Primary Care Edition Winter 2011

insight

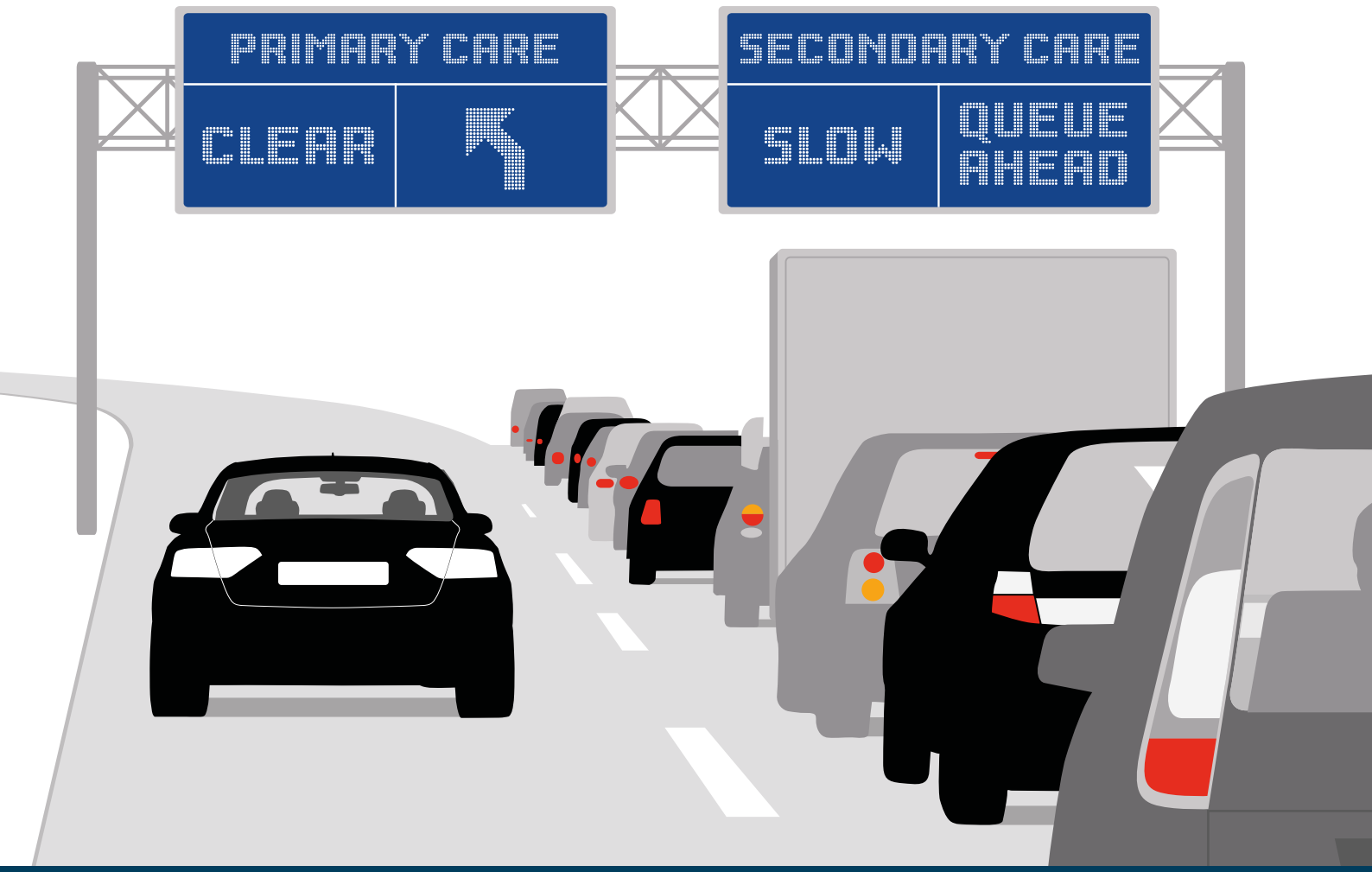
pda the pharmacists' defence association

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

Developing new roles for primary care pharmacists

PDA describes how it is supporting members involved in the NHS re-organisation exercise.

See pages 2, 10 & 22...



Chairman's Letter

Challenging times for Primary Care Pharmacists

Whether working in England, Scotland or Wales the established pattern of working for primary care pharmacists is changing significantly.
In many respects, the demands being placed upon primary care pharmacists by their primary care organisations are changing and if anything are becoming ever more complex. Member feedback also indicates that whilst pharmacists in some respects, mainly through financial constraints are taking on additional and in some cases more professionally challenging roles, there is now an ever greater involvement of pharmacy technicians in some of the more routine primary care pharmacy operations.

Beyond that, and this is obviously where most of the concerns lie, is the big English PCT dissolution exercise. This, quite understandably is creating a huge amount of employment related anxiety amongst primary care pharmacists. The fact that so many primary care pharmacists are facing uncertainties is highly damaging to this entire sector of pharmacy.

There is no doubt that the PCT changes in England have caused chaos and this is unsettling for all the personnel involved. Although the government has given some indicative target dates during which the transition from the old to the new would be completed, the current view is that it is uncertain as to whether these can be achieved. Consequently, the uncertainties faced by many primary care pharmacists will continue for some time to come.

Where to from here?

Whilst recognising that it will not be possible to seek the cancellation of the government reforms, nevertheless we will do what we can to try and help our members through this time of uncertainty and we intend to do this in several ways:

1. Seek a periodic status check as to what is happening so as to reduce some of the uncertainties. We have already undertaken some survey work to assess the current position and in the near future we will be repeating this process. We ask members to keep a look out for forthcoming activity and to participate in any survey work. We will use the results to inform our policy work and also to post the results on the website for the benefit of primary care pharmacists.

2. We are working reactively to support members who are facing any serious and immediate employment status issues. Despite the changes being proposed within the NHS, employment legislation exists to protect the rights of employees and PDA lawyers and advisors are on standby to support members and to ensure that these laws are observed. We recognise that members will have concerns about accrued rights and various other entitlements. The special feature on pages 22 and 23 provides some useful tools called 'the NHS Staff Passport' that may be of assistance to pharmacists who, because of the NHS reforms are transiting from one structure / job to another.

3. We are working pro actively to seek to create new roles for pharmacists that rely on their unique skills, but especially those demonstrated in the provision of pharmaceutical care as seen in the primary care setting. Our strategic work to date in this respect which we call 'The PDA Road Map' is described in outline on pages 10 and 11. Our member surveys of primary care pharmacists indicate that whilst many enjoy working ostensibly in a GP surgery setting, there would be many who would relish such a new role, especially if undertaken as part of a developing portfolio career. In Scotland in particular, the government has announced a review of the services provided by pharmacy (see page 6). We believe that this offers some excellent opportunities for developing new roles for pharmacists particularly in the provision of pharmaceutical care.

On a wider point, the good news (although this may provide little re-assurance to any primary care pharmacists reading this magazine today) is that during the many meetings that we have had over several months, whether with the BMA, the government or other relevant organisations, the view is that the primary care pharmacy role will continue to be a pivotal one required by the health service. The issue therefore is not about the future of the role, but the future of the format in which this role is to be undertaken.

We will continue to focus our efforts on supporting primary care pharmacists through this time of great upheaval and change.

The kindest regards

Mark Koziol
Chairman, The PDA

Contents

News:

Big shake-up for PDA Conference 2012

Since 2004 the PDA has always held its annual conference at the end of February in Birmingham. In recent years, the conference has become increasingly elaborate with conference strands for certain sectors of pharmacy, pre-reg's and even pharmacy students.

Last year, with more than 500 delegates attending, the conference was the largest PDA event yet.

From feedback that we received from delegates and also from those members who did not attend we have decided to change the format. The main issue is that with delegates required to travel to Birmingham and return home in a day, this puts the PDA Conference out of reach for many members in other parts of the country.

Responding to member feedback and recognising that the practice of pharmacy is beginning to diverge within the different devolved administrations, in 2012 the PDA Conference format will radically change.

Instead of one conference, the PDA will be holding at least four separate events; one in Scotland, two in England and one in Wales. Furthermore, as the two current Pre-reg conferences are usually oversubscribed we will also be providing at least two more events for pre-reg's to attend.

Two conference themes will be developed in 2012

Are we over producing pharmacists?

The number of Schools of Pharmacy in England has dramatically increased and already there are 40% more pharmacy students in the current undergraduate programme. This means that in the next few years a much larger number of pharmacists will be qualifying.

The objective of this PDA Conference will be to;

- Understand more about the demographics of the pharmacy profession.
- Consider the potential impact of such large increases in the number of pharmacists.
- Consider mechanisms that can manage the increase so that it can be beneficial and not damaging to the profession.
- Develop any necessary policy to support PDA members going forward.

Birmingham April 22nd
London May 20th
Cardiff June 24th

Re-engineering the delivery of pharmacy services

The Scottish Government has announced a formal review of the services provided by pharmacists. This provides an excellent opportunity for the hopes and ambitions of Scottish Pharmacists to be strongly articulated and fed into the review process.

This conference will provide an excellent opportunity for individual pharmacists to share their views and also to consider some of the proposals already being developed by the PDA following focus group work with pharmacists in Scotland.

Glasgow March 18th

Final details of all these events will be published on the PDA website and emailed to members nearer the date.

News

PDA meets with BMA

The Health and Social Care Bill was introduced into Parliament on 19 January 2011; one of the planks of the legislation was to dissolve the PCTs in England,

As many PDA members have been and are likely to continue to be affected by the proposed changes the PDA Union recently met with the British Medical Association in London to discuss some of the issues emanating from the Bill and from the NHS restructure that may impact on both pharmacists and GP's.

The topics of discussion included the operational issues and questions that still remain around the transition that could affect the employment and pension rights of NHS employees.

"It was important for us to gain a good understanding of the BMA's position on the Bill and their approach on some of the organisational matters" said Mark Koziol who was part of the PDA Union delegation. ***"The meeting was very useful to us because the BMA have been around a long time and have remarkable resources to invest in a vast programme of lobbying. They gave us some useful insights into their take on the status of the current situation and also their general concerns about some of the Bills proposals. Additionally, we discussed the NHS passport agreement which we believe should provide a useful foundation against which any future clinical consortia personnel decisions affecting pharmacists could be made"***
(see article on pages 22 and 23).

