitness to practise procedures in Schools of Pharmacy

The GPhC plays no part at all in student fitness to practise procedures. It does, however, require every School of Pharmacy to have such processes in place (as part of course accreditation) and to use them where needed.
The GPhC also issues guidance on the scope and operation of such processes, most importantly requiring that the school "must tell students that poor behaviour or health before or during their course might affect their ability to enter pharmacist pre-registration training or to register as a pharmacist". Importantly, the guidance clarifies that a students fitness to practice as "a student" is being considered, and not as yet as "a pharmacist". Most schools now introduce workshops into the first few weeks of the course to make sure that this requirement is well understood, often, these are supported by the PDA.

What might bring you before the school's FTP panel?

The student code of conduct and the FTP guidance is available on the GPhC website. To illustrate the threshold that undergraduates might cross, the guidance lists some useful questions:

- Has a student's behaviour harmed patients or put patients at risk of harm?
- Has a student shown a deliberate or reckless disregard of professional responsibilities towards patients, other students, staff or others?
- Is a student's health or impairment compromising the safety of patients, themselves, other students, staff or others?
- When acting in a professional or academic-related activity, has a student abused the trust of another person or violated another person's autonomy or fundamental human rights?
- Has a student behaved dishonestly, fraudulently, or in a way designed to mislead or harm others?
- Has a student failed to abide by the code of conduct for pharmacy students?

Five years on

At a recent session[1] at the RPS annual conference for pharmacy lecturers, it was clear that some trends were emerging. A mere handful of cases – mainly criminal – were considered by the GPhC prior to pre-registration or full registration. The GPhC will review the code of conduct and may add in more about professionalism, the need to understand and learn from one's mistakes, a duty of candour and how the code is applied across a five year integrated course.

The PDA expressed concern about the unexplained lack of consistency at some of the Schools of Pharmacy; the need to avoid conflicts of interest and the requirement to follow the principles of natural justice. All undergraduates, for example, must be entitled to see all the evidence and to be accompanied by the representative of their choice and according to the PDA, this does not always happen.

For the Schools of Pharmacy and the staff who are involved in implementing the procedures, sitting in judgement on student behaviour is no easy task. Most recognise that now is a good time to compare notes for students and academics to look at consistency and proportionality in outcomes and to share best practice.

1. This was organised by the Pharmacy Law and Ethics Association **www.plea.org.uk**

PDA determined to fight on after Judge has change of heart

The Judge who invited the PDA Union to make an application for a 'declaration of incompatibility' had a complete change of heart following the government's direct representations at a hearing in December 2014.

Judge Keith rejected the application of the PDAU, which if successful would have made it possible to seek changes to the law in Parliament enabling the Union to achieve statutory recognition by Boots.

The hearing in question, to seek the 'declaration of incompatibility' was the most recent in a long line of legal proceedings to decide the issue as to whether Boots pharmacists could have their terms and conditions of employment negotiated on their behalf by a union of their choice. Something that Boots has consistently resisted.

In the initial stages, the PDAU made an application to the Central Arbitration Committee (CAC) for formal recognition because Boots had refused its voluntary application on the grounds that it already had an agreement with Boots Pharmacists Association (BPA). During one CAC hearing, a Boots Director conceded that one intended consequence of the current agreement with the BPA was that it blocked the PDAU's efforts to negotiate on terms and conditions. The CAC allowed PDAU's application because it said that the Boots/BPA agreement, in specifically excluding any negotiations on salary and holiday, had in effect breached the human rights of all pharmacists because they were, in essence, barred from holding such negotiations with their employer. Boots challenged the decision of the CAC and took it to a Judicial Review.

Whilst awaiting the Judicial Review hearing, the CAC continued with the process which involved statutory disclosures by Boots and PDAU. By analysing comparisons in this data in combination with other measures. The CAC decided that the PDAU was likely to receive the support of more than 50% of all Boots pharmacists if a ballot was to be held.

In his interim Judicial Review decision in February 2014, the Judge had said that he was of the opinion that the agreement between Boots and the BPA had potentially breached the human rights of pharmacists but that the UK law as it stood allowed them to do so because it was not yet compatible with the European Human Rights Convention. The judge therefore invited the PDAU to make an application for a 'declaration of incompatibility' of the British and European law. Between the time of this invitation and the hearing to decide upon the 'declaration of incompatibility, the Ministry of Business Industry and Skills (BIS) got involved in the matter and lawyers from the government attended the most recent hearing arguing against the PDAU. This intervention appears to have been crucial in the outcome of the case.

