HOSPITAL PHARMACIST EDITION

autumn/winter 08

insight

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

Responsible Pharmacist

steering clear of danger?

Also inside

Chairmans Letter

Mark Koziol, Chairman, The PDA

How will the **responsible pharmacist regulations** change your life?

Although the introduction of the Responsible Pharmacist (RP) provisions was primarily aimed at the community sector, some of them will have an impact on hospital pharmacists.

The PDA has sought legal counsel and as the feature on pages 11 to 13 will show, these changes represent a very significant uplift in the levels of personal responsibility and risk for anyone who signs up to being a Responsible Pharmacist.

"This is a shift in personal responsibility of astonishing proportions!"

The RP provisions require a record of the name of an individual pharmacist who would now be made personally and legally responsible not only for the supply of medicines to the public, BUT ALSO for ensuring the safe and effective running of the pharmacy - in so far as it relates to medicines. This is a shift in personal responsibility of astonishing proportions!

There are many more concerns about these proposals and unless some changes can yet be made, then they will represent a very unwelcome development.

After some significant lobbying, the PDA has been belatedly invited to join the Society, employer representatives, the government, academics and others to draft the regulations in a series of meetings held during Autumn 2008. The idea is that these regulations will 'go live' and will govern pharmacists from the autumn of 2009.

Despite the fact that you cant make a silk purse out of a sows ear we will nevertheless be doing our level best to argue against the worst of the proposals in the interests of both pharmacists and patients.

For more detailed information why not read the formal PDA response to the DoH consultation on the Responsible pharmacist **www.the-pda.org/responsiblepharmacist**

To comment on this feature **www.the-pda.org/is/001H**

Patently bad advice !

Recently, the PDA was invited to address a meeting of pharmacists to discuss some of the risks being faced daily by pharmacists, such a civil action after errors have been committed, work place conflicts, employment disputes, professional disciplinary and criminal prosecutions. During the meeting we were astonished to hear a senior hospital pharmacist, state that in their opinion the involvement of the PDA in these matters was unnecessary. In their view, if pharmacists found themselves in difficulties, then by working with the Trusts lawyers, or their line managers and with the support of other senior pharmacists in a spirit of measured cooperation and with a little goodwill then these conflicts could usually be resolved.

Senior managers inevitably have a lot of credibility particularly with more impressionable junior colleagues and it was therefore particularly disturbing to see **advice being given which was so patently bad!**

Professional conflicts are sadly a fact of life in the fast pace of modern pharmacy practice. They can be complex and often have career threatening consequences for pharmacists unfortunate enough to have found themselves involved. They are often difficult to resolve and pharmacists will need and deserve prompt, committed and expert assistance. The view that was expressed by the senior pharmacist at that meeting could, if taken up by any pharmacist lead to them finding themselves with no independent expert support in the event of a serious incident at work – until perhaps it was too late.

Senior managers enjoy a position of influence within hospital pharmacy and it behoves them to offer guidance based on fact and not opinion and then only where they have the relevant competence and knowledge to back up their advice.

We describe a range of considerations (pages 21-23), all of which have emerged in real life hospital pharmacy situations which may help pharmacists to understand the issues.

In terms of handling professional and workplace conflicts we respect the fact that hospital pharmacists can decide on how they want to handle them. Fortunately, with well over 4,000 pharmacists that work in hospital already in membership of the PDA, we know that the majority have already made their choice.

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Cover Image: '**Iceberg**' Steering clear of danger

Responsible pharmacist or Pharmacist Prescriber The choice is yours

These are the two most popular subjects that we have been asked by PDA members to consider in some detail at the 2009 PDA conference.

Both of these important developments will fundamentally affect the way in which pharmacy is practiced, both deserve significant time and attention. Undoubtedly, many pharmacists will want to know and understand the risks and benefits.

Rather than deal with just the one subject at the expense of the other our conference programme has some common parts for all delegates and also a split section giving delegates the choice of either subject.

By organizing the conference in this way, it gives us an opportunity to spend a significant period of time on both subjects in some considerable detail and thereby to give delegates a choice of which strand they would like to attend.

Whether or not you are a pharmacist who is likely to be affected by the Responsible Pharmacist provisions, or whether you are currently, or are soon to become a pharmacist prescriber, there will be a lot on offer.

News

Professor Linda Strand

visits PDA to develop new pharmacist roles.

Historically, pharmacists have been reliant on their salaries from predominantly hospital or community pharmacy employers; however, it is a stated objective of the PDA to develop new roles and new funding streams for individual pharmacists who are providing a new range of services.

In the past, it has been the financial investment in the stock, facilities and equipment, as is seen in the current 'bricks and mortar' NHS contractor model and in hospital facilities, which has driven the financial model of remuneration for pharmacy.

> "create new roles and income streams for individual pharmacists"

It is the view of the PDA that with many new roles emerging, an opportunity to re-engineer this model presents itself and that this change could be to the significant benefit of patients and pharmacists. With a move away from the supply of products to one where there is a much greater provision of services, the significant prerequisite will be that of intellectual and professional investment and the risk that will need to be taken by the individual pharmacist.

As such, this 'person-centered' development can give the skills and knowledge that will enable any particular new service to be provided. This approach needs to be fostered and remunerated. Consequently, for the past two years, the PDA has been working to ensure that this particular vision can become a reality. It will be important to be able to demonstrate that it can be beneficial to patients – and also that it can create new roles and income streams for individual pharmacists.

Professor Linda Strand from Minnesota, USA, is internationally held to be a principal author of the pharmaceutical care concept, and for over a year, she has been working with the PDA to seek and explore opportunities for the individual pharmacist-led pharmaceutical care concept in the UK.

In September 2008, Linda Strand visited the PDA in Birmingham to work up the detail of a project which will, hopefully, enable individual pharmacists to operate patient-centred pharmaceutical care clinics.

It is hoped that an initial pilot involving a small number of pharmacists will be launched in 2009. The PDA will be reporting developments to members in due course.

To comment on this feature www.the-pda.org/is/002

Report effectively slates remote supervision

Concerns about the proposal to allow a pharmacy to operate in the absence of a pharmacist have been raised consistently by the PDA, which has always contended that the proposals to let pharmacy staff run a pharmacy, without a pharmacist present, are being pushed through without proper debate or due regard to patient safety.

The DoH, in its thinking about remote supervision, appears to believe that as long as a substantive protocol process is in place and that the pharmacist is contactable, then it will be safe for

SHORTS

BBC REPORTS ON PDA ACTIVITY

The PDA continues to raise awareness about the stress being endured by pharmacists. The PDA's stress audit was highlighted on the BBC website in August in an article entitled "Chemists under too much strain".

The journalist pointed out that there has been a huge increase in the number of prescriptions issued; pharmacists have also had to take on extra work to ease the pressure on GPs. The article states that the PDA is so worried about the issue of workload that it has launched a stress audit of pharmacists.

The full article can be found on
http://news.bbc.co.uk/1/hi/health/7563149.stm

NEW APPOINTMENT AT RPSGB

Since the departure of Mandie Lavin as Director of Fitness to Practise (FtP), the RPSGB has restructured with an eye on the devolvement of the function to the General Pharmaceutical Council. Wendy Harris has been appointed Deputy Registrar and Head of Regulation; and will be recruiting a director of FtP but will be in overall control.

The PDA is looking forward to working with Wendy and hopes that she will be sensitive to the impact that unnecessary and over-zealous regulation and its unacceptable tone has on pharmacists without compromising the public protection agenda.

the pharmacist to supervise while absent from the pharmacy.

The PDA believes that this is a disaster waiting to happen. The DoH's proposals should be seeking ways to make the pharmacist even more accessible to the public; instead they are seeking to take the pharmacist out of the pharmacy. This is neither in the public's nor the profession's interest.

The latest *Which*? report into the advice provided by community pharmacies points to marked differences in quality of advice and service provided by pharmacists compared with that given by some support staff.

Clearly, pharmacists have the benefit of a four year degree education and a further year to achieve professional qualification. Consequently, perhaps unsurprisingly, the report supports the position of the PDA in that it raises concerns regarding the DoH's proposals to allow pharmacists to be absent from the pharmacy.

The PDA believes that however many protocols are put in place, they can never replace the presence of a pharmacist in a pharmacy, nor the pharmacist's substantial knowledge and professional skill. The idea that pharmacy should rely more heavily on protocols and that the pharmacist can be absent is a leap in the wrong direction. **Consequently, the PDA has urged the DoH to go back to the drawing board and redesign its proposals.**

To comment on this feature **www.the-pda.org/is/003**

Work on the locum front

Over the past few months, the PDA Union has been considering how best to support members who are working as self-employed locums. Queries received by the PDA from locum members cover a wide range of issues and although the PDA advisers are available most of the time, the Locum Membership Group of the Union has requested that locums are provided with a reference source to give them a degree of self-sufficiency to deal with some of the common problems if they find themselves isolated.

"We have identified the topics that need to be included in the publication," said Orla Sheils, a PDA Union official and one of the PDA legal advisors, "and we are currently in the process of putting this information into a format which, while not a substitute for specific legal advice, will be a portable reference source that can help members to deal with the more common legal and professional issues they encounter".