In a recent briefing to journalists, as in the meeting with the PDA, the BMA reiterated its opposition to the Bill not withstanding some good ideas within it.

During the meeting, the PDA shared its vision for its Road Map proposals and discussed some of its finer nuances. Whilst not in any way formally supporting the PDAs proposals, the BMA representatives indicated that the philosophy espoused within the PDA's strategy was in line with the emerging direction of travel in healthcare provision. They provided some useful pointers as to the additional organisations that the PDA should be lobbying with regards to these proposals.

"Overall the meeting was very encouraging" said Mark ***"they were very sympathetic to our members' anxiety about their jobs and reiterated the value of the pharmacist as part of any primary care restructuring".***

All Change on the PDA Union Executive

In recent Union by-elections three new National Executive members were elected unopposed. Manish Patel, David Tyas and Harminder Lall assume their new posts as Treasurer, Assistant General Secretary Administration and Membership and Communications Officer respectively.

John Murphy the General Secretary welcomed their appointment and was also quick to thank the officers who had stepped down for their dedicated work in the past. "I am pleased that the Executive is now up to its full complement and can assure the new members that there is plenty for us all to do to continue to make strides as a still relatively young union", said John. "I would also like to thank all those that put themselves up for election for the Membership Groups; they certainly have a big job to do in ensuring that they feed their constituency's ideas, thoughts and feelings to the executive so that we can represent them to good effect". The results of the by-elections can be found on the union web site **www.pda-union.org**.

The decriminalisation of dispensing errors

Many PDA members will remember pharmacist Elizabeth Lee who was given a suspended jail sentence in 2009 for making a dispensing error. Even though the legal appeal crafted by PDA succeeded in overturning her original conviction under section 85.5 of the Medicines Act (wrong labelling) in the Royal Court of Appeal, the Crown Prosecution Service substituted that failed prosecution with a fresh one under Section 64.1 (wrong product supplied) albeit the original prison sentence was replaced with a fine. Since then, Section 64.1 has never been challenged in law.

Following that episode, the government committed to decriminalising inadvertent dispensing errors and this was to be done during an MHRA review of the Medicines Act. However, towards the end of 2011, the MHRA announced that for technical reasons they would now not be able to deliver the requisite changes.

Shortly thereafter, representatives of the various pharmacy bodies, to include the RPS, CCA, NPA, AIMpS, IPF and the PDA joined forces to agree the best way forward.

The RPS had discussed an amendment to the Health and Social Care Bill that was currently going through Parliament with Lord Clement Jones which revolved around a concept called due diligence defence for pharmacists. However, whilst the RPS was obviously trying its best to solve the problem; due diligence would not have resulted in de-criminalisation for pharmacists. Consequently, what was agreed was that the discussion of this amendment in parliament was to be used simply as an opportunity to try and commit the government to taking the necessary steps that the MHRA in their review had failed to deliver.

It was necessary to brief numerous Lords and other parliamentarians to ensure that the debate in Parliament was to be as helpful to pharmacy's cause as possible and this was a task that was delivered more effectively through collective action. It was also necessary to send a formal communication to the Department of Health and then to brief officials, indicating exactly what it was that we hoped would be achieved.

The thrust of the briefing note to the Department was as follows;

The pharmacy profession calls for the removal of all risks of prosecution following a genuine dispensing error, in line with the statements previously expressed by the Pharmacy Minister, Earl Howe.

The notion that a genuine mistake which causes a dispensing error to occur can lead to the criminal prosecution of a healthcare practitioner acting in good faith is damaging to both the public and the professional interest.

The aim of amendment 337a is that dispensing errors committed by registered healthcare professionals that have not occurred through gross negligence, recklessness or wilful harm should not face the prospect of criminal prosecution, but should instead be dealt with by the relevant healthcare professional regulator.

We are seeking a change to the law that would remove the strict liability basis of the offences for supply in the Medicines Act and be replaced by criminal intent, gross negligence or recklessness. We believe that genuine errors in dispensing should not be criminalised and that it should remain within the remit of the General Pharmaceutical Council to hold professionals to account where no criminal prosecution takes place.

We believe that this must be a priority for primary legislation and we seek a commitment from the Department of Health to bring forward an amendment to the Health and Social Care Bill at report stage in the House of Lords. We will work with the Department to ensure that proposals seeking to achieve our aims have the support of the pharmacy sector.

This was co-signed by all of the pharmacy organisations to show the extent of the consensus within the profession.

Facebook; post online at your peril and face dismissal

It has been reported that two thirds of people use networking or blogging sites, and it's easy to see how it can become a way of letting off steam about work. The PDA warns members of the risks of facing employers, the regulator and possibly the law, if boundaries are overstepped.

In Preece v Wetherspoons Plc the Employment Tribunal held that a Manager of a pub was fairly dismissed, having posted derogatory comments about customers on her Facebook page. The employers alleged that she had thereby undermined the Company's reputation with the public at large.

The Manager argued – without success – that her rights to freedom of expression/ privacy ought to have prevailed but the ET were not persuaded.

In one recent case, a pre-registration student was dismissed from a multiple, after having been found guilty of gross misconduct. The student had used Facebook as an outlet for his daily experiences and had written derogatory comments about his colleagues. Neither the Company nor his colleagues were named specifically, but the view was taken that the link could easily be made.

Unfortunately, this is not an isolated case and there have been a number of pharmacy cases resulting in dismissal, where either comments or photographs have been posted on-line.

What can you do? Exercise caution, assume all information you put onto the World Wide Web, is accessible and could potentially be used as evidence against you, and check you are familiar with e-mail, internet and intranet policies.

Think twice, before you tweet!

News Contd...

Employee's should expect appropriate support from their employers

Mr Nuttall the Chief Executive of the Co-Op Pharmacy recently gave his opinion to the Chemists and Druggist magazine about a GPhC fitness to practice determination in which a PDA member and former manager of one of his pharmacies was given a warning for "sexual harassment" of staff.

In the news report he expressed "disappointment" at the outcome and was quoted as saying to the press "We believe that the circumstances of this case warranted stronger sanctions including a requirement to actively demonstrate a change in behaviour following completion of the equality training programme,"

Although our member admitted that he had used some of the behaviours he was accused of, it was accepted that he did not mean to distress his colleagues and as the manager and professional pharmacist that he should have set an example. There was no doubt from the evidence that there was a culture of 'inappropriate banter' amongst certain staff which our member found himself engaging in "It may be that, for some reason," said the Chairman of the professional disciplinary hearing, "[the registrant] felt that he had to participate in this culture". What may have escaped Mr Nuttall's notice however when he spoke to the press, were the testimonials that our member received after he had left the Co-operative's employment. One of many glowing statements made by a manager of a competitor pharmacy organisation and highlighted by the Chairman in his summing up stated;

"The allegations made against him do not sound like the same gentleman that I have met and worked with. I have not seen or received any reports that would cause me any concern, and would have no qualms about employing him to work in our pharmacy."

The Chairman of the panel also concluded "We believe that there was lack of training and support in management skills for [the registrant] at the pharmacy where all of this happened." John Murphy, the PDA Union General Secretary who was at the hearing said "We could never condone any member sexually harassing staff but many young inexperienced managers will relate to what has happened to this member and will understand how it might have happened; I know its a lesson well learned by [our member]. However, in saying what he did to the press Mr Nuttall would appear to be distancing himself from the fact that he and his organisation has somewhat failed in its duty of care to provide the appropriate training and support necessary for inexperienced managers who are thrown in at the deep end".

In a further professional disciplinary episode involving an ex - employee of Co-Op pharmacy who had been involved in the falsification of MUR records, the Investing Committee in determining that a warning should be given to the pharmacist also took the unusual step of asking the GPhC secretariat to write to Co-Op pharmacy to request that it reviews its practices to ensure that pharmacists do not feel under such intense pressure to complete MURs.

The PDA Union believes that employees should have the right to expect a working environment, which is free from intense pressure to complete MUR's and for their employer to provide support structures which will help them to perform their role to an acceptable standard. This includes management skills training if it is integral to the job and if it leaves the pharmacist vulnerable without them as it did in this case. Where this support and training is lacking then the union is of the belief that the employer should have a case to answer.

Role of pharmacists in Scotland to be reviewed

The role of community pharmacists in Scotland is to be reviewed. It will consider how to make better use of pharmacists expertise and enhance their involvement in primary healthcare.

The review aims to encourage closer working with GPs and other community based services and will examine the fitness for purpose and long term sustainability of the current arrangements for providing NHS pharmaceutical services. It will evaluate group pharmacy practice and specialisation and consider areas such as personalised patient care for the management of long term conditions and minor ailments. Evidence will be taken on making the best possible use of resources, particularly in relation to pharmacists' contribution to the safe and optimal use of medicines.

Mark Koziol, PDA Chairman, comments: "We are absolutely delighted that this review is taking place. We fully support its aims, which correspond to our Road Map vision for the future of community pharmacy. If you align the interests of patients, pharmacists and the NHS then you are on to a winner. But at the moment these interests are not always aligned. Better use of pharmacists' expertise can improve NHS care and the patient experience."

The review of NHS Pharmaceutical Care of Patients in the Community will be carried out by Dr Hamish Wilson, Vice Chairman of the Board of Healthcare Improvement Scotland, with support from Nick Barber, Professor of Pharmacy Practice at the University of London's School of Pharmacy. It will also consider the infrastructure needed to deliver pharmaceutical care fit for the 21st Century, the education, training and continuing professional development of pharmacists, and integrated working between hospital and primary care pharmacists.

Chairman tells pharmacist "your actions were not sexually motivated"

A female pharmacist charged with requesting to see a patient's rash for a "sexually motivated reason", has been completely exonerated at a recent hearing of the Fitness to Practice Committee.

The complainant described how the pharmacist asked to discuss her medication after she presented a prescription for a 'rash'. The patient maintained that she was told that unless she showed the pharmacist the rash, which was in and around the anus and vagina, that she would not be given the tablets. She said that she felt so humiliated and upset that she, "cried all the way home". She complained to the PCT three days later and sought compensation from the pharmacist employer – which she received.