All the way through these proceedings, Boots had argued that the law did not need to be changed and that PDAU could merely use a formal process to seek a de-recognition of the Boots Pharmacists Association. This is a process that would unravel the agreement between Boots and BPA and remove the blockade on PDA's application for recognition.

Boots referred again to the de-recognition of BPA argument at the most recent hearing on the 'declaration of incompatibility'. At this hearing, the government also argued this point; it was strongly opposed to any change in the law. Although the Judge had previously not supported the view that the PDAU could seek to de-recognise the BPA he reversed his position. In his determination he said;

"It hardly needs to be said, but Boots' success on this claim may prove to be a pyrrhic victory. It is now open to the PDAU to apply to the CAC for the ending of the bargaining agreement between Boots and the BPA."

The irony does not appear to have been lost on the Judge that on the one hand Boots has resisted any statutory recognition of PDAU because it claimed that it had an agreement and a strong relationship with BPA. On the other, Boots used as its argument in law, that pharmacists have an avenue open to them to have their terms and salaries negotiated by de-recognising the BPA.

This is a fight that the PDAU is unwilling to walk away from in the interests of all of its members in Boots and beyond. The Union has been given leave to appeal the judgement and a hearing date has been set for October 2015. John Murphy, the General Secretary of PDAU said

"It was never our intention to have open warfare with BPA by seeking its de-recognition but if the legal processes are exhausted without success, then the only way that Boots pharmacists will be able have their terms and conditions negotiated on their behalf is if we pursue such a route."

Boots in court after losing whistle blowing case

An Employment Tribunal recently considered a claim by a PDA Union member who was forced to resign after raising patient safety issues that Boots failed to take seriously.
The Tribunal identified a catalogue of failures and heavily criticised senior managers. Names have been changed for the purposes of this article.

The facts

Boots wanted to pilot a sponsored OTC healthcare initiative in one of its flagship pharmacies. The GPhC registration details of the store pharmacist were required to confirm the training had been completed by staff. Debbie, the non-pharmacist manager was under pressure from her Regional Manager to meet a deadline for the training. Peter, the store pharmacist was supporting the training but unaware of any deadlines to meet; in addition there were staff shortages.

After one Regional meeting, Debbie rang Peter at home to ask for his GPhC registration number so that the staff declaration could be completed. Peter refused and made it clear to Debbie that the staff were not yet competent to provide the service. Peter later found out from the staff that Debbie had asked a locum for his registration number which was then used to accredit their training.

Soon after Debbie told Peter that he was "not performing" and one reason was that he had not supported her in signing off the training; it was his duty to support her at all times. Debbie then placed him on a Performance Improvement Plan (PIP). Only a few months earlier Peter's previous manager has awarded him "performing" status, so he decided to express his concerns in an email to the clinical governance team.

Peter heard nothing more from Boots after his complaint and found the working relationship with Debbie strained. Further meetings took place during which his job security was threatened and he was subjected to an unwarranted character assassination. This behaviour culminated with an invitation to a disciplinary meeting on performance grounds. At this stage Peter took advice from the PDAU who helped him draft a grievance and recommended that the meeting should be postponed until the grievance was concluded. On hearing this Debbie took HR advice and then made threats to Peter about gross misconduct if he did not attend.

The PDAU representative insisted that Peter was provided with all the evidence that the PDDM used to reach his conclusion. Staff statements directly contradicted Debbie's position and did not support the conclusions reached. At this point the PDAU wrote to the HR Director of Boots to flag up serious concerns; the Director assured the Union that the grievance was being investigated correctly.

Peter appealed and the PDAU representative carefully explained that the outcome reached by the PDDM was unsustainable and Debbie was not being honest. As the initial investigation was of poor quality, the union representative suggested how the independent appeal manager should conduct his investigation in order to get to the truth.

> The staff statements revealed that Debbie had lied and the evidence did not support the conclusions reached by the PDDM.

The PDA Union assisted Peter to lodge his grievance directly with the pharmacy superintendent, as his complaint related to patient safety. The task of arranging the grievance was then delegated to a Regional HR manager who initially chose one of Debbie's close friends as the investigating manager. After a complaint was raised about a lack of impartiality, a Pharmacist Development and Deployment Manager (PDDM) was appointed.