The information will include: guidance and suggested approaches to dealing with entering into contracts for services; status as a locum; cancellations of bookings; recovering unpaid locum fees; agency issues; rest break entitlements; health and safety issues in the workplace, among others. In addition, professional advice will include options for dealing with support staff, workload and work environment difficulties. The publication will be available from early 2009.

"Our legal advisors who deal with queries on a daily basis are well aware of the issues affecting locums," said Orla. "We will be working in conjunction with the Union's Locum Membership Group which has hands-on experience of the job, and we are keen to hear from members with any suggestions regarding the information they feel should also be included in the booklet."

Please contact either Orla Sheils or Lindsey Gilpin (Union Executive Locum Membership Group representative) on enquiries@pda-union.org

To comment on this feature **www.the-pda.org/is/004**

PDA TEAM GROWS

Paul Summerfield a pharmacist and also a qualified barrister has joined the PDA team. "We are responding to the growing membership need, by increasing the level of expertise in the team," said John Murphy, PDA director. "Having another pharmacist with legal experience is a powerful addition."

PDA AND C&D JOIN FORCES

The PDA Union and the Chemist & Druggist will establish an annual salary survey for community employee and locum pharmacists. The two organisations have conducted their own surveys in the past, but are now excited at the prospect of combining their expertise to get an unequivocal and consistent picture across the sector. The survey will be conducted in January. The PDA Union will still be conducting its own survey on hospital and primary care pharmacists.

LOCUM CONTRACT FOR SERVICES

Rowlands and Boots has recently issued a new contract for services and the PDA has been contacted by many members seeking its view. Advice on those clauses, which the PDA believes could be detrimental to members if not clarified or changed, has been posted on the PDA website. "Don't sign any contract until you understand the implications," advised Karen Weekes, PDA's employment solicitor. "Contracts can be negotiated; if the other party is not prepared to compromise then you need to decide whether or not you want to enter into it at all."

Stress? I'll give you stress!

Remark that costs employer £64,000 in compensation.

Work-related stress emanates from a multitude of causes and manifests itself in a variety of symptoms. Regrettably, many people who have not suffered illness as a consequence of stress are often sceptical of those who do.

In a recent case, in which the PDA was involved, a junior manager insisted, as was his right, that his company conducted a stress audit because he was unhappy with the workload and the impact it was having on his health; he was also concerned that this could affect patient safety.

Enquiries were made within the business by his line manager who had no experience of these matters; the reaction of a senior manager was inadvertently forwarded to the junior manager which read; "Stress! I'll give him stress!". This typical, macho remark was an expensive mistake; **a settlement of £64,000 was negotiated by the PDA rather than the employer facing the ignominy of going to an employment tribunal for constructive dismissal**.

Employers have a duty of care towards their employees and can be held accountable under health and safety legislation if stress-related illnesses can link causation with working conditions that an employer can control.

What does the law say?

The Health and Safety at Work Act 1974 states that 'every employer should ensure, so far as is reasonably practicable, the health, safety and welfare at work of all their employees'.

The Management of Health and Safety at Work Regulations 1992 includes stress as a work hazard and requires employers to adopt modern risk management techniques such as:

- Identifying any hazards.
- Reviewing risk assessments at regular intervals particularly after adverse events.
- Providing health surveillance where a risk assessment shows that the health of employees can be affected by poor work conditions.
- Applying risk management principles eg. combating risks at source, introducing improved working methods and technologies, and incorporating risk prevention strategies as part of a coherent policy.

What is stress?

We all need pressure to motivate us or to give us an edge, however, what may be one person's excitement may be another's stress. In addition, different employees have different thresholds (One day may not be the same as the next for instance), different pre-dispositions to mental ill-health and different coping strategies.

A definition that most people understand, therefore, is that **stress is unwanted or unrealistic pressure** and can be different for different people. This makes measuring stress difficult.

Why do we need to tackle stress?

The Health and Safety Executive (HSE) has researched the impact of work-related stress for many years and has concentrated on the effects it has on the individual worker's health and, as a consequence, the staggering loss to businesses because of absenteeism.

David Palferman, a psychologist with HSE, speaking at the BPC, PDA session in September, indicated that there were estimated to be 13.8 million days lost to stress-related illness in the UK in 2006 - a significant cost to British industry. "But what is even worse," he said, "is that we don't know how many hours of productive work are lost in '*presenteeism*' which is new jargon referring to people who are at work with work-related stress symptoms and are not functioning properly as a result".

The PDA is in the process of conducting a survey among its members using the HSE model and has incorporated additional questions so as to assess the impact pharmacists' perceived stress levels have on patient safety.

"I was impressed with the HSE model," said John Murphy, General Secretary of the PDA Union, "they take out any variables that are immeasurable, such as predisposition to mental health and domestic and personal stress inducers; they have concentrated on measuring management and organisational behaviour against national standards; however, it is important, because of the role we play in the health sector, that we introduce the dimension of patient safety, something which has not been well researched".

Figure 1.

HSE standards when measuring in pharmacy		Score
Demands	Work overload, rest breaks, intensity, environment	
Control	Work design, involvement in decision making	
Managers' support	Support and backing, listening without blame	
Peer support	Support and backing in difficult working conditions	
Relationships	Respect, bullying, harrassment	
Role	Clarification, conflict, ambiguity	
Change	Lack of staff involvement, poor communication	

Red = below the 20 percentile of the national standards; urgent action required
Amber = above the 20 but below the 50 percentile; clear need for improvement

The PDA stress audit

Nearly 2,000 pharmacists have already replied to the PDA stress audit and were asked to rate the stress of their job on a grading system. Early indicators are shown in Figure 1.

In analysing and comparing the HSE management standards, results showed that no group of pharmacist employee or locum respondents thought that the standard of management and organisational behaviour was above the national norms. It would appear that collectively, employers within the community pharmacy multiples sector came out worse than other sectors.

To gain pharmacists perceptions of the level of stress in their job, they were invited to classify it in one of six categories:

LEVEL

5 Extremely stressful to the point at which I feel I cannot cope and want to give up.

4 Extremely stressful to the extent that I am losing sleep and/or making myself ill.

3 Stressful enough to leave me frequently worrying about whether my patients are safe.

2 Stressful enough to leave me occasionally worrying about whether my patients are safe.

1 Very occasionally stressful but not sufficiently frequent to unduly concern me.

0 No stress at all.

Over 54% of members rated the stress of their job in the top three and a third (32%) in the top two most stressful categories (Figure 2). Less than 1% said that they experienced no stress at all. It is accepted that level 1 is a 'good place to be' for good performance.

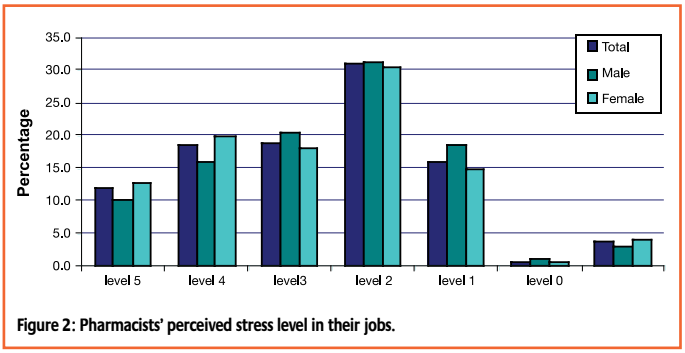


Figure 2: Pharmacists' perceived stress level in their jobs.

Some of the most disconcerting statistics that came out of the audit include:

81.6% of all pharmacists say that they have to work intensely either always or often, and 69% of pharmacists say that they have to work "very fast" always or often. Both these results are perceived as highly stress-inducing.

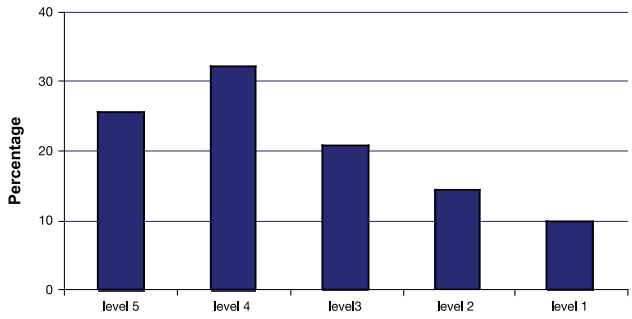


Figure 3: Time off for diagnosed work-related stress in past five years (grouping by individuals' perceived stress level).

It is significant that 40% of pharmacists who perceive that their stress levels are in level 5 (and 34% in level 4) said that they had been subjected to 'bullying' and only 53% of all pharmacists say they get the respect that they feel they deserve from other colleagues. This is a trend that PDA can attest to anecdotally based on the type of cases it handles.

In correlating the effects that stress have on absenteeism, results showed that a third of pharmacists (32%) who perceived their stress levels to be at level 4 have had time off for diagnosed symptoms of work-related stress in the past five years.

This may be the tip of the iceberg because over the past 12 months, 60% of the same group had taken time off for any (not necessarily work-related stress) illness.

Despite the advice given to pharmacists to the contrary, the vast majority still believe that they are under pressure not to take rest breaks (Figure 4) and yet over two-thirds still recognise that they could have put their patients at risk at some time as a result of not doing so.