The PCT referred the pharmacist to the GPhC Fitness to Practice Directorate and an application was made for an Interim Suspension Order. Following the PDA's intervention the suspension was downgraded to an Order with Conditions of Practice. This allowed the pharmacist to continue in her role but put an onus on her to:

- inform any (future) employer that she was under investigation and for what,
- inform the GPhC of her whereabouts of practice at all times
- refrain from going into consultation rooms alone with patients.

At the full hearing some months later, the pharmacist's version was quite different to that given by the patient. She told the Committee that not only was the patient starting on the new medication but she also had six other items on the prescription which she wanted to discuss. In conversation about the medication it seemed appropriate to ask to see the 'rash', having been given the impression that it was on her arms and/or neck. It was only when the patient immediately removed her trousers and undergarment that the pharmacist realised that it was in an intimate area and, shocked, she gestured to cover it up immediately.

The GPhC's advocate "strongly" put to her that she wanted to look at the rash "for professional curiosity and sexual excitement". We believe this to be an outrageous allegation and not one that even the complainant had made. Unfortunately in the PDAs experience pharmacists may have to face this hostile style of interrogation when they appear.

In rejecting all the allegations made against our member, the Chairman of the Committee said of the complainant - "[she] showed no sign of vulnerability". The medicines assistant on duty at the time remembered the patient leaving the pharmacy in a "bubbly" mood and showing no signs of trauma whatsoever. Also based on the manner in which she gave evidence, he went on to determine that he could not imagine how she would have had difficulty in refusing a suggestion to do something (remove her clothing) that she didn't want to.

He lavished praise on the pharmacist when he said: "We found her to be an impressive witness and we expect she is an excellent pharmacist". The committee rejected the complainant's account and accepted our members.

The committee rejected the complainant's account and accepted our members version.

The Chairman intimated criticism of the patient when he said "We do not know why she has given the account that we have rejected and which will have caused the pharmacist so much distress but we reject her account and accept the registrants."

What motivated the patient to make such a complaint? The PDA believes that she may have been motivated by greed. Possibly going home and giving her account to others; she may have been told she could get compensation and decided to add credibility to her story by making a complaint to the PCT. She followed this up almost immediately with a claim for compensation, and the NPA paid out £500 on behalf of the pharmacist's employer. This may have been to protect the image of the pharmacy and to keep her quiet. To what extent the NPA considered the pharmacists personal reputation is not known.

Pharmacists should beware of the dangers that can lie in wait when they invite patients into the consultation room, regardless of whether the patient is the same sex, and should insist that their employer has a comprehensive chaperone policy. This is a classic case of an excellent pharmacist unjustly being subjected to the humiliation of a public hearing, having been wrongly complained against.

The default position of the regulator has been to apply for a Suspension Order where there is a complaint of a sexual nature, whether proven or not. This of course would deprive the pharmacist of his/her livelihood whilst a full hearing was being prepared (sometimes a year hence). It has been of great comfort to those who have found themselves in such situations to have the PDA behind them. We now have much expertise in deterring the regulator from automatically applying for a Suspension Order in cases where there are uncorroborated allegations. There is now much more of a preparedness to negotiate conditions of practice whilst an investigation takes place.

Medical Negligence, Professional Indemnity and the Pharmacist

How does it work?

The cost of claims; how can lawyers justify this?

Over the last eighteen months, a trend has emerged whereby lawyers' fees are exceeding the payments to claimants by a factor of as much as eleven to one. The PDA is dealing with one claim where compensation to the patient was agreed at £1,500, only to be presented with a lawyer's bill of in excess of £17,000.

Outside pharmacy, the most commonly known types of personal injury claim falls into categories such as road traffic accidents (RTAs), accidents at work and tripping accidents.

Causation (the link between the negligent act and the harm caused) in these sorts of personal injury claims is often difficult to prove. The defendant (the person against whom the claim is made) may deny liability and even if he erred may argue that the claimant has a pre-existing condition which has affected the injury. In some cases causation may even be denied altogether because it is contended that the injury or the extent of the injury was not caused by the accident. A minority of cases end up in court.

Medical negligence is another category of personal injury claim which lawyers are diverting their attention towards because there are no regulations preventing them from running up unnecessary costs.

Government has regulated legal fees and capped compensation for road traffic accident claims because they were getting out of hand and adding to the increase in premium for the average motorist.

The formula which drove up costs to such an extent that resulted in government intervention involved the use of a Conditional Fee Agreement (CFA) commonly known as a no-win-no-fee arrangement, which allows lawyers to claim an additional 100% of the costs that they have accrued on behalf of their client. This would be paid by the defendant if liability was admitted. The strategy therefore was for lawyers to identify a negligent act and work up a large bill of costs in proving causation before then approaching the defendant to admit liability and at the same time be able to claim their 100% success fee.

When dealing with dispensing incidents, there is minimal risk of the lawyer not receiving his/her fees – which is what the CFA was designed to support so as those who did not have the means to make a claim and could not find the money up front for legal fees were not denied justice. The link between the error and harm is easily determined and liability is limited to either the pharmacist's and/or the pharmacy owner's insurers. Our policy is to admit liability as soon as we can establish that our member is liable - sometimes within days – in order to keep down any costs. Often we find that lawyers have milked the system by incurring what we consider to be unnecessary costs to which they add their success fee just because they are entitled to do so and because there is no regulation stopping them.

There has been public outrage following the publication of a report in August that negligence claims against the NHS had increased by 30% to £867 million over the previous year, well over a quarter of which went directly to lawyers. The PDA understands that the Ministry of Justice is about to act on the Jackson review of civil litigation costs, which recommended that success fees should not be recoverable which will hopefully restrain currently allowable but in many people's eyes, unjustifiable lawyers costs.

In the meantime, members can help us keep down the cost of claims by informing the PDA as soon as they become aware that a patient has been administered the wrong medication, have been shown a letter or given an indication that a claim is likely or have been approached for their Policy number in the aftermath of an incident. The sooner we know the quicker we can act and members should NEVER assume that a claim will not be made against them.

A dispensing incident; it's your car crash!

What do you do when you are involved in an accident with your car? This is what Direct Line insurers advise;

Make sure you get the names, addresses and phone numbers of any drivers, passengers or pedestrians involved, and details of any witnesses. By law, drivers must provide details of their insurance company and their policy number.

A diagram of the accident scene is often helpful. Try to draw one as soon as possible after the accident – show vehicles, the road layout, other relevant features and the positions of any witnesses. Gathering this information may help ensure that information about the incident is correct and may prevent inaccurate or exaggerated claims from third parties later on.

Do not admit blame or liability for an accident or offer to pay for any damage.

In the vast majority of cases people who have been involved in an traffic accident behave in the way their insurer expects them to; they know that they have a great deal to lose by not doing so particularly if it is not their fault. That is the way pharmacists should think and behave when they are involved in a dispensing incident.

Take a recent scenario where a pharmacist dispensed the wrong medication and the patient ingested the tablets. The pharmacist dealt with her in a polite and professional manner, but having done so, was of the opinion that the matter was closed and did no more about it other than to complete the pharmacy's error reporting system to alert the owner.

Pharmacists should never assume that an error will not lead to a compensation claim. In this particular case a claim from the patient's solicitor was passed to the PDA via the NPA whose member was the owner of the pharmacy. In the letter of claim some months later it was alleged that the patient had taken the medication for at least a month yet the pharmacist when tracked down by the PDA (because she did not inform us of the error) "thought" that at the time the patient had said that she had only taken seven tablets. This information, if it had been documented or evidenced through the inspection of the packaging and witnessed would have been vital in defending a large claim for compensation.

It is becoming increasingly difficult to dispute causation (the link between the negligent act and the harm allegedly caused) following a dispensing error when there is so much medical information available to the public. Allegations of adverse effects are difficult to disprove whether they are real, imagined, or plainly fabricated. Technically the onus of causation is the patient's to prove but armed with little information the pharmacist will be left in a difficult position if the patient says they suffered certain credible side effects and there is no information to disprove their version of events. In reality if a case went to court – an extremely costly exercise and one insurers would want to avoid – the judge would almost certainly rule for the claimant because the negligence is a 'given' and they will determine that there must be some harm as a result.

In this case the PDA had no option other than to pay out a sizeable compensation to the patient based on her version of events as proving otherwise would have been very difficult indeed. The result could have been so different had the pharmacist collected the required evidence at the time.

When a dispensing error happens therefore, a pharmacist should look on this as his or her car crash and automatically assume that damage has been done and where possible find out potentially what it might be and to what extent.

It is vital that when a pharmacist becomes aware of a dispensing error that they follow a simple procedure in the way car drivers instinctively do.

1. Check that the patient is well and if necessary direct them to a place where they can get a medical assessment. If they have already had medical attention, find out what this was; this could be important information when settling a claim. It is important to notify the patient's doctor about any error where there is the potential for harm to be caused.
2. Apologise for the incident but do not admit liability. Phrases such as "I am sorry that the error has happened" and "I will look into it to see how it has occurred" are acceptable. Saying "I am sorry that I made an error and caused you harm" is not and will usually lead to problems later. Do not write to the patient without seeking advice from the PDA first.
3. Obtain as much information about the usage of the erroneous medication as possible; the pack from which the medication was taken, how many doses have been removed and how feasible it would be for the patient to have taken so many or used so much in the time since the error. If the patient is reluctant to give you the offending article then it may be a sign that s/he is going to make a claim or a complaint against you and it is not unreasonable to ask if you can take a photograph of the pack and its contents. Check the PMRs to establish how many packs were dispensed and try to retrieve them to ensure that there are no other offending packs. Where evidence has been obtained ensure that it is not discarded.
4. Make contemporaneous notes of what the patient told you and try to ensure that a witness is present so as you can verify the story told at the time.
5. Make sure that you inform the superintendent pharmacist through the normal channels of error reporting.
6. Immediately report the incident to your insurer.