Peter attended the grievance with a PDAU representative who set out the case and raised a number of key issues that needed to be investigated. It took the PDDM four weeks to reach a conclusion which Peter felt was wholly unsatisfactory and it appeared to be a muck raking exercise mainly to find information to discredit him. The main substance of his complaint about being put onto a PIP after refusing to allow his registration number to be used was never dealt with properly.

Both Peter and the Union expressed the view that there had been a cover up.

Shortly after the appeal, Peter felt that for specific operational reasons the pharmacy presented a risk to patient safety and decided to temporarily close the pharmacy to resolve them. Debbie did not like this and expressed her dissatisfaction after she found out that he had emailed the Clinical Governance team about the closure. Peter could take no more and was signed off with work related stress; he resigned shortly after receiving the appeal decision in which the area manager suggested his complaint could be dealt with informally by meeting with Debbie. Assisted by the PDA Union, Peter lodged a claim for suffering a detriment as a result of whistle blowing and unfair constructive dismissal.

Tribunal hearing

Debbie did not attend the hearing and her absence was described as "unusual" by the court. No explanation was given; the PDA Union believe the company knew how damaging she would be to its case and decided not to call her as a witness.

The judge concluded that healthcare staff had been pressurised by Debbie to falsify company records by using the locum's registration number. The tribunal were scathing about a key conclusion reached by the PDDM concerning the reasons for Peter being placed on a PIP.

> With the assistance of the PDA Union Peter lodged a claim for whistle blowing and unfair constructive dismissal.

Debbie's actions in pressuring the staff to falsify company records were described as "inherently dishonest" by the judge and he expressed reservations about the company sign off process used to confirm staff competence.

The threats to Peter's job security and the language used by Debbie to besmirch his character were found to be "entirely inappropriate" and "unacceptable". Two members of the panel felt there may have been some justification to start a PIP process; however the judge disagreed and felt there was "an undue haste to place the claimant on the PIP and a lack of process….." The Tribunal found Peter had whistle blown and suffered a detriment after Debbie criticised him for emailing the Clinical Governance team after closing the pharmacy,

The Tribunal also concluded that the company investigations should have progressed far more speedily and Peter's complaint was treated with a lack of seriousness. Investigations contained "glaring omissions" and did not deal properly with fundamental issues. The appeal manager was "not fully engaged" with the allegations that Debbie was dishonest and did not challenge her about key points. The Tribunal felt his suggestion to resolve his complaint informally was "insensitive" and "inappropriate".

Peter won his case and the Tribunal concluded that he had been unfairly dismissed after the behaviour of both Debbie and Boots had destroyed the employment relationship. They agreed that Peter had suffered a detriment because he blew the whistle after closing the pharmacy on patient safety grounds.

Implications

The findings of the Tribunal shine a spotlight on the difficulties that pharmacists can face when reporting serious patient safety concerns. It is rare for a Tribunal to articulate criticism in such forthright terms and clear from the judgement that the panel were unhappy with the conduct of senior managers and the application of company processes. The PDAU is also aware of a case in Scotland where a pharmacy staff member was singled out by several company managers and put through a sham reprofiling exercise as a result of blowing the whistle. Again the Tribunal were scathing about the conduct of senior managers and misapplication of company processes. In response to one whistle blowing incident, a manager deliberately placed sensitive and personal medical information about the whistleblower on the pharmacy notice board for all to see.

> It is clear from the judgement that the panel were unhappy with the conduct of senior managers and the application of company processes

Conclusion

The judgement shines a spotlight on the difficulties that pharmacists can face when reporting serious patient safety concerns. Pharmacists should be aware that it is rare for a Tribunal to articulate criticism in such forthright terms; it is clear the panel were unhappy with the conduct of senior managers and the application of company processes.

Boots tried to portray Peter as a pharmacist about whom it had genuine performance concerns and that his complaint was merely a reaction to these. The Tribunal saw through that argument and found he was a genuine whistle blower and a capable pharmacist who had resigned as a result of the poor treatment he was subjected to by both the manager and the company.

Peter's success was down to following carefully the advice of PDA Union lawyers, expert representation and good record keeping; this case was a textbook example of how a Union can secure the right outcome for a pharmacy whistle blower in a tricky area of law.

Our member is currently waiting for his financial compensation to be decided by the court.

See page 7 for further developments relevant to this case.

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