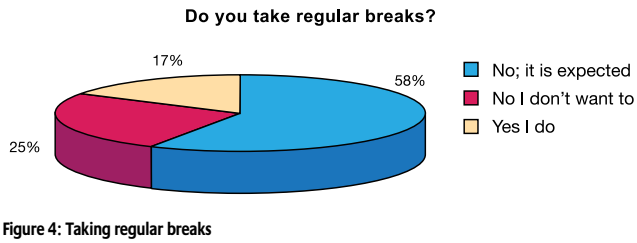


Figure 4: Taking regular breaks

What next?

The PDA intends to be proactive to the results of this audit and will encourage employers to work with it to undertake a stress audit using the HSE management standards model as part of their duty of care towards employees.

Our agenda is to address work related stress head on and we will lobby for new research to be funded to assess:

- The affect on pharmacists' health and the commercial impact on organisations as a consequence of unreasonable demands placed on pharmacists.
- The impact of ineffective management behaviour on pharmacists' well-being to produce management development models.
- Working environment influences on stress.
- The impact of work-related stress suffered by pharmacists on patient safety.

The PDA calls upon employer's to help address this malaise; the anecdotal evidence was already compelling that stress is a major issue and this audit gives it even more authority. We say to employeer's that we would rather tackle this with you but if that's not possible we will tackle it without you!

We urge as many pharmacists as possible to participate in the survey which will continue to be active until 31 December 2008, at which time we will produce a full analysis. Visit www.the-pda.org for more details.

To comment on this feature www.the-pda.org/is/005

THE PDA union
strength in numbers

The PDA Union was registered with the Trade Union Certification Officer on 13th May 2008. This feature outlines union business that has taken place since then.

In the six months that the PDA Union has been legally recognised, the Executive Committee has met three times. The Locum and Community Employee membership groups have held inaugural meetings, and the Hospital and Primary Care groups will have met by the time this magazine is distributed. In the meantime, the Executive has been busy organising the structure and future policy while the day-to-day support for members has continued as before.

Individual representation

To date, there have been more than 20 cases in which a union officer or official has accompanied a pharmacist involved in a disciplinary or grievance hearing. It is evident from the outcomes that we are having a significant impact, though we are most troubled by the lack of training that middle managers receive to conduct these processes. In a recent employment tribunal hearing, the tribunal criticised a large employer organisation for the quality of their investigations and the lack of training in such matters.

Group representation

The PDA Union has not only acted for individuals but also on behalf of groups of pharmacists, as the following shows:

- We became aware of a proposal by a company, owning a number of 100-hour pharmacies, to withdraw security guards at night. The Union highlighted Health and Safety concerns and the company agreed to drop the proposals pending further discussion.
- In another case, we represented 10 (medicines management) pharmacists employed by a PCT. Their grievance was that the team had been undermined and under-resourced, as part of a management plan to separate the commissioning and provision of services, making ready for outsourcing without any proper consultations. As a consequence, the management has been forced to review their options.
- We have also been invited to meet the Lloydspharmacy employment relations manager to discuss relevant issues.

Governance activity

The Executive has spent time on key organisational matters in the formative months; it has now achieved all the immediate targets to ensure the Union has satisfied its legal requirements, and the challenge now is to put a structure in place to better support our members in the future and to continue to develop communication channels with our members.

Locum Group Committee meeting

Locums are acutely aware of problems that exist in communications between primary care organisations and their members. Letters and notices are sent to contractors and employees; locums are often left out of the loop and frequently have no information about whom to contact in the PCOs regarding any key issues. Locum members' difficulties in practising across PCO boundaries are exacerbated by the need to be accredited for additional services with each PCO. The locum group calls for a national accreditation scheme and better communications to our members.

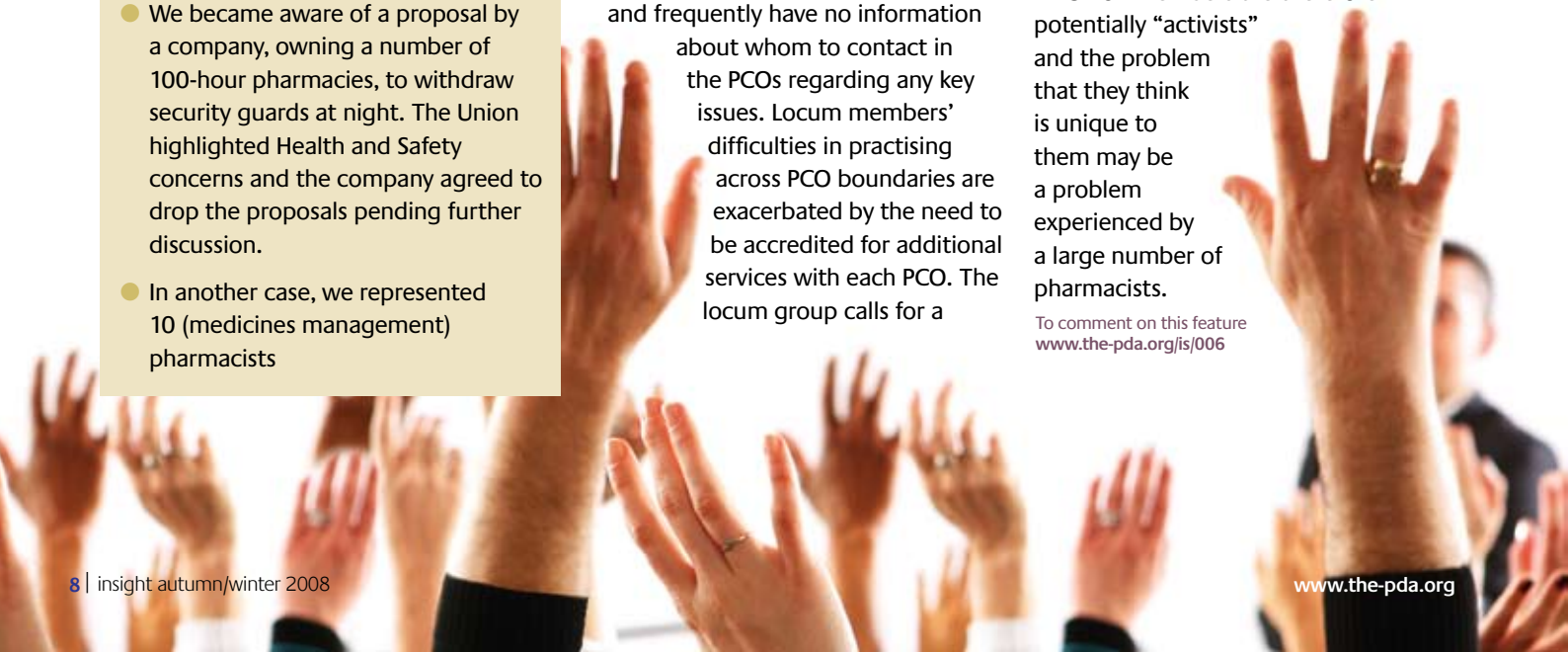
In addressing the issue of suppressed locum fees, the membership group is aware that publication of a suggested scale of fees is legally not allowed under competition rules; however, it will be possible to produce a guide based on workload and additional services similar to that produced by the BMA for locum doctors. The Union has recently sent all members a response to the new Lloyds, Boots and Rowland's contracts for locums, showing the average fees secured by locums in certain geographical regions.

The Community Employee Committee

The stresses placed on employee pharmacists to meet medicine use review targets, often with no additional resources, and the problems brought by the increasing trend of non-pharmacist manager appointments, were two key issues addressed by the community employee membership group. Investigating occupational stress is a key cornerstone of Union strategy.

Although it is the membership groups' responsibility to canvass opinion, we want to encourage members to raise issues for consideration proactively. All Union members are therefore potentially "activists" and the problem that they think is unique to them may be a problem experienced by a large number of pharmacists.

To comment on this feature
www.the-pda.org/is/006



Governance of the PDA Union

The Union is governed by an executive of eleven people. Six are directly elected and five are nominated by the relevant membership group. The membership group representative although a conduit between the executive and their section of the union membership, has the duty to act, at executive level, in the best interests of the membership as a whole.

The PDA Union Executive

Directly elected executive officers

General Secretary	John Murphy
Assistant General Secretary (strategy)	Mark Koziol
Assistant General Secretary (administration)	Mark Pitt
Assistant General Secretary (membership)	Elizabeth Doran
Treasurer	Bharat Nathwani
Communications Officer	Eddie Newell

Membership Group Representatives

Locum	Lindsey Gilpin
Community Employee	Richard Flynn
Hospital	John Farwell
Primary Care	Duncan Jenkins
Pre-registration	vacancy

The rules state that there should be four meetings per year of Executive Committee and it is recommended that there should be one Membership Group meeting prior to every executive, though the rules allow for a minimum of three per annum.

Membership group

In addition to the Executive representative, the membership groups consist of the following all of whom were returned in the January elections and June by-elections.