Investigating a dispensing error is an important exercise and should be done by pharmacists as a matter of course even if this causes inconvenience e.g. if a pharmacist has to return to a pharmacy that they no longer work at – but putting errors right is part of the job and investigating a dispensing error is part of that.

The PDA aims to deal with claims for compensation promptly and to agree a figure that reflects any genuine harm caused. It does so to minimise the risk of further complaints being made against members and to keep membership fee increases to an absolute minimum.

Direct Line leads with a strap line "Help us to help you". The PDA echoes that sentiment and urges all pharmacists to play their part in a thorough investigation which will enable us to make just and fair settlements on your behalf.

Shifting costs from secondary to primary care – the emerging new role for pharmacists

For the last two years, the PDA has been consulting and engaging with stakeholders about how pharmacy could contribute solutions to the unprecedented financial challenges currently facing the NHS.

This article provides a glimpse on the work to date which we have called the PDA ROAD MAP.

The PDA Road Map proposals

> "The significant problems we face cannot be solved at the same level of thinking we were at when we created them."
>
> ***Albert Einstein***

Central to these proposals is the principle that the unique skills possessed by members of the primary healthcare team can be used to much better effect than is currently the case and with much greater integration. Our proposals harness the under utilised potential of the pharmacist as an individual healthcare practitioner and the community pharmacy network as a resource in a way that seeks to increase GP surgery capacity. In turn we argue that GP surgeries should be able to reduce the number of costly hospital and unnecessary A&E presentations.

Community pharmacists regularly express their desire to deliver a wider range of clinical services; yet the relentless increase in dispensing volume and the focus on ensuring safety means pharmacists are spending more time involved in dispensing activities.

As a consequence, they are generally less available to counsel patients and provide clinical care to support patients.

However, it is important to emphasise that pharmacists involved in the dispensing process are not in any way a wasted resource.

Over more than two decades, community pharmacy has risen to the efficiency challenges set out in its current contractual arrangements. Contractors have driven harder bargains with medicines suppliers on behalf of the NHS and have delivered the second lowest prices for generic medicines and one of the most efficient supply chains in the world.

Furthermore, it has also been shown that pharmacy delivers a very low error rate of 4 in 10,000 – a very safe supply process. It will be important for these solid achievements to continue and whilst we advocate a greater use of skill mix and technology, we do not advocate removing the pharmacist from the supply process in the community pharmacy setting.

A more integrated primary care model

We argue that every pharmacy must have a pharmacist who is central to the routine operation of the pharmacy work. This 'patient-facing pharmacist' should be both visible and accessible. Although continuing to ensure a safe supply of medicines to the public, via skill mix and a greater reliance on pharmacy technicians, the 'patient facing pharmacist' should largely not be involved in the physical act of dispensing. This pharmacist would be ideally placed to focus upon medicines wastage, adverse drug reaction and a compliance agenda delivering improved benefits to patients and reducing costs. They should also provide a minor ailments service – where patients that otherwise would present at the GPs surgery, would instead be treated in community pharmacy.

In a proportion of pharmacies a second pharmacist - a 'clinic pharmacist' could provide more advanced services as currently provided by GP surgeries to stable patients with long term conditions. We argue that the 'clinic pharmacist' would spend more time with a patient on more complex medication regimes in the pharmacy than the GP is currently able to in the surgery. This enables the pharmacist's unique skill to be fully used to improve clinical outcomes and ultimately reduce hospital admissions from this significant group of patients.

The 'clinic pharmacist' would do this on a registered patient and planned care basis.

> "Given that pharmacists are medication experts and Long Term Condition prevalence is likely to increase in line with the ageing population, pharmacy should have a greater role in treating Long Term Conditions, helping to optimise the use of medicines, reduce waste and monitor health goals."
>
> ***Bow Group Report 2010***

We believe that these developments will produce a significant shift of patients away from the GP and into community pharmacy. We propose that the additional GP capacity thus created would need to be orientated in such a way so that many patients currently presenting in secondary care could be seen instead in primary care – in the GP surgery.

We believe that this new, integrated approach will:

- Improve the patient journey and provide more convenient and timely access to services;
- Create capacity to enable services to shift to primary care so commissioners are able to rebalance secondary care capacity;
- Improve outcomes for patients and avoid significant numbers of unplanned hospital admissions
- Encourage self- care and active participation in care.

The change imperative

Doing things differently opens up many new possibilities to deliver integrated care. GPs currently undertake the bulk of routine care of patients with long term conditions (LTCs) resulting in overloaded surgeries. This means regular patients get to see their GP for only a few minutes and can often end up being absent from work for at least half a day. It is therefore unsurprising that many patients feel they have no alternative but to present at the local A&E department and parents in particular are bypassing their GP and taking their children to the emergency department for common childhood ailments.

It is also easy to see how the current system can leave patients confused about their medication, ultimately resulting in a waste of medicines, poor compliance, at risk of adverse drug reactions or more prone to costly admissions to hospital.

In community pharmacy, we believe that the current model is now at breaking point. Our experience with MURs in England teaches us that the existing contractual arrangements are not driving quality. We believe that the more advanced clinical services should be commissioned separately and in addition to any existing traditional contractual arrangements for the supply function. In such an arrangement, specialist 'clinic pharmacists' freed from the responsibility of the dispensing process could focus upon and be truly accountable for quality and outcomes.

To succeed, this model would need to engage large numbers of pharmacists. Our surveys indicate that many practicing pharmacists from all sectors of practice; many with specialist qualifications such as independent prescribers would be keen to undertake this new work.

Increase General Practice Capacity

> "Practice capacity will be critical in determining practices' ability to improve patients' experience of urgent care."
>
> ***Steve Field Chairman of Council, RCGP; Laurence Buckman, Chairman, BMA GP Committee***

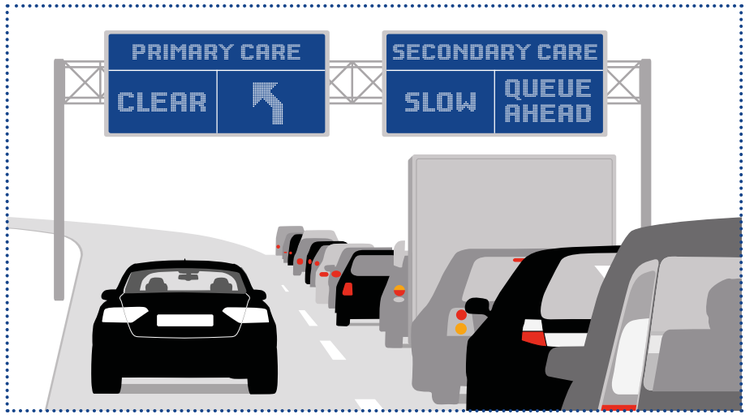
An improved practice capacity would enable GPs to gear their operations to being able to handle the more acute presentations so that patients would not have to resort to A&E attendance for urgent care.

Focus upon reducing unnecessary hospital admissions

There are nearly five and a half million emergency hospital admissions in the UK per annum which cost more than £12 billion. The sheer size of this cost means that the PDA proposal would be a prize, well worth pursuing and could be delivered through;

a) Reducing hospital admissions through greater access to urgent Care

Surgeries with enhanced capacity should become more orientated to handling acute presentations. Many GPs are frustrated when they learn that their patients presented at their local A&E for conditions that they could easily have dealt with at surgery level.



b) Preventing hospital admissions through smarter care of patients

The virtual ward approach

A virtual ward is a way of focusing support in the community on patients with the most complex medical and social needs. Virtual wards use the systems and skill mix of a hospital ward without the physical building and provide preventative care for people in their own homes.

The virtual ward approach would be led by a GP, with the day-to-day clinical work operated by a senior nurse who may be an assertive case manager or a community matron.

How would all of this be funded?

The transfer of patients from Secondary care to primary care

Fundamental to the business case for investment is the significant difference in costs paid by the NHS when a patient presents to the A&E department (£95 average costs 2010), when a patient is admitted to the hospital (£2,200 – average cost 2010), as compared to the cost of a GP consultation (£32 average cost 2010) and the cost of a pharmacy consultation (£17.75 average cost 2010). (All based on costs in England)

In the simplest of terms, a transfer of patients away from expensive secondary care towards less costly primary care will deliver significant savings for the NHS.

Medicines related savings delivered by 'Clinic Pharmacist' service

The more specialist 'clinic pharmacist' would spend much more time with registered patients in the pharmacy.

They would apply their specialist knowledge of medicines and deliver high quality pharmaceutical care in a way that is difficult to deliver under current GP arrangement.

Statistics that support this model;

1. A recent study, (York and London 2010), estimated that wasted medicines in England cost £300 million with around half of this being preventable.
2. The National Patient Safety Agency estimates that avoidable hospital admissions due to adverse drug reactions cost the NHS around £359 million per year.
3. A further study found poor compliance was associated with both higher costs and poorer outcomes - resulting in a further £750 million of preventable cost.

When combined, the better use of the skills of the pharmacist and the GP delivers considerably enhanced NHS efficiencies whilst at the same time substantial improvements in the patient journey.

What next?

This feature briefly describes the general direction of the PDA's Road Map initiative. We believe it represents a significant opportunity for pharmacist role development and could provide an excellent future for those pharmacists currently in the grip of NHS re-organisation. The full programme will be officially launched in the New Year. We urge all pharmacists to seriously consider the role that they could play in this new scenario and how to turn this vision into reality.

Five year PDA campaign leads to major RP breakthrough

Many PDA members will be familiar with the sorry tale of the RP regulations. The RP regulations and remote supervision were tentatively aired within the profession during 2006. The major bodies in pharmacy appeared disinterested in these issues at that time leaving the PDA as the lone voice raising concerns. The activities of the PDA were met with constant rebuff from most of the institutions, and government, on the grounds that the PDA was the only pharmacy organisation voicing these concerns and therefore there must be otherwise widespread acceptance.

July 2009 - Delaying the launch

Months before the RP regulations were to be enacted, the PDA launched a petition supported by many thousands of practicing pharmacists who indicated that they were not ready for them. We asked the Department of Health to delay the implementation of the regulations due on 1st October 2009.

During an infamous RPSGB council meeting in July 2009, the Council decided not to lend its support to the PDA's call for a delay and full implementation began.

October 2009 - The launch

Prior to launch, the PDA was already aware of some serious operational issues that would be caused by these regulations. Like the requirement for the RP to take statutory responsibility for matters outside of their control; that RPs could not remain signed on during rest breaks as this would conflict with the working time regulations; that locums could not possibly be expected to establish and maintain SOPs and many more issues besides. However, it was not until the regulations went live that the true extent of the problems could be seen.

The regulations where meant to;

a) *Promote safe and effective pharmacy practice*

b) *Enable pharmacists to work more flexibly and play a greater clinical role beyond the pharmacy.*

It quickly became apparent that the rationale behind the regulations was not supported by the application of them. Instead, pharmacists could not operate pharmacies in a way that they saw fit and due to the master / servant relationship that existed with their employer, they worked in an environment controlled by their employer but yet they took the legal and statutory responsibility. Public protection measures that were available in the previous regulations were weakened as a result.

Secondly the two hour absence provided in the regulations was not being used for professional purposes. In some of the large multiples, the RP was being asked to arrive for work at 9.00am and take legal responsibility from 7.00am for work that had already commenced prior to their arrival. In short some employers were using absence to extend their business hours whilst reducing the cost of pharmacy cover.

In hospitals the situation was even worse, PDA members were reporting back many difficulties. These included; satellite dispensaries being closed down altogether because of the inability to adhere to the letter of the RP law; ward based clinical pharmacists suspending their wider clinical services so that RP cover could be provided in the dispensary. In some hospitals a list of random pharmacists names were entered into the RP register by a junior member of staff simply to keep the register system going. Of greater concern to PDA members were situations where senior pharmacists were making clinical decisions about medicines out on the wards, which dispensary based RPs were having to take the statutory responsibility for by dint of the RP regulations.

In community many PDA members had faced disciplinary action at the hands of their employers either because they were trying to use the regulations to improve the pharmacy environment or because employers were using the RP regulations to hold pharmacists responsible for matters that they could never have a chance of being able to control. An example is where a RP was disciplined because unbeknown to the RP shop staff had been stealing and the employer decided to discipline the pharmacist citing that the RP was responsible for securing the safe and effective running and that they had failed in that duty.

July 2010 - The letter to the Pharmacy Minister

In July 2010, the PDA wrote to the Pharmacy Minister asking him to suspend the regulations as they were now (in some situations) damaging the interests of patients. The Minister was also asked to remove the RP regulations for hospitals altogether.

The minister replied that repealing or amending the RP regulations could not happen without public consultation. He also reinforced the widely held view that no other pharmacy organisations were raising concerns about the regulations. Consequently whilst declining to suspend the regulations he wanted further dialogue with the PDA regarding the consultation on supervision.

However, the government did commit to review the regulations and the RPSGB (subsequently RPS) was charged with that task.

Dec 2011 - The formal review of the RP regulations

The formal review results were published in December 2011 and the primary recommendations are;

1. Distinguish the responsibilities between the RP and the Superintendent / owner.
2. Empower the RP to make decisions around how absence is used as well as to make changes to safety procedures.
3. Provide clarity on the role of the technician and liability in relation to dispensing errors.
4. Clarify the policy intent around absence; define what can be done; enable the role of the clinical pharmacist.
5. Reduce the complexity of SOPs to a minimal standardised framework.
6. Address the poor operational and strategic fit with hospitals (either disapply the regulations or fundamentally change the regulations for hospitals)
7. Address the impact upon locums
8. Ensure that the regulations are future facing, accommodating changing models of professional practice.

PDA members would be forgiven for thinking that they have seen these recommendations somewhere before. They have – as they are the PDA policy first described at the 2011 PDA Conference in February and published in the 2011 Summer Insight magazine.

The Emperor has no clothes – and that's official!

The Royal Pharmaceutical Society concluded;

"The RPS believes that this report, its findings and recommendations have given the profession, its leaders and stakeholders a clear mandate to affect change which will both improve the professional lives of pharmacists and staff and critically, increase patient safety and patient care."

Finally after a lengthy PDA campaign the detractors and doubters have realised there is a problem and it must be fixed.

The leaders of the old RPSGB are no longer in power and the RPS is led largely by candidates who were elected on a stop remote supervision platform. An event for all of the relevant stakeholders to try and agree a way forward has been arranged for January 2012. So now we have a real opportunity to make some changes.

The way forward on RP and supervision

The PDA is well placed to play an active role in the discussions on putting it right. However the recommendations only address the symptoms of the RP regulations rather than deal with the root cause. Historically there may only have been the option of trying to make a 'silk purse out of a sows ear' by tinkering with the regulations. However now, there is momentum from the independent review and even the government has conceded that the RP regulations have not delivered. This consensus of opinion creates the opportunity for a more holistic and fundamental rethink to produce a supervision regime for pharmacy that genuinely supports the public and the professional interest – a policy fit for the 21st Century.

Those who do not learn from history are doomed to repeat it. Some of the lessons learned are:

1. *The profession needs to agree a unified vision and be able to understand and accept a future model(s) of practice before it can determine a policy on supervision.*

The big fear for pharmacists is the spectre of remote supervision – the plan to operate a pharmacy in the absence of a pharmacist. Policy makers in government were determined to see this become law even though the profession was united against it. Pharmacists asked the question; "why would someone want to operate a pharmacy without a pharmacist?" and no-one could give an answer. Instead of expending energy on a remote supervision debate that appeared to have been proposed in a policy vacuum, that energy would best have been spent on filling the policy vacuum, from which the policy and legislation on supervision would have emerged.

2. *Another way must be found to drive new roles in the community pharmacy setting that does not require pharmacists to simultaneously ensure the safe supply of medicines to the public.*

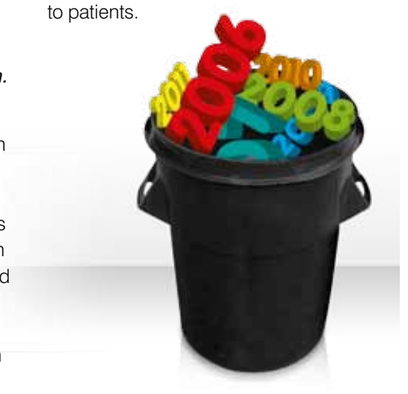
The supervision policy espoused by the current approach in the regulations relies on a pharmacist taking responsibility for the supply of medicines to the public as well as providing a range of clinical services simultaneously.

Whilst in the hospital setting this approach may begin to work – it can only do so for two reasons;

a) The wider clinical team is working in a much more integrated fashion including the presence of highly qualified dispensary based technicians.

b) The pharmacists often find themselves out on the ward and therefore in a patient facing situation where the clinical input can be delivered.

There are different dynamics at work in community pharmacy. The prescribing exercise is remote and disconnected from the pharmacy operation. Highly qualified registered technicians are not generally available and the pharmacist must be available to supervise medicines sales and provide high quality advice to patients.



Continued overleaf...

Continued from previous page...

The pharmacist therefore must be available to assess prescriptions when they are presented and when medicines are supplied to the patient.

The 'simultaneous responsibility' applied in the current approach is flawed as pharmacists inherently know that their invaluable contribution to the safe supply of medicines must not be diluted down due to participating in other clinical tasks at the same time. No matter how much reliance is placed upon registered technicians (the skill mix argument) or upon the use of technology (robotic dispensing and bar code checking technology), the pharmacist is still required to provide the most important input of all – the clinical check and any necessary interaction with the patient.

The conclusion here is stark; another way must be found to drive new roles in community pharmacy whilst at the same time ensuring the safe supply of medicines to the public.

3. *The Standard operating procedure (SOP) must be removed as a cornerstone of the RP regulations.*

The SOP will always be an important tool in the pharmacy, it will set out the general operational framework and act as a template to guide technicians to ensure that dispensary operations comply with agreed standards. However, such standards should NEVER restrict the professional decisions of pharmacists as this can easily lead to the public interest being harmed.

The current RP policy relies very heavily upon the use of SOPs. By appearing in the legislation, it elevates SOPs from being a support tool to having quasi statutory status. It requires RPs to understand the SOPs, to have read them and digested them before they can even sign on in the first place and to have accepted legal responsibility for their content and operation.

This approach was intended to ensure a quality standard in the pharmacy for the public but it has failed to do so, largely due to its unworkability and through a variety of unintended consequences.

Firstly, it is very difficult to properly comply with the SOP requirements; consequently a significant proportion of an RPs work can be technically in breach of procedures which devalues their importance and impedes wider adherence to such documents. Secondly, where RPs try to change SOPs they find that many employers require them to first to consult and agree any SOP changes with their superintendent / employer. Since certain SOPs are considered by RPs to be driven by a cost cutting agenda, it is possible to see how this can lead to friction in the work place. Furthermore,
it is often difficult to make contact with the superintendent of a large multiple.

Most importantly is that the greatest benefit to patients is where the unique skills and knowledge of a pharmacist are deployed to allow that pharmacist to exercise their professional judgement in the interests of the patient. This is much less likely to happen if the slavish SOP led culture in pharmacy continues to occur.

PDA members have described many instances where they have to operate defensive practice by rigorously adhering to SOPs to minimise the likelihood of professional, criminal and employer disciplinary proceedings. There is good reason for this as certain employers routinely discipline and dismiss pharmacists for not following SOPs to the letter.

In the first instance of its kind (see page 15) an Employment Tribunal has ruled that the SOP must be obeyed and upheld the decision of the employer to dismiss a pharmacist for non- adherence. If the RP regulations were intended to empower pharmacists through SOPs, then they have abysmally failed and these documents must not be the underpinning foundation of the regulations.

4. *Future supervision policy must ensure that the pharmacist becomes MORE available to the public in the community pharmacy and NOT LESS available to the public because the pharmacist is removed from the pharmacy.*

In the hospital setting, the pharmacist is heavily involved in patient facing situations because they operate in locations physically proximate to patients. Hospital pharmacists increasingly find themselves out on wards or in clinics. The dispensing role has largely been delegated to dispensing technicians and the pharmacist has become more available to patients.