Locum Group

Randeep Tak,	Oluwaseyi Fasogbon
Bob Gartside	Catherine Armstrong
Susan Howshall	Richard Harris
Martyn Lewis	Andrew Jukes
Graeme Stafford	Keith Davies
David Tyas	

Community Employee

Eddie Newell	Tony Sutton
Dennis Meyers	Ravinder Sandhu
Jahn dad Khan	

Hospital

Rebecca Ellis	Joanne Harding

Primary care

Stephen Innes	Katherine Hingston

PDA Union Officials (appointed posts)

Michael Radcliffe (Executive consultant)	Karen Weekes (legal advisor)
Orla Sheils (legal advisor)	Shenaz Patel

Way forward

A great deal has been achieved in 12 months. This time last year it was just being announced that the PDA was to form a union and committee nominations were being requested. Since then, elections have been held, the union formed, listing has been achieved, 13,000 members have enlisted and the work of representing those members has started in earnest. The Executive will now consolidate the achievements of the past year and formulate a strategy for the future. It is clear that the issues affecting pharmacists that led to the formation of the Union are still a concern and we forecast that the next 12 months will continue to be a busy time.

As the largest voluntary group of pharmacists in the profession, we enjoy a unique position. Let us put that influence to good use; the more you can encourage your colleagues to join and the more involved you can be, the stronger we will become.

Announcing PDA PLUS

NEW - a range of PDA member benefits

The PDA prides itself on listening to its members through focus groups and surveys. Following on from one strand of discussions, some considerable time has been spent researching the possibility of launching a range of new and additional benefits to PDA members.

This initiative recognises that beyond their work as pharmacists, PDA members do actually have a life!

PDA members have needs that go beyond those simply dictated by their occupations. They go on holiday, buy wine, use hotels and dine out.

Consequently, the PDA is now proud to announce a new service (to PDA members) which we have called PDA PLUS.

PDA PLUS provides access for members to a range of specially negotiated preferential services that are designed to save them money. These benefits are also available to immediate members of the family.

Price Promise

To give PDA members peace of mind, where possible these special offers come with an exceptional discount guarantee. This means that if you can find these services from these providers on a like-for-like basis at better prices anywhere else in the UK, then PDA Plus will not only honour that lower price, but will also compensate you for your trouble by giving you monetary vouchers*.

The full range of benefits currently being made available can be found on **www.the-pda.org/pdaplus**

We reckon that it will take only a few short months of regular use of the new PDA Plus Benefits service on routine purchases, for members to save themselves enough to fund their entire annual PDA membership subscription - eg. six meals at the 2 for 1 offer or one Virgin holiday for the family with 7.5% discount.

In addition to that, in some instances, the provider will pay an introductory fee to the PDA, which because it is a not-for-profit organisation, will mean that any income so generated will help to fund more services for members.

The Win Win Scenario

We believe that this creates a classic WIN – WIN scenario: PDA members and their families save hard-earned income by gaining access to quality services at guaranteed discounted rates. The PDA generates additional funds which it can use to keep PDA membership subscriptions down while still being able to invest more in developing more services for members.

Subject to a successful launch and positive member experience, more PDA PLUS benefits will be launched in 2009.

Why not take a look, it could mean big savings for you and your family!

*Terms and conditions apply. Correct at time of print.

To comment on this feature **www.the-pda.org/is/007**

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- **Family days out at Tussauds Group venues** (15% – 20% off)
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The responsible pharmacist

steering clear of danger?

There is little doubt that the Department of Health is driving hard to establish what it calls 'remote supervision' and, through new legislation (Health Act 2006), to create a situation in which a pharmacist will no longer be needed to be present in a pharmacy. The PDA opposes this plan and has been very persuasive in bringing the dangers of this proposal to the attention of relevant decision makers, including those in Parliament.

This opposition will be growing into a more concerted campaign when the time is right; however, at this time, remote supervision has been put on the backburner (temporarily) and instead, the DoH has decided to implement what could be considered an important pre-requisite to its remote supervision plan, which is to introduce the concept of the 'responsible pharmacist' (RP).

As described in the Chairman's letter (page 2), although the PDA has always been against remote supervision, we initially gave some of the proposals to be found in the RP consultation a cautious welcome. We felt that if pharmacists were indeed to be made operationally responsible for the pharmacy, then this could help to bring about the end of understaffing and excessive workloads. This could mean that the additional responsibilities would be worth it.

However, in September 2008, the DoH revealed its final plan and announced its intention to proceed. The PDA now believes that the proposals as currently written provide no such advantage; instead, they represent a tremendous risk for patients and pharmacists alike. Subsequently, we have (albeit belatedly) been invited to participate in a formal group established by the RPSGB which involves the DoH, to draft the regulations on how this will work in practice. It is intended that these regulations will 'go live' and therefore govern pharmacists from 2009.

Legal counsel has been sought by the PDA and this feature describes what we believe to be the issues of concern for any pharmacists who could be asked to sign up to become a responsible pharmacist.

The issue of increased responsibility

Currently, under Medicines Act 1968 requirements, the law states that for a pharmacy to operate, the company needs to have a superintendent pharmacist who is in charge of managing the business and, additionally, that each pharmacy in that business has to have a pharmacist in 'personal control'. This 'personal control' pharmacist has to be able to supervise the sale and supply of medicines to the public.

> "It is patently obvious that this new regime is much more onerous on pharmacists than under the current arrangements."

Clearly, this indicates that primarily it is the superintendent who controls the broader operations of that pharmacy.

The changes brought about by the Health Act 2006 now mean that the pharmacist in the pharmacy becomes the 'responsible pharmacist' and, upon arrival at the pharmacy, has a much longer list of statutory responsibilities to worry about.

Here are just a few examples from the list:

- Supervising the sale and supply of medicines to the public (as before).
- Ensuring the safe and effective running of the pharmacy as far as it relates to medicines (to include GSLs).
- Checking that a pharmacy procedure is in place.

- Approving the pharmacy procedure (i.e. that it is safe and appropriate).
- Completing the record and indicating that he/she is the responsible pharmacist, and outlining exactly when the responsibility started and when it ceased.
- Recording the exact times of any absences of the RP during the course of the working day.

It is patently obvious that this new regime is much more onerous on pharmacists than under the current arrangements.

Failure to observe these requirements would render the RP subject to a charge of misconduct; additionally, certain aspects (such as the record keeping) can result in a criminal prosecution.

It is therefore of concern to the PDA that it is being suggested by some that the new RP provisions are merely a 'tidying up' of the old personal control regulations and that the responsible pharmacists' responsibilities are merely personal control under a different name – so it is business as usual! **Any attempt to create such an impression is unhelpful at best.**

Any one of these added requirements places more responsibility on the shoulders of the RP; however, the one which produces a shift in responsibility of greatest proportions is the requirement for the RP to ensure the safe and effective running of the pharmacy as far as it relates to medicines. It is the RP who is now charged with the task of ensuring not only that the supply of medicines is supervised (as currently) but that the entire running of the pharmacy in relation to medicines is safe and effective. Based on the opinion of legal counsel, this means that the policies relating to such areas as sourcing, dispensing, sales and display of medicines (including GSLs), supplying medicines such as to residential homes or through methadone clinics, and provision of services involving medicines, now fall under the statutory responsibility of the RP. This should mean that ensuring safe staffing level and workloads will now also be the responsibility of the RP.

The hazards ahead

No doubt there will be some (even many) pharmacists who will be concerned about these additional responsibilities and others who will welcome these changes and eagerly await the opportunities which are now on the horizon. However, there are some further matters which appear in the DoH proposals which are of concern and will need to be resolved before these regulations can 'go live'. It is the intention of the PDA to ensure that these are given due consideration during the RPSGB 'regulation committee' phase. The proposals about which we are most concerned include:

1. The RP will be subject to the directions of the superintendent pharmacist

The regulations make the RP responsible, but suggest that the superintendent will still have power over the RP. How can this be?

Clarity is needed here.

We believe that there should be no problem with the superintendent (owner) being in control of the strategic direction of the business, e.g. by deciding how many pharmacies there should be and where they should operate.

Operational decisions relating to the running of the pharmacy should be decided by the RP, or at least, should be formally agreed by the RP.

2. The requirement for written procedures to be kept at the pharmacy

The DoH has not provided any guidance on what they expect should be covered in the written procedures. The PDA will be pressing to ensure that the procedures describe what should be the normal staffing template for the pharmacy, to include the qualifications of the staff that should be present.

> "RP should ensure that the entire running of the pharmacy in relation to medicines is safe and effective"

We will also be pressing to ensure that the procedure document is one that can be readily digested by an incoming pharmacist locum.

3. The records that are kept at the pharmacy

The DoH says that it is committed to avoiding unnecessary regulatory requirements that impose disproportionate burdens on businesses, and consequently, have said that they will leave the decision on what is kept in the pharmacy record up to the owner or superintendent. Surely, this standpoint is pregnant with potential problems.

We believe that as a minimum, details of the personnel present in the pharmacy on any day must be recorded. We have dealt with numerous incidents where a pharmacist is being held solely responsible for an incident for no other reason than the

fact that no records exist showing who else was there on the day in question. Worse still, we have even supported PDA members in error situation cases where employers have actively refused to provide us with the details of their staff complement.

> **"This could help to bring about the end of understaffing and excessive workloads"**

The idea that a regulatory burden should be removed from the shoulders of the business owner and simply placed on to the shoulders of the RP is not acceptable.

4. Sign on and sign off

The PDA wants to ensure that as well as signing on in the morning and signing off in the evening when going home, RPs must be able to sign off during the course of the day. This facility could be used by RPs in the event that they feel that they are no longer prepared to carry the responsibility and that this would be more appropriately passed over to someone else who was better placed to handle any dangerous environmental issues (eg. an owner, area manager or principal pharmacist). Such a short-term measure can more appropriately lead to safety changes being effected. The responsibility could then be handed back to the original pharmacist by mutual agreement once any deficiencies had been resolved. This facility would be particularly useful to locums.