In the community pharmacy setting, the only way that pharmacists can currently interact with patients is if they are based in the pharmacy. Consequently, any supervision changes for the community setting must aim to make the pharmacist more available, by permitting more time with patients in the pharmacy and less time involved in the physical mechanics of dispensing.

The final debate on supervision is yet to be had and this feature has set out the principles and lessons to be applied first. This independent RP review has given the clear message that the community pharmacy is the place where the public should expect to always find a pharmacist.

Since October 2009, a two hour absence has been available under the RP regulations. Experience shows that the two hour absence has not been used to support pharmacists develop healthcare roles. Some employers have simply used the two hour absence to extend their business hours by operating the pharmacy for two hours before the pharmacist has arrived and others have insisted that despite the two hour absence option pharmacists are not allowed to leave the pharmacy at all - not even to enjoy a lunch break.

An absence provision may create unwelcomed and unexpected consequences that are neither in the patients nor in the professions interests and careful thought needs to be given before any new supervision regime is finalised.

Where to from here?

The PDA, along with other organisations will now be seeking ways to progress these plans and we will update pharmacists of any progress that will be made in due course.

The PDA will also be seeking to generate a more fundamental debate within the profession around the wider issues relating to how pharmacy should be positioned so as to deliver the best possible outcomes for patients and pharmacy practitioners. We urge all pharmacists to participate in that process.

• RP BREAKTHROUGH • RP BREAKTHROUGH • RP BREAKTHROUGH • RP BREAKTHROUGH • RP BREAKTHROUGH • RP BREAKTHROUGH •

ET decides dismissal for failing to follow SOPs is a proportionate sanction

Employers usually make it clear in their Employee Handbooks what they consider to constitute misconduct that will in all likelihood result in an employee's dismissal. It is obvious to most staff that if they steal from their employer or assault a colleague that the chances of them retaining their employment are remote. What is not as clear is where an employee stands when it comes to targets not being met or Standard Operating Procedures not being followed; is dismissal a proportionate sanction?

The PDA was able to test this recently when one of our members was dismissed from his employment for failure to follow an SOP when dispensing a CD prescription. Our member decided to deviate from the SOPs that stated that the patient's ID should be requested. He recognised the man as a regular patient who lived in the locality and as he had no reason to believe that the patient was not genuine but didn't have any identity on him he dispensed the medication. Regrettably, it materialised that the person was not a patient but someone posing as one.

The police were notified by our member when his suspicions were subsequently raised and upon apprehending the offender, the police praised the pharmacist for being instrumental in the arrest.

Shortly after this, the employer instigated a disciplinary process alleging that an act of gross misconduct had occurred as the SOPs had not been followed.

His PDA Union representatives who attended the hearings argued that a failure to follow the SOPs had not been listed as an example of gross misconduct in the Employee Handbook; that he had used his professional judgment to issue the medication without ID being supplied; that he had been duped by the man posing as a patient and that the sanction of dismissal was too severe. The argument was advanced that the matter had even been brought to the attention of the GPhC who did not consider it necessary to warrant any further investigation.

Unfortunately these arguments fell on deaf ears and he was dismissed which led to him lodging a claim in the Employment Tribunal for unfair dismissal. The ET Panel had to consider the following:

The Law

- Whether it was reasonable for the employer to have dismissed our member for gross misconduct
- The size and administrative resources of the employer
- Did the employer have a genuine belief that our member was guilty of misconduct?
- Was the belief based on reasonable grounds?
- Was the belief reached after a reasonable investigation?
- Was the misconduct sufficient to justify dismissing our member?
- Would a reasonable employer have considered it sufficient to justify dismissal?

Our member had admitted that he had not obtained ID from the man posing as a patient from the outset so there was no dispute that the employer had a genuine belief that he was guilty of failing to do so. There was however a dispute over the fact that what he had done should amount to gross misconduct. The ET Panel were made aware that SOPs were a framework under which the pharmacy operated and that the pharmacist could deviate from them using his professional judgement. It was made clear that SOPs were not followed in every pharmacy every day and that this should not necessarily amount to gross misconduct.

The Judgment

The Panel took ten minutes to reach their determination that our member had not been unfairly dismissed. In summing up the Judge said that the employer was entitled to regard the incident as serious enough to be classed as gross misconduct and the police/GPhC stance was irrelevant. The employer, funded by the NPA made an application for their legal costs and the Judge awarded them £1,000.

Lessons Learnt

In assessing whether our members stand a realistic prospect of success at disciplinary meetings and Tribunals, all cases are examined by the PDA lawyers and pharmacist advisers. Based on their knowledge of past ET judgements they believed that it may be difficult to argue that a failure to follow SOPs was not a matter of misconduct or that even if it was, it was not so serious to justify dismissal. Nevertheless, it was felt that clarity on the issue was necessary for the general benefit of our members so we supported his claim to the Employment Tribunal.

Exercising professional judgement apparently holds little weight in the eyes of employment law especially if there are SOPs in place. If you divert from an SOP and the employer has the mind to dismiss you for it the chances of defending an unfair dismissal claim have receded as a result of this judgement. This episode raises fundamental questions about the use of SOPs in pharmacy.

Pharmacist Adviser Harminder Lall, commenting on the case said "What this Judgment now means for employees on a day to day basis is that SOPs have to be followed or you run the risk of being dismissed 'fairly' by your employer. We always advise that should you feel that you wish to deviate from SOPS that you inform your employer of your intentions or if this is not possible and time is of the essence that you note what action you took and why you took it so that you can justify your decisions if required".

The most rewarding job in pharmacy

PDA Union reps have saved the reputations and careers of numerous fellow pharmacists. Four of them describe the challenges they face and why they love their job...

Nothing can beat the satisfaction of helping a fellow pharmacist to get their job back. The role of a PDA Union rep is a challenging one, representing members in a wide variety of cases and scenarios, but the satisfaction of delivering what is often career-saving advice and support can be huge.

Union reps are dedicated individuals representing the rights of individual pharmacists who would otherwise be unsupported in their fight for a fair hearing from their employers. Reps are backed up by PDA central office, but when feelings run high in disciplinary meetings, the rep must be quick thinking, calm, assertive and eloquent. This is not a job for the faint hearted.

There is no such thing as an ordinary day for a PDA Union rep, but their involvement in a case typically begins when head office sends them all the relevant background information. Preparation is key, as case notes can be hefty and members can need a lot of support. Even apparently simple cases can be more complicated than they appear. Shenaz describes this preparation as good CPD, often needing to refresh her memory on points of employment and professional law.

The rep then contacts the member to discuss the case, sometimes calling several times to build up a rapport. "The critically important thing is that the chemistry is right between the rep and the member," says Jim. The rep will consider the case from the pharmacist's point of view, particularly on matters relating to professional issues. They will compare expected outcomes from the PDA perspective with that of the member.

Members from all over the country need support from the PDA, and travelling to meetings can often take longer than the meeting itself. The rep will usually arrive early to meet the member beforehand, to discuss the case, explain their role and explain the likely outcome. This can range from a decision made on the day to a decision in writing in five days time.

Reps' case loads fluctuate, from only two or three meetings a year to up to 70. Common cases involve both community and hospital, pharmacists and pre-registration students. They can include:

- Disciplinary matters
- Employment issues, such as changes to contract terms
- Grievances – both from members and about members
- Appeals against dismissals
- Return to work interviews.

The role of the rep

The tone and professionalism of meetings vary considerably, with their effectiveness often depending on the experience and approach of the employer representative. If the employer representative is a store manager they may have had no previous experience or training, and can be as nervous as the member. Meetings in the hospital setting are generally professionally run, often with an HR manager present.

Members can be extremely nervous and unsure what to expect. It is up to the rep to ensure that they put their case across as well as possible, while being realistic about the likely outcome. "I tell them if you've done something wrong there will be a penalty to pay, but I will make sure that you get a fair hearing," says Richard.

Employers' attitudes vary widely, but they can be aggressive and are often unhappy that their employee is being represented. Many are not used to dealing with pharmacy specific representation.

The rep's role is to advise the member, and ensure that procedures are followed and members' rights to representation are upheld. Support and advice during the meeting can include reminding the member of things they have forgotten because they are upset, and advising them when a break is appropriate.

Employers can try and prevent the Union rep from contributing to the meeting, so the rep must be forthright in explaining their rights. "You've got to think on your feet as much as possible," says Richard Flynn. Reps can advise the member, but are not allowed to answer a direct question put to the member. They can also ask for an adjournment to the meeting if they want to seek advice from the PDA office.

Meet your reps

Shenaz Patel, based in Newark

Manish Patel, based in Brighton

Jim Durrand, based near Nottingham

Richard Flynn, based near Newcastle

Drawing on valuable experience

All union reps are pharmacists and therefore ideally qualified to understand the practical and professional issues members face. They also have a wide range of pharmacy experience that they can bring to discussions.

Jim's management career with Boots, culminating with a post as retail implementation director, helps him to see both sides of any dispute. "This is about seeing things done rightly and fairly, and then you are helping the corporation as well as the member. If there's been a wrongdoing on the part of the employer and it goes the way you want it to, then next time the employer will hopefully improve their procedures. And if the employee wins the case then that's a 'win win'. At the end of the day we're all part of the one big profession."Shenaz's experience in training and development at Boots, and as an operational manager with Sainsbury's, proves useful. "Sometimes you need to see things from both sides - even though at the end of the day you're still trying to support the member, it sometimes involves a bit of a reality check."

But she admits that times are hard for employees. "Employers don't seem to be taking any prisoners at the moment. If they don't want you because you don't fit or because you're not a yes person they will try and get rid of you."

And non-pharmacist managers are increasingly taking out grievances against pharmacists, she says.

"The role of the pharmacist is not really understood at all by so many in terms of how much responsibility it carries. You're often just seen as retailers."

The unfairness of some cases can be quite shocking. Manish describes a case where the employer offered to type up the notes from a meeting because the note taker's handwriting was so poor. Manish was convinced that the notes were doctored during the typing up.

In another case a member had been dismissed, apparently based on CCTV evidence, for using their phone in work time. When Manish insisted on viewing the CCTV records it turned out that the member had only been on the phone for half as long as the employer claimed, and in one instance the tape showed that she had not been on her phone at all.