5. RP absence permitted for up to two hours

The proposals suggest that a pharmacist may be absent from the pharmacy for up to two hours, as long as they are contactable and can return promptly. In such a situation, there may be no sales of P medicines nor dispensing; however, other parts of the business may still operate. The confusion arises because it has been suggested that such an absence can also provide for the much needed rest break for pharmacists. However, on legal grounds, this is not applicable since the legal definition (as recently established in the Court of Appeal) means that if an employee is 'on call' then this does not constitute a rest break.

Clarification of what happens in the event that a pharmacist takes a rest break is required.

Further matters to be considered

There are a number of other detailed matters that space does not permit to be covered in this article but which the PDA will be arguing for through its membership of the RPSGB regulation committee.

> **"We have been invited to participate in a formal group established by the RPSGB to draft the regulations"**

In particular, the PDA will do all it can to ensure that the interests of PDA members, and also the patients that they serve, are not overlooked.

The RPSGB should have produced its guidance in the New Year and as a consequence, the PDA will seek to provide members with a detailed analysis of what this will all mean at the PDA annual conference in Birmingham on 1 March 2009.

To comment on this feature www.the-pda.org/is/008

Excerpts from legal counsel's opinion

The DoH plans to launch the new programme in 2009. What legal counsel says:

1 *"The experience of other professions demonstrates that when substantial procedural requirements are introduced it takes time and training for professionals to become accustomed to these changes."*

The view of the PDA is that this entire idea will take several years to properly bed in and also for it to be introduced appropriately at undergraduate level.

2 *"There can be no suggestion that the physical presence in the pharmacy previously held to be 'personal control' is sufficient to discharge the obligations of a responsible pharmacist."*

3 *"Where there is significant confusion in the new provisions is where ultimate responsibility lies and therefore power should lie. It is difficult to see how someone is 'in charge' but 'subject to the directions' of others in the context of the operation of a pharmacy."*

4 *"What is to happen if a [business] agrees to take on the provision of services to a care home and the superintendent directs the responsible pharmacist to undertake the dispensing, but the responsible pharmacist is of the view that the workload imposed is too great to allow the pharmacy to be run safely and effectively? These matters must be set out with some clarity in the regulations."*

5 *"The written procedures ought to make express provision for the adequacy of staff numbers and ability of those staff members."*

6 *"There ought to be a log kept of who is there to serve customers at any particular time. This will provide the responsible pharmacist with the ability to demonstrate, in the event of a complaint, that there was adequate staff present at any particular time."*

Is an **individual pharmacist contract** on the cards?

The BPC session on "*The White Paper: Pharmacy in England: Building on strengths – delivering the future*, and its implication for pharmacists" gave a clear overview of the Department of Health's intentions for pharmacy in England.

During the question and answer session, Mark Koziol, PDA chairman, told delegates that he was more excited about the opportunities provided within this White Paper than anything that he had seen the DoH propose before. However, he argued that the current problems identified with the provision of MUR's for example indicated that the way that the new cognitive services were being currently delivered and remunerated needed to be re-examined.

In particular, issues surrounding health and safety at work, staffing levels and a strategic review of remuneration were important, given that pharmacists are at the centre of service provision and yet they were not really recognised in any remuneration models. Mr Koziol then threw down the gauntlet and challenged the panel (all representatives from the Department of Health) to consider introducing the concept of an individual pharmacist NHS contract, which would be specifically designed for the provision of specialist services.

> "pharmacists are at the centre of service provision and yet they are not recognised in remuneration structures"

This 'new style' contract would not seek to replace the existing 'bricks and mortar' contract which is held by owners of pharmacies, but would be as an adjunct to it.

In reply, Keith Ridge, Chief Pharmacist, England, said that the idea needed to be thought through, as well as a timescale for implementation. Jeanette Howe, agreed that it was an idea worthy of thought and suggested that some form of franchise arrangement may even be one way forward.

To comment on this feature www.the-pda.org/is/009

What's the **Society** ever done for me?


RPSGB Lambeth Headquarters

By government decree, in 2010, the current arrangement in which the RPSGB is both the regulator of pharmacists and their professional leadership body will come to an end. Regulation will then be operated by a new body - the General Pharmaceutical Council to which membership for practising pharmacists will be a legal requirement.

The professional leadership function will be undertaken by a new leadership body. Its membership will be voluntary.

The process of creating the new professional leadership body is being managed by a Transitional Committee (Transcom), which is headed by an independent chairman - Nigel Clarke. This work is being 'supervised' by the current council of the RPSGB.

Since all this has been announced, the PDA has been resolute in its view that this new professional leadership body, although voluntary, is entirely necessary. It is our view that the new body should not only provide the tools to enable pharmacists to do their jobs, such as supporting CPD and other forms of practice support, but that it should also champion the cause of pharmacy to the outside world. Equally, it must also nurture leading-edge developments and bring them into mainstream pharmacy practice.

Consequently, the PDA has been working hard to support this process, and has also been active in trying to ensure that the new leadership body is a body for pharmacists and not one that is controlled by the large organisations with many employees.

It is important for the PDA to continue to influence the direction of travel. In particular, after a PDA membership survey where members told the association that they wished this body to be a pharmacist body, the PDA has been involved in some active lobbying. PDA officers have argued that pharmacy technicians should have their own body (such as their existing body, APTUK) and that they should not become members of the new professional leadership body for pharmacists.

A survey undertaken subsequently by the *Pharmaceutical Journal*, corroborated the position of the PDA. Consequently, Transcom has now decided that pharmacy technicians will not become members of the new body but should seek their own organisation; we are pleased with this result.

We continue to be involved in the Transcom process; indeed the PDA is one of the organisations that formally sits on a broader reference group that Transcom refers to for specific feedback.

Members wishing to understand the more detailed reasons behind the PDA's support of this process are invited to listen to a podcast which can be found on **www.transitionalcommittee.com** and which features the PDA Chairman, Mark Koziol, along with Catherine Duggan (UKCPA) and Graham Phillips (IPF).

To comment on this feature **www.the-pda.org/is/010**

Refunds on NPA insurance premiums

Most members will be aware that the PDA believes that the National Pharmacy Association (NPA) should not be involved in the provision of individual professional indemnity insurance to pharmacists. The reason for this is because of the conflict of interest that it may face when attempting to decide how a matter should be handled in a conflict situation involving both the NPA member (pharmacist employer) and the employee or locum.

It would appear, from explanations that we are being given from new PDA members that pharmacists too are coming to realise that taking out a PI insurance scheme with the NPA may not be in their best interests. In recent months numerous pharmacists have contacted the PDA to suggest that they were now moving their indemnity arrangements from the NPA to the PDA. However, some of these pharmacists have told us that when they contacted the NPA to ask for a refund on the balance of their cancelled policy, it was explained to them that the NPA does not give refunds.

We have discovered that some of these pharmacists have decided to join the PDA immediately and simply let the NPA policy come to its natural expiry.

We do not know whether this is a formal NPA decision, or whether it is simply an individual NPA staff member decision. We believe that that as a matter of good practice refunds should always be available to policy holders although we do accept that the NPA should be allowed to make an administrative charge for providing such a facility.

Consequently, we have written to the NPA for clarification.

We ask any pharmacist who is experiencing difficulties in this respect to contact the PDA for assistance.

To comment on this feature **www.the-pda.org/is/011**

Treating mentally-ill pharmacists like criminals

- is this really in the public interest?

Until April 2007, if you became so mentally or physically ill that it impaired your ability to work, the RPSGB could do nothing about it other than request (and pressurise) you to resign from the Register or to transfer to the non-practicing part (2) of the Register of Pharmacists. The only way that the Society could get you off the Register against your wishes, was to wait until you did something that could be classified as misconduct, and then bring you before the Statutory Committee under section 8 of the Pharmacy Act 1954. This meant that there were often occasions when practitioners who were 'unfit' were on the Register and practising, to the danger of the public and the detriment of the profession.

In April 2007, the Pharmacy Act 1954 was repealed and replaced with the Pharmacists and Pharmacy Technicians Order 2007, commonly known as the Section 60 Order. This major change in legislation occurred almost silently with most pharmacists totally unaware. In this legislation, the RPSGB ensured that it obtained far reaching powers to change its ability to control registration, once and for all.

Pharmacists can now remain unaware until the day, perhaps, when the postman delivered a file of papers, comprising 250–500 pages, containing allegations and 'charges', set-out like a Crown Court criminal indictment, seeking an 'interim order' for immediate suspension from the Register or conditional registration until a full hearing can be convened.

Interim orders can be applied for against not just those whose health is impaired, but also against any pharmacist whose fitness to practice is thought to be seriously enough impaired to warrant one (e.g. someone who is being investigated for multiple dispensing errors and where the Investigating Committee thinks they could be a danger if left practising while the investigation proceeds).

All phamacists who have received such applications have been horrified by the aggressive way in which the Society behaves in seeking these orders; pharmacists who are mentally ill find it particularly difficult to cope.

Whereas pharmacists are often given as little as two weeks, and rarely more than three weeks, in which to digest the allegations, find a lawyer specialising in healthcare regulation and (usually) also to find a medical expert in the relevant field, the Society when launching its application for an interim order has almost always worked and investigated the case unbeknown to the pharmacist for months (or even years in some cases). In health cases, it usually demands that members agree to make available from their GP all their medical notes since birth and that they also attend a medical examination by the Society's own appointed expert. If members refuse access to medical records then the Society can gain a court order under the new regulations. Additionally, it can threaten the pharmacist with a Code of Ethics breach for failure to co-operate with an investigation.

The Society is therefore very well informed and prepared for the application; its lawyers are well-briefed, in advance of the hearing. Against this of course, members (now more fashionably called 'Registrants') usually had no idea what was coming and have no idea what to do; much worse, those who are mentally ill usually have little or no insight into their condition and no capacity to take on the Society's legal machine.

> "members usually had no idea what was coming and have no idea what to do"

Any members who seek to defeat one of these applications acting on their own would do well to understand that this is an area for specialist advice by those qualified in law and well-versed in healthcare regulation. A visit to their friendly high street solicitor could eventually lead them to appropriately knowledgeable counsel, but generally, one of the very few firms in the country specialising in pharmacy law and regulation will need to be instructed. The cost is not cheap; typical costs are in the order of £5,000+ and that is before any medical specialist is instructed; these experts typically add another £3,000-£5,000 to the costs, according to how

complicated the case is and whether or not they are called to attend the hearing.

Members of the PDA will be relieved to know that the PDA has a great deal of experience, more than most, of dealing with applications for interim suspension orders and of advising members how best to approach their defence and to what they should or should not agree.

Members should not, however, think that a defence will be easy; to date, the PDA has only successfully opposed three such applications for interim orders. One was

> "Most Registrants say it is just like a scene from a Crown Court trial in 'The Bill'"

brought against a pharmacist who was alleged to have made multiple dispensing errors. While this fact was actually admitted, the PDA's legal representative successfully argued that matters from four years previously did not necessarily put the public in immediate danger in the present, and the Disciplinary Committee did not make the order. His Honour Judge Mota Singh said: "It [the interim order] has to be necessary to stop it [conduct that is ongoing and that places the public at risk]". He said that because the misconduct had happened in the past and there was no evidence that fitness to practise was currently impaired, there was nothing to stop, because the Society had failed to establish that there was any ongoing problem.

How it works

Interim orders and full case hearings are all held in a similar way except that health cases are held in private and Discipline Committee cases are usually held in public.

The proceedings open with the Society's lawyer presenting the case for the Society; most Registrants say it is just like a scene from a Crown Court trial in 'The Bill'; they feel just like criminals on trial, not health professionals who may have made a mistake (discipline cases) or have had the misfortune to be taken ill (health cases). The 'charge sheet' contains a list of allegations, which always finishes by saying that "by reason of the above facts, taken either individually or cumulatively, your fitness to practice may be impaired."

In health cases where applications are made for interim orders, the Society rarely calls witnesses; applications are usually decided on the written evidence of ill-health provided by the Society's experts. Unless Registrants can counter this with a report from similarly qualified experts, they face the near certainty that an interim order will be made, because all that is necessary is for the Society to establish that the person's fitness to practice could be impaired and that there could be a risk to the public. If it is a choice (as it often is) between depriving people of their living and placing them in dire financial straits overnight, and potentially leaving them practising and putting the public at risk, the Committees always come down against Registrants. Recently, a Committee Chairman observed that the person affected could always apply in six months (review time) to have the order reconsidered, to which the PDA responded that in that time they would have lost about £25,000 and possibly their home too.

Even in cases where Registrants supply reports from psychiatrists and other appropriately qualified medics, the Society's experts always seem to get the last word; recently, it has been suggested by the Society that any physicians treating the pharmacists (who, the PDA believes, have the most intimate knowledge and are best placed to assess risk), could "lack objectivity" by reason of their position as consultants in charge of treatment. It has also recently been suggested by the Society that members' consultants possibly do not have the necessary understanding of the health regulatory system.

In any health proceedings, when there are findings against Registrants that their fitness to practice is impaired, the Committee then proceeds to determine what 'sanctions' to impose. Frequently, mentally-ill pharmacists are also condemned in determinations for failing to have insight into their illness; the PDA believes that this shows how little understanding some of these Committees must have, because a lack of insight is the very essence of a psychotic illness.

The Committees lack 'bedside manner' in imposing their sanctions. It can be understandable that in a disciplinary case, where deliberate wrongdoing is proved, the use of the word 'sanctions'

> "There is some better news on the horizion"

is appropriate; in health cases, however, Registrants are made to feel they are being punished for illness that is not usually of their making. It would be open to a Committee to say it is "very sorry that it has found that the person's fitness to practice is impaired and that it is 'sadly' its duty to impose registration conditions or suspend registration in order to protect the public. Unfortunately, the Committees choose not to show such sympathy; they just read out the sanction imposed, as if they are sentencing a villain who has been convicted of armed robbery. Respondents in health cases frequently leave hearings in a state of serious shock and distress, and their physicians repeatedly complain of the serious and damaging effect the proceedings have on their already fragile state of mind.

What comes next?

Despite all this, there is some better news on the horizon. With the creation of the new regulatory body for pharmacists in 2010, there will be an opportunity (through the public consultation process) to influence the content of the new Section 60 Order which will be required as a result. **PDA members can be assured that we will be doing our utmost to try and persuade the government lawyers to ensure that the new regulations whilst protecting the public, do not create additional and unnecessary misery to pharmacists who may have made a mistake or who may through no fault of their own have fallen ill.**

To comment on this feature **www.the-pda.org/is/012**

Pharmacist as Scapegoat

Approximately 60% of the defence work done by the PDA involves dealing with disputes between employers and employees and every day we receive calls from members who have been asked to attend investigation and disciplinary meetings. Recently, this trend has worsened significantly. Whilst in some cases employers have acted properly, on the whole our experience is that the action they take is inappropriate or is disproportionate. In many cases the pharmacist in question becomes a scapegoat.

Employer's Role/Duty

The most common allegation made against a pharmacist is that he/she has bullied subordinate staff. Employers must treat such complaints seriously by investigating the complaint and deciding whether or not it has any merit. If the complaint is upheld, the employer needs to take action to show that improper behaviour is not condoned and the disciplinary action taken is appropriate.

Our Concerns

Lack of fairness - guilty from the outset.

In nearly all the cases we deal with, the individual is considered "guilty" from the outset. Our members are made aware that allegations have been made however there is a real reluctance by employers to provide specific details. In many cases pharmacists arrive for these meetings to face irrelevant and non focused questions and often are not even told what is being alleged against them.

We have received reports from members that some individuals conducting these meetings have been aggressive, raising voices, pointing fingers at interviewees and rather than taking an independent view of things, seem to have already made up their minds.

Lack of clarity

If statements or details are provided they can still be very vague; for example that the pharmacist has been "rude". However, they do not state how the pharmacist's behaviour could be considered rude by referring to what was said or done. This is of great concern as without specific detail, how can an employer expect you to put forward your defence?

Lack of experience

In many cases, the interviewer has had no previous experience of dealing with meetings of this nature or has experience and training but is still unaware of what their role is in the process. In one recent case an employer, when challenged by PDA admitted that it did not provide training to its senior staff on how they should handle disciplinary meetings.

Lack of process

Many incidents show a complete lack of procedure when employers arrange and conduct these meetings. These have to be in line with the Statutory minimum procedures and indeed employer policy. These include employers failing to issue a written invite to pharmacists required to attend disciplinary meetings; failing to give sufficient time to prepare for the meeting e.g. just 24 hours notice; failing to inform them that they have a right to be accompanied by a fellow colleague or trade union representative and failing to write explaining what the final outcome has been.

Grievance Meetings

For those pharmacists who have raised a grievance in respect of the behaviour of their colleagues or their line manager, similar problems exists. Despite providing sufficient detail concerning their grievance, some interviewers fail to appreciate the seriousness of their complaint. Furthermore, the quality of the investigations that are carried out can be extremely poor. Statements are rarely taken from relevant witnesses and when those identified as being a problem are interviewed the minutes tend to reveal that the interviewer accepts what they have said at face value with no further questions.

Lack of transparency

Perhaps even worse than this, based on actually attending these meetings to support our members, is the attitude of some of those who conduct grievance meetings. Some interviewers are clearly not happy to be conducting these meetings and attempt to discourage pharmacists from bringing the grievance in the first place. Some interviewers have stated that the subject of the grievance would never have done or said what was being alleged as the interviewer knows the person well or because they are a principal pharmacist or Area Manager and no such person would ever do such a thing! This shows a complete lack of probity and transparency. The fact that an interviewer knows the individual complained of well and makes their views known without having even attempted to ask that individual for their version of events calls into question the entire process.

Lack of balance

Whilst under investigation a pharmacist may be disciplined if on the balance of probabilities his/her employer considers they have behaved as alleged. If however a pharmacist raises a grievance, it appears that the burden of proof needed to substantiate their complaint increases. Some employers indicate that 100% positive proof is required or the grievance will not be upheld. There appears to be one rule for when a pharmacist is under investigation and another for the staff and the line manager when concerns are raised regarding their conduct or capability.