Richard describes a case where the interviewing manager was 20 minutes late. Then he discovered that the note taker was to be the manager who had made the complaint about the member. Richard complained about both points, and got the note taker changed. "This gave the clear message that I wasn't going to be messed around. I'm not saying you go in aggressively but they have to know that you're not just going to acquiesce."

Standing up for the individual pharmacist

The PDA Union uniquely fills a tremendously valuable role on behalf of individual pharmacists. "Before the PDA Union started nobody was there for the individual pharmacist," says Richard.

Manish became a Union rep in 2005, and has seen a great deal of change since then. "It was unheard of back then for pharmacists to get the type of quality representation that's available to them now," he says.

But there are limits to what the PDA can achieve, and members can help themselves to get the best possible outcome. In some cases they do not seek PDA advice early enough. "That's often naivety or they simply don't think they've done anything wrong," says Shenaz. "It can be quite a big mountain to climb if they've left it late. If they seek advice a lot earlier it will help their case."

The qualities of a good Union rep

"Openness, honesty and integrity are important qualities in a rep because you have to be able to build up a rapport with the member. And it's almost as important to be able to build up a rapport with the employer."
Jim

"You have to be Teflon coated - you can't let these things get to you because if you do you're not going to be able to do your best for the member."
Manish

"Union reps should have the ability to think on their feet, to be objective, to think strategically and tactically and have an ability to not be cowed. They should also have integrity, a degree of eloquence and enthusiasm."
Richard

Job satisfaction

"If it goes the way you want it to and you see the members face light up, that gives you a real buzz."
Jim

"It's the only job I would like to do full time if I could. It is also the only job where I have to use my full range of competencies from previous jobs."
Shenaz

"I come away feeling absolutely elated. One of the reasons I do this is that I just don't like the way that the big companies are treating people – they're asking more and more for less and less."
Richard

Customer Driven Profiling and protecting your rights

Customer driven profiling is a term that those who work for Alliance Boots will be familiar with but the principle should be familiar to everyone. In essence it is where a business need has been identified and a corresponding change to the working hours or pattern of an employee is proposed by the company to meet that need. When all parties agree, there is no problem and the employment contract is varied by mutual consent; however if the employee does not accept the proposals then in most cases a revised work pattern can only be imposed where a legitimate business objective exists and proportionate means are used to achieve this.
The PDA Union has been contacted by a number of pharmacists whose personal and family lives have been threatened with great disruption by the CDP exercise. Members report that business objectives put forward have been ill defined and little attention has been paid to the personal circumstances of the individual. Fortunately for these members the PDA Union has developed a very successful strategy to help members resist unwarranted changes and as a result has exposed serious failings in the processes being applied. In a number of cases the proposals have been dropped or substantially watered down in favour of the member.

Two recent cases highlight some of the problems encountered by members:

The Pharmacy must stay open all day

One company manager informed a PDA pharmacist member that ***"we need to ensure that we have [sic] 7 day mindset to ensure that the pharmacy is open for all trading hours of the store".*** The pharmacist was informed that he would not be able to take a lunch break away from the store, but had to remain in the pharmacy all day. If he didn't acquiesce to this demand he would either have to move onto the relief team or be dismissed from his employment. The pharmacist had always been flexible and took his lunch break to suit the business and was upset at being treated this way.
The PDA Union legal advisors knew that the company proposals were unlawful because this pharmacist merely wanted to take the breaks he is entitled to in his contract and under the relevant legislation. He could not be forced out of his place of work for exerting his statutory rights to have a break. He immediately sought the assistance of the PDA Union who attended a meeting with the employee and his manager. The company manager was ill prepared and even informed our member that there were no other pharmacies in the area which could accommodate his wish to have a lunch break. The pharmacist was left with a stark choice of either being forced to work through his lunch break or having his employment terminated.
The PDA Union representative made it clear the manager had got it badly wrong and his approach was untenable under employment law and prevented the pharmacist from complying with the Code of Ethics. A few days after the meeting there was a disturbing development when the manager remonstrated with our member both in the pharmacy consultation room and the tea room. Our member felt at one stage the manager was going to assault him and was so concerned by this behaviour a grievance was raised; the member was supported throughout by a PDA Union representative. The outcome of the grievance, heard at a senior level, was that the manager admitted to behaviour that could be seen as intimidating and assurances were given that appropriate steps would be taken to ensure he did not behave in the same way again. Also the threat to force our member out of the store was lifted pending the announcement that there was shortly to be a supportive company communication regarding pharmacist lunch breaks. Although this case was concluded several months ago, this communication has yet to be issued.

Changing weekend working hours; Boots say "sorry!"

Alliance Boots management were forced to admit that they got it hopelessly wrong by threatening a pharmacist with dismissal as part of the Customer Driven Profiling (CDP) project, if she wouldn't move out of the store she had worked in for fifteen years. This debacle arose in a flagship store in the North of England, despite the availability of specialist employee relations staff to advise the management team on the process.

CDP is supposed to be a rigorous process with documented meetings and the manager is instructed to read from a carefully prepared script. Our member was put through the CDP process over the phone without even being informed of the nature or purpose of the discussions. One telephone call received at 7.30 am, was to discuss her working pattern. These calls were later represented as 'informal' meetings which constituted stage one and two of the CDP exercise and notes were purported to have been taken which our member was unaware of at the time.

The PDA member lost faith in her manager's ability to handle the matter fairly at an early stage and declined to attend any further "informal meetings' forming part of the CDP process because she believed the new working pattern had been predetermined. The company had failed to provide a valid business reason for wanting her to change from Sunday to Saturday working in a different location. They also failed to take into consideration the alternative proposals she had put forward or her personal family circumstances.

The pharmacist wrote to say that she did not want to attend a third informal meeting and would prefer to go straight to the next stage where she could bring along a PDA Union representative. Upon receipt of this letter, she was then threatened with a charge of gross misconduct (failing to follow a reasonable management instruction) if she would not meet informally to discuss the matter and faced being disciplined.

Finally the company agreed to a meeting conducted with the help of a PDA Union representative. Her complaints about the process she was put through were treated seriously and upheld unequivocally and she was informed she could retain her current role. Although rather late in the day, it was commendable that Alliance Boots were prepared to admit their failings and issue an apology.

The Company's embarrassment was summed up when the manager who heard the grievance wrote ***"I would like to sincerely apologise to you for the fundamental failure to follow the company's CDP guidance properly from the outset of this process and I am extremely disappointed that you have suffered so much distress as a result."***

John Murphy, PDA Union General Secretary commented. "Thank goodness she sought expert advice from the PDA legal team. What worries me is how many others have been ridden roughshod over and given in to the constant pressure from management to change their working pattern regardless of their personal circumstances or whether there are even valid reasons for the change in the first place"

PDA warns pharmacists not to compromise their standards when pressurised to reach MUR targets

The PDA has told pharmacists that they must not report MURs which cannot be later verified, just to appease their manager's insistence to reach targeted levels.

An increasing number of pharmacists have found themselves dismissed and reported to the GPhC by their employer for this practice.

"We are very concerned at this trend even though we recognise the unrelenting harassment managers exert just to bump up the MUR payments." said John Murphy the General Secretary of the PDA Union "However pharmacists must be aware that regardless of the vile tactics used to pressurise them into doing MURs, misreporting to the NHS or the employer is a serious fraudulent practice and some employers will sacrifice them just to protect their relationship with the PCT. As well as dismissal for gross misconduct pharmacists can face a counter fraud investigation and the threat of regulatory sanctions including removal from the register, which comes as a complete surprise to many who find themselves in this situation.

One pharmacist who found herself in this situation reported that she had received two telephone calls every day from her manager to ask whether she had done any MURs; she admits that she succumbed just "to get him off my back." Others maintain that they perform them over the counter, but John Murphy points out, "It is tempting to complete MURs over the counter to save time or decide to write them up later at a quieter time. However If asked, patients may not be able to recall having an MUR if further enquiries are made and serious questions are then asked about whether the consultation actually took place".

The PDA is warning pharmacists that they must therefore not be tempted to report inaccurate information about their MUR performance because it will come back to haunt them and can severely damage their professional livelihood.

John Murphy did reflect "Employers need to start asking themselves why is it that perfectly honest people who have shown integrity in every other respect in their professional and personal lives suddenly commit a 'dishonest' act which does not benefit them in any material way whatsoever. Employers really do need to start taking their responsibility seriously in this regard".

Some managers can be intimidating and disciplinary measures are frequently threatened for non delivery of MUR targets. Pharmacists should be aware that the PDA Union has a very successful track record in helping pharmacists who feel under unreasonable pressure to deliver. This includes the removal of performance plans, lower targets and in some cases disciplinary action being taken against area managers for their behaviour.

THE PDA PLUS
additional member benefits

Pension and Retirement Planning

The PDA established the PDA PLUS partner programme to provide members with a raft of preferentially negotiated services the purpose of which was to make their lives and those of their families easier and also to reduce the costs of certain transactions. Originally the programme provided discounts on items like holidays, meals, wines and cinema tickets etc. More recently, the PDA PLUS programme has provided members with access to service providers and now members can rely on the PDA PLUS programme to support them in areas like completing their CPD, completing their tax returns, organising protection in the event that they are off sick from work and more recently by providing support with their financial planning. In this special feature, the PDA seeks to provide members with some wider insight into the importance of planning for retirement and has teamed up with PDA PLUS partner Lloyd Whyte to survey member's opinions about their retirement plans. The survey has provided some interesting results.

PDA Survey Results

The survey conducted by the Pharmacist's Defence Association and run in conjunction with a PDA PLUS partner Lloyd & Whyte and independent Financial Advisor, received well over 1,000 responses and has revealed a worrying lack of understanding of pension and retirement planning among PDA members.

According to the survey, 79% of PDA members want to retire by the time they are 65 with 16% stating they want to retire at 55. Despite wanting to retire before the State Pension age of 68, a substantial 64% of respondents have not sought any independent financial advice about how to provide for their retirement.

Realising Your Objectives

Knowing what you want to do when you retire is the first step to retirement planning. 56% of survey respondents would like to travel or pursue hobbies in retirement, yet a significant 36% had not considered their retirement plans.