Learning points

If you are ever called to an investigation or disciplinary meeting or you wish to issue a grievance, we suggest you consider the following;

1. Investigation Meetings

- Establish what the allegations are at the outset of the meeting **before** you provide your version of events. Ask questions which will assist in identifying the individual who complained, what is alleged you have said or done, when and where and what supporting evidence is available.
- Provide your version of events ensuring that you cover all the allegations that have been raised. Refer to any witnesses that will support your recollection of events.
- Take a representative or companion with you if you are permitted to have one present. If you are a PDA member, then make contact as soon as you can.
- If seeking formal resolution always put your grievance in writing and keep a record.
- Attend meetings with a representative.
- Ask about the experience of the individual conducting the grievance and whether they have received training.
- Ensure that you receive the outcome of your grievance in writing.
- Challenge any decisions that you do not agree with within the requisite time frame.

On a final note, to avoid being made a scapegoat in the first place you should ensure that you document any incidents that could give rise to a complaint so that a contemporaneous record exists. In particular if you are a manager and your staff behave inappropriately or you have serious concerns regarding their capability, you need to make a record of this so that an audit trail exists, discuss matters with them on an informal basis and if necessary with your line manager or HR function. **Ignoring the difficulties that exist in your workplace in the hope that staff behaviour will improve or management will eventually see the light and support you is not an option. If you take this road you may well find yourself under investigation and being made the scapegoat.**

> "Recently, an employer, when challenged by PDA admitted that it did not provide training to its senior staff on how they should handle disciplinary meetings"

2. Disciplinary Meetings

- Ensure that you have received a letter inviting you to attend a meeting, that you have been given a reasonable period of time to prepare for the meeting and to secure the attendance of a representative.
- Establish that you have all the information that the investigators have which they will rely on during the meeting.
- Ask to review any CCTV footage that may exist if available.
- Ensure that you receive the outcome of the meeting in writing.
- Challenge any decisions that you do not agree with within the requisite time frame.

3. Grievance Meetings

- Attempt to resolve grievances informally if at all possible – but always make a written record.

To comment on this feature www.the-pda.org/is/013

Cases on Record

- **Pharmacist A** was supplied with statements that had been taken from staff regarding his inappropriate behaviour. The identity of the complainants were concealed by the employer making it impossible to put forward his version of events. His employer saw nothing wrong with this and could not understand why the pharmacist deserved sufficient information to put forward a defence to the complaint.
- **Pharmacist B** was required to answer allegations concerning her failure to supervise staff working in a late night pharmacy. It was accepted that she was newly qualified and had received no training or guidance regarding her specific managerial responsibilities. Nevertheless, her employer sought to discipline her. Fortunately for this member we were able to intervene and the result was that her employer quashed the disciplinary meeting, issued an apology and arranged for the appropriate training to be provided.
- **Pharmacist C** who had submitted a grievance which was in the process of being investigated was suddenly suspended from work and then transferred to another department before the conclusion of her grievance because someone subsequently made a complaint against her.
- **Pharmacist D** was informed that her employer accepted that the person named in her grievance had behaved inappropriately. However, the employer considered that because he did not intend to cause offence, he would not be disciplined, neither was there a need for any remedial training.
- **Pre-Registration graduate E** who had raised informal grievances which were ignored, then raised a formal grievance. She was told that she should investigate her own formal grievance by approaching potential witnesses to take statements. The individual conducting the formal grievance meeting failed to realise that this was his responsibility as the person tasked with dealing with the grievance and that such a request could be regarded as interfering with witnesses and could compromise the entire grievance process.

President apologises for Society's failings

The President of the RPSGB, Steve Churton, is asking pharmacists to look to the future in the creation of a new dynamic professional leadership body. At the BPC he apologised for the Society falling short of members' expectations in the past, but he gave assurances that the Society is determined to change.

However, he felt that without the re-engagement of the members, the chances of building a new professional leadership body from the de-merger of the Society will be compromised. He felt that it would be the aim of the new leadership body to focus on the needs of the members, enabling them to reach their professional aspirations.

On the current transitional process, he said:

"We need opinions, input, engagement and constructive debate from all sectors of pharmacy. Standing on the sidelines is not an option. It would be a tragedy if, in 2010, we are the only leading healthcare profession that cannot call on the support of a strong and united professional body. I don't intend to let that happen."

YPG pharmacy opens

In 2001, the Young Pharmacists' Group initiated the idea of opening up its very own pharmacy. This pharmacy, unlike any other in the UK, was to be run primarily as an experimental practice laboratory that would enable new models of practice to be developed. Because this pharmacy was to be closely linked to schools of pharmacy, it would be able to gather valuable data and an evidence base which could be used subsequently to support pharmacy's negotiations with the government on new role development. This pharmacy could also be used as an under/postgraduate learning facility by schools of pharmacy nationally.

The YPG pharmacy would run on a not-for-profit 'social enterprise' basis, where any proceeds would be ploughed back into the project for the benefit of further practice development.

For many reasons, it was always hoped that this pharmacy would deliver huge benefits for pharmacy practice in the UK.

While the hopes for this project were great, the YPG, a voluntary organisation, had no funds to deploy these ideas. However, six years later, and after much behind-the-scenes effort, more than £250,000 had been raised, and the YPG project has secured an LPS contract in Dudley, West Midlands. Finally, the YPG pharmacy opened in September 2008.

It may surprise many PDA members to learn that the PDA is one of the supporters of this project – despite it being a 'bricks and mortar' pharmacy. Indeed, over the past seven years, PDA Chairman, Mark Koziol, has played a significant role in taking this idea from vision to reality. **The reason for the PDA's support, is that this pharmacy can now be of significant strategic significance because it can be used (among other things), to develop new models of practice, including those that also benefit the individual pharmacist contractor model.**

To comment on this feature www.the-pda.org/is/014

BPSA Pre Registration Conference @ BPC

For the second year running, the PDA sponsored the biannual BPSA preregistration graduate conference. Over 100 delegates from hospital and community registered to attend this event, held alongside the main British Pharmaceutical Conference (BPC) in Manchester during September.

The conference delivered an exciting and interactive programme focussed on: practical hints and tips for gathering evidence, how to develop and apply the skills needed to be able to give and receive feedback on performance or behaviour, as well as preparation tips for getting the most out of the cross-sector experience.

BPSA graduate officer, Victoria Heald kept the conference flowing smoothly and to time. In the morning James Davies (BPSA President) and James Wood (Past President) used their extensive knowledge and recent experience of the preregistration programme to help delegates understand how to gather a portfolio of high quality evidence and get the most out of their cross sector experience.

The afternoon was taken up by a series of scenarios and interactive skill development sessions, delivered by John Murphy, PDA director and Mark Pitt, the membership services manager. John and Mark used their extensive training experience, as well as drawing on actual PDA cases to provide a fun and participative afternoon that kept everyone on their toes.

This was the first in a two part series of conferences and the second one "Finishing First" will take place on March 1st 2009. This conference will focus on preparing for and passing the preregistration exam. Places can be reserved by emailing **conference@the-pda.org**

To comment on this feature www.the-pda.org/is/015

The **Annual BPSA Preregistration Graduate Conference**

Sunday 1st March 2009

International Convention Centre, Birmingham

A one day conference showing you how to get the most from your pre reg year. Sponsored by the PDA

To reserve your place email: **conference@the-pda.org**

Limits of trust?

It is now widely recognised that mistakes committed while providing healthcare services do occur and that they can lead to the harm of patients.

When mistakes occur in the community pharmacy setting it is usually relatively easy to establish the causes and then to apportion responsibility. However, the situation is often much more complex in the hospital pharmacy setting; moreover, checking procedures are different. There is a much greater reliance on policies and procedures, which are usually provided by the trust, and more often than not, several pharmacists of varying levels of seniority are involved. There is a much greater proximity and involvement of a whole range of other members of the healthcare team such as technicians, nurses and doctors. As a consequence, in the experience of the PDA, when errors occur in hospital pharmacy, the job of protecting the interests of the individual pharmacist becomes that much more difficult. What can happen is that the individuals and organisations mentioned above, who could all have been involved in some way, may wish to ensure primarily that they are extracted from any potential firing line as quickly as possible.

Fortunately, the vast majority of errors do little if any harm, many do not even surface. However, it is inevitable that some result in very serious consequences and are even linked to a fatality. Recent cases dealt with by the PDA have shown us that in the hospital setting the pharmacists most likely to be in the firing line of errors are the more recently qualified, or those working in less than ideal conditions. In some cases they had not been provided with the appropriate training to undertake their particular role, or have insufficient time to complete their tasks; in others they have had too little supervision.

What are the implications if it happens and where can help be found?

In the hospital setting, even though a pharmacist may not be directly responsible for a serious error, there will usually be an investigation; in the event of a fatality the pharmacist is sometimes called to give evidence at a coroner's inquest. Depending on the seriousness, when things go wrong, there is also the possibility of civil proceedings (i.e. being sued), professional disciplinary action (RPSGB), criminal proceedings and/or employment disciplinary proceedings.

The PDA has seen numerous members involved in some very difficult situations in recent months. In some cases this has occurred even though the coroner's verdict has absolved them of causing the death.

When things go wrong some pharmacists naturally look to the trust employing them or to their senior line manager for guidance and assistance; often this will lead them to the trust's solicitor.

So what's wrong with that?

Such an offer may seem very attractive to pharmacists who have ended up in situations involving an error or other form of conflict. After all, their managers could be trusted and excellent pharmacists; they could be well known in hospital pharmacy circles because of articles they have written or committees on to which they have been voted. In our experience of defending pharmacists, we have formed the view that a reliance on offers of support from the trust, or senior managers appointed by the trust, can lead to more problems. The reason is that the managers have probably little or no experience of litigation and the complexities of handling a serious situation potentially involving many conflicts with both intra- and interdisciplinary teams. Even in cases where they possibly have some experience of these matters, such experience will merely be incidental to their regular job, e.g. of being a manager of a pharmacy department or other senior hospital role. Additionally, they will have even less experience of dealing with the new and highly complex nature of 'modern' pharmacy regulation at the hands of one of the RPSGB's several new statutory committees, let alone know how to handle civil litigation or potential criminal prosecutions involving the Medicines Act, Misuse of Drugs Act or the new Health Act. The PDA has encountered situations where despite their good intentions, this lack of experience, has detrimentally affected the interests of the pharmacists in question. As far as a reliance on the trust to defend the interests of pharmacists is concerned, imagine if the working conditions, staffing levels or policies provided by the trust caused or contributed to an error. In this situation, pharmacists will need to defend themselves by drawing attention to these shortcomings. Under these circumstances, imagine the difficulties

> "Managers have probably little or no experience of litigation and the complexities of handling a serious situation"

that would emerge for pharmacists if their trust lawyers were actually helping them conduct their defence. What these pharmacists actually need is someone who will look exclusively after their personal interest; this is often a distinctly different interest from that of the trust and even that of the senior line manager.

Equally, if you are the senior line manager in this situation, then you will want to ensure that you, too, are receiving advice that is independent of the trust or any other parties. It is important that all pharmacists recognise this difference because their professional futures may depend on it. The trust solicitor is paid by the trust to look after (primarily) the trust. Inevitably, the pharmacist's interests will be deemed to be secondary to those of the trust by the trust solicitor. This is not just a theoretical concern, but a situation seen routinely by the PDA.

Pinning the blame

Another difficulty is the situation where it is not clear who made the error. A pharmacist can stand accused of an error made by a colleague – be this another pharmacist or other member of the hospital team. Clearly, the trust solicitor would have a decision to make about the strategy to be taken in the defence, especially if the trust was implicated as a result of the conditions or the processes it allowed to prevail.

This decision may well be detrimental to the interests of all the pharmacists involved in the situation, whatever their level of seniority. The pharmacist's interests are possibly at further risk if all the other parties potentially involved have their own independent defence, but the pharmacist was relying solely on the support of the trust solicitor. It is almost a given that doctors and nurses, for example, will always be represented by their own counsel because they are members of their own respective defence associations.

> "The trust solicitor is paid by the trust to look after (primarily) the trust"

Further considerations

Once a serious incident has occurred, new and increasingly complex implications for the relationship between an employee and employer can emerge. Examples include employment disciplinary proceedings that are being taken against a relatively junior pharmacist by a senior pharmacist line manager who arguably, can well have been implicated in a particular incident and can even have had a theoretical case to answer.

In addition to this, the new RPSGB fitness-to-practice regulations place significant pressures on employers to report pharmacists they consider to have competency issues to the RPSGB so that an investigation into their fitness-to-practice can be instigated.

Police involvement

In the more serious cases including a fatality, pharmacists, including a number of PDA members every year, have found themselves being arrested and investigated by the police. Manslaughter proceedings are usually instigated; at the very least, if these fail, then the pharmacists are prosecuted instead under the Medicines Act and end up with a criminal record. The PDA has been involved in numerous situations where it has defended pharmacists in these situations; however, we are also aware of cases (where we have not been directly involved), where lawyers retained by the employer simultaneously acted on behalf of both the pharmacist AND the employer; and in at least one case, the technician also. It is interesting to note that the net result was that the lawyers persuaded the technician and the pharmacist to plead guilty, and interestingly, the employer was totally absolved!

Union involvement

The issue of compromised representation and defence may also apply to a large union (one that does not exclusively deal with pharmacists). Whilst large unions undoubtedly have significant influence in the broader NHS and have a lot of expertise particularly when it comes to pay and conditions, they may have very little detailed knowledge of pharmacy specifically and may have limitations when an expert defence in a serious professional conflict is required. We have seen well-meaning union representatives with no detailed knowledge or experience of pharmacy matters seeking to assist pharmacists in dispute situations and this has been to the detriment of the pharmacist.

The union may decide to ask a local pharmacist, perhaps a union official to get involved, this may be a senior work colleague. We have already demonstrated earlier in this feature how this could be to the detriment of the pharmacist in question.

Even if it decides to instruct an independent solicitor, the pharmacist could still be disadvantaged because although many law firms will take on criminal work and most are fully competent, very few have any knowledge of pharmacy beyond having a prescription dispensed.

Dealing with the media

Often, in the event of a drug-related death at the hospital, the national media (usually the Sunday papers) get involved. They make contact with the trust and it is usually their intention to secure information that seeks to describe an uncaring health service that employs incompetent staff. In these situations it is not unusual for them to name and shame individuals. Often, the press do not appreciate the whole picture and often ask the trust's press office one-dimensional questions such as: "What disciplinary action has been taken against the pharmacist?". The trust's spokesperson may prepare a reply saying there has been none, but fails to state this was because the inquest had established that the pharmacist's involvement was not in any way linked to the cause of death. It may be that the pharmacist involved is sent a copy of the draft reply at 5pm on a Friday evening. Publication will be damaging and extremely upsetting for the pharmacist. A published apology or subsequent retraction by the paper will be of little consolation. The PDA has experience of dealing with situations where the media was managed effectively and the naming of the pharmacist was successfully avoided. The Association knows that pharmacists would find it extremely difficult to handle this kind of problem and get support at that time of the week and at such short notice.

Recent conflict situations

- **Following the death of a patient**, pharmacist A was summoned to a Coroner's inquest. In PDA's opinion, he was potentially exposed to manslaughter proceedings and because of this, senior counsel was retained to represent his interests and to ensure that the Coroner also considered the 'wider environmental picture' within the hospital and the Trust. The Trust pressurised the pharmacist to abandon the use of his own defence and to use instead, the Trust's lawyers – which he resisted. The outcome was that the Coroner criticised the wider healthcare team, the Trust and various hospital departments, however, pharmacist A was absolved and did not face any criminal charges nor any other form of disciplinary sanction.
- **Following a serious injury to a patient** following a medication error and at the request of the Trust, pharmacist B wrote a report about what happened. The pharmacist did so without seeking independent legal advice. When the police ultimately became involved they were handed the written report which now severely prejudiced her. Eventually she involved the PDA, nevertheless, she spent three anxious months and endured a police interrogation before it was eventually decided that charges would not be pressed.
- **Pharmacist C was involved in an acrimonious dispute** with his Trust and eventually with the support of his local lawyer, a compromise agreement was signed by both sides which resulted in a financial settlement being paid to the pharmacist in lieu of his resignation. However, two months later he was contacted by the RPSGB and told that following a report by his old Trust that his fitness to practice may be impaired he was now to be investigated. His lawyer, unfamiliar with the nuances of pharmacy had negotiated a good financial settlement, but had failed to ensure that the compromise agreement included a clause which would prevent the possibility of any subsequent bitter recrimination. Eventually after a lengthy investigation, and now with the support of the PDA, there were to be no professional disciplinary sanctions laid against him.

Reviewing your defence arrangements

In the fast-paced, multi-professional healthcare environment in which most pharmacists currently find themselves working, professional conflicts are becoming, sadly, a more frequent occupational hazard. The implications of something going wrong can be far reaching and may represent some very serious career-threatening implications for those pharmacists unfortunate enough to have become involved.

Doctors and nurses have recognised this a long time ago and consequently are almost universally members of their respective defence associations because they see this as a necessary adjunct to their practice. In a few short years, well over 4,000 pharmacists working in hospital have chosen to be members of the PDA. We hope that this feature will assist those not yet in PDA membership to reflect and review their current defence provisions.

To comment on this feature www.the-pda.org/is/018H

ANOTHER DAY.
ANOTHER RESTRUCTURING OF THE NHS.

ARE YOU AFFECTED?

In the last year the PDA has supported many hospital pharmacists who are concerned about their employment prospects.

Who's defending your reputation?

The NHS is one of the largest employers in the world, but it is also an employer that is particularly keen on constant restructuring and reorganisation. The real effect is felt by the people who are employees - in terms of their jobs, their terms and their pay and as is usually the case, there will be winners and losers.

Whilst laws exist to protect the rights of employees, hospitals have HR departments to fall back on.

They will have their interests well covered - but will you?

We have already provided more than 8,000 of our members with advice and support and now, through union status, we have the legal right to accompany members to certain internal meetings.

In many cases we resolve disputes through mediation, but in others we pursue employers who have treated our members harshly, illegally or unfairly. Already, we have secured more than £500,000 worth of compensation for our members from employers in this way.

You might call this defending your rights and your reputation. We would have to agree...

Pharmacy employment specialists available
Union membership option available
Experienced hospital pharmacists available
Backed by £500,000 of Legal Defence Costs insurance
£5,000,000 worth of Professional Indemnity insurance

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~~11,000~~ **pharmacists have already joined the PDA.**

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