Planning for your retirement is essential -the old adage of "fail to plan, you plan to fail" is very much the case. Take a medical condition as an example, you start with diagnosis of the problem, you then prescribe a remedy, but it is as equally important to review the progress of the condition and make sure the medicine prescribed is working and achieving the goal that is required.

Financing Your Retirement

When you have decided how you would like to spend your retirement, you can decide how much income you will need. 36% of respondents would like to have an income of half their current annual salary.

For example, a community pharmacist earning approximately £30,000 per annum in full time employment might anticipate wanting an annual income of £15,000 upon retirement. With the average population expecting to live for at least 15 years after retirement, this could mean the pharmacist will need a retirement fund of at least £300,000 (taking into account a Tax Free Cash lump sum as well as an income).

It is troubling that 39% of respondents either don't know how to calculate their retirement income or have never considered how much income they might require. This is especially concerning considering the age at which the majority of pharmacists are looking to retire.

When considering how much you need to save for retirement it is worth remembering what could lie ahead in your future. For example, 60% of respondents stated they were the main earners in their household, would this change if you decided to start a family? How would you manage your pension contributions if you were unable to work?

Funding Options

55% of respondents plan to use a pension to fund their retirement, yet a worrying 58% are not currently part of a pension scheme or have any form of pension provision. 28% of those not in a pension scheme do have the option to join a scheme offered by their employer.

Pensions provide a tax efficient savings plan which accumulates over your working life. In an employer scheme, your employer may also make contributions alongside your own, which over time can make a significant difference to your final retirement fund. If you are able to join a pension scheme provided by your employer it is recommended that you do so as contributions benefit from tax relief.

70% of respondents do not know how much the State Pension provides. The current basic State Pension for a single person is £102.15 (source: www.direct.gov.uk) per week, although some people get less than this.

There are many ways to help provide for your retirement, from purchasing a property with plans to let, to investments such as ISAs and investment bonds, each have their own risks.
Our experience has shown that many people view their home as part of their retirement fund, because when they retire the believe they will not need 4 bedrooms, however when they have retired, they find that they wish to spend more time with their families, children have now brought them grandchildren, all of whom need a room in which to sleep. This is why it is essential to have a plan, review the plan and reassess the situation on an ongoing basis.

The best funding options will depend on your circumstances. An Independent Financial Adviser can discuss with you how the options work and how much you should be contributing.

With the volatility that we are currently seeing across global markets it is more important than ever to make sure that your pension fund is invested in the best way for your circumstances, and review the progress of you plans on a regular basis. Many people who have a pension plan have a sense of achievement, because they have a pension. If that plan is not reviewed and the outcomes are unknown and understood, then regardless of the level of contribution, the pension may not deliver what is required.

A strategy of investing your money into a single investment fund within the pension can increase the level of investment risk that you are taking and leave you exposed to a fund that may or may not perform.

A recent study by Standard Life found that 90% of all investment returns come from the correct asset allocation. This means not having all of your eggs in one basket. Spreading your investments in a strategic way will provide you with the best chance of a positive return. So whether you are starting a new pension plan, or have existing pension plans in place, it is essential to review the performance and understand the likely returns that you are going to have and what level of income this will give you when you retire.

Seeking Advice

Of the respondents who have sought advice about their pension and retirement plan, 65% consulted an Independent Financial Adviser. By seeing a qualified professional, these respondents have benefited from advice that is specific to their situation and ongoing requirements. Independent advisers are not tied to any one product provider so advice is provided based on what is best for you.

Whether you are approaching retirement or have just started your career as a pharmacist, it is never too early or late to consider your retirement plan. You should be comfortable that your retirement plan will provide you with your desired standard of living. If you are unsure or would like to discuss any aspect of this article in greater detail, PDA Plus can help. Our team of independent financial advisers offer expert financial knowledge and understand the unique requirements of the healthcare profession.

PDA Members wishing to speak to PDA PLUS partner Lloyd Whyte should call 01823 250750 to speak to an adviser.

THE PDA PLUS
additional member benefits

Arranged through Lloyd & Whyte (Financial Services) Ltd

Affinity House, Bindon Road, Taunton, Somerset, TA1 2PN

Authorised and regulated by the Financial Services Authority.

PDA Plus is a trading style of Lloyd & Whyte (Financial Services) Ltd used under licence from the Pharmacist's Defence Association

Email: info@lloydwhyte.com

Web: www.lloydwhyteifa.co.uk

A passport to protected rights

Worried about your employment rights in any NHS re-organisation? The NHS Staff Passport provides members with an easy-to-use toolkit to help them understand their employment rights if they change jobs as part of NHS reforms

Primary care members are facing an anxious time due to a very significant amount of NHS re-organisation. This is causing stress to PDA members whether they are working in England, Scotland or Wales as there are great changes going on. In England in particular, primary care pharmacist members are now being required to transfer from established roles within PCTs to new positions possibly elsewhere in, or alongside, the NHS. With many changes to their employment status in the offing, it is necessary to ensure that the hard earned rights of members are not simply lost in the general shake-up of the primary care organisations and that any transfer of employment also involves the proper transfer of employment rights. In this feature, we explore the concept of the NHS Staff Passport, which we believe can provide a valuable tool to protect the rights of primary care pharmacists who are affected by the changes.

The NHS Staff Passport

The best, and most established system for transferring pharmacists' employment rights is by relying on the principles described in the NHS Staff Passport. This is a toolkit launched by the Social Partnership Forum in 2009, designed to provide NHS staff facing transfer with an easy to use, practical guide to employment standards and rights they can expect when being transferred either to another NHS provider, or outside the NHS to a provider who is contracted to offer NHS services.

The NHS Staff Passport:

- Is not meant to replace discussions between staff and their employers and/or trade union representatives.
- Covers standards and rights after the point of transfer – not at the point of transfer.
- Sets out the minimum standards and rights; it is not an exhaustive list of all associated employment policies and practices, but rather a guide to facilitate further discussion with local employers and/or trade union representatives on individual circumstances.
- Is applicable to NHS staff working in England.
- Is not specific advice on individual circumstances; your existing contractual terms and conditions are protected under TUPE and Cabinet Office Standards of Practice and will remain in place post transfer – they cannot be changed post transfer except in very exceptional circumstances.

All terms and conditions (except pensions, which are handled separately) are contractual and written into the contract of employment, and therefore automatically transfer under TUPE (Transfer of Undertakings Protection of Employment rules). For any transfer under TUPE, individuals have the right to be consulted through their trade union representative. Any proposed transfer should therefore be discussed with the employer and/or union representative.

An individual's terms and conditions cannot be unilaterally changed after transfer, except in very exceptional circumstances. After the employee has been transferred, however, the new employer can change their terms and conditions, but only with the agreement of the individual and/or their trade union representative.

How to use the NHS Staff Passport

The NHS Staff Passport is an easy to use online guide to employment standards and rights that individuals can expect when transferring.
A summary of information can be printed and kept for future reference. The NHS Staff Passport can be found at:
www.socialpartnershipforum.org/StaffPassport/Pages/StaffPassport.aspx

The NHS Staff Passport can be applied to the following types of transfer:

- To another NHS organisation
- To a local council job
- To a job with a charity, a social enterprise or the voluntary sector
- To a job in the private sector
- To work in a GP practice or primary care contract holder.

Users select the correct type of transfer from the website and it takes them to the relevant information page, explaining how the transfer will affect:

- Pay and terms and conditions
- Pension
- Staff engagement and partnership working
- HR policies and practices
- Education and training.

What's transferred?

All staff working for the NHS have the right to NHS pay, terms and conditions. And staff employed by other organisations delivering NHS services have the right to equivalent pay, terms and conditions.

The NHS Pension

All staff employed in the NHS have the right to be members of the NHS Pension Scheme. Other staff not employed by the NHS but delivering NHS services have the right to access a good quality pension scheme. Individuals compulsorily transferred from the NHS to another organisation providing healthcare services to the NHS can, in certain limited circumstances, continue with membership of the NHS Pension Scheme. Continued membership depends on the nature of the new employer, and the circumstances of transfer.

The NHS Pension Scheme has two sections – the 1995 Section, and the 2008 Section for staff who joined on or after April 1, 2008. All staff currently in the 1995 Section will be offered the choice to remain in the 1995 Section or to transfer to the 2008 Section. This Pensions Choice Exercise (PCE) commenced its implementation in January 2010 in the South West, moving up the country to the North East, and finishing in Wales.

Individuals compulsorily transferred to an organisation with a GMS/PMS contract (usually GP surgeries) that meets the NHS Pension Scheme employing authority conditions, and who are not a shareholder, will be treated as 'practice staff'.

Both shareholders and practice staff can retain their membership of the main NHS Pension Scheme, but 'practice staff' will not have access to the separated but related NHS injury benefit and early retirement compensation schemes.

All staff delivering NHS services can expect to be engaged by their employer in decisions affecting them and the services they provide. Trade union recognition will transfer from the existing employer to the new employer in certain circumstances. New employers are committed to the principles of effective joint working as set out in the NHS Constitution and the NHS Partnership Agreement, which means that they should talk to employees and their trade union about decisions that affect them. Individuals who move from one NHS Trust to another recognised NHS organisation should also have the same access to education and training before and after their move.

Those transferred to independent providers will not necessarily be affected by future changes in NHS terms and conditions, unless the new employer has agreed to adopt the changes. Everyone should have a free choice on whether to accept or reject new terms and conditions. In some cases, a trade union can be involved in negotiating a new contract.

Panel: The Social Partnership Forum

The Social Partnership Forum brings together NHS Employers, trade unions and the Department of Health to discuss, debate and involve partners in the development and implementation of the workforce implications of policy.
It aims to:

- Promote partnership working at all levels of the NHS
- Contribute trade union and employer perspectives to the development of policy
- Provide constructive comments on emerging policy at a formative stage
- Contribute ideas on the workforce implications of developing policy and implementation
- Promote effective communications between partners.

Further developments

The NHS re-organisation situation in England in particular is a fast moving one and the general pattern being followed is that many PCTs are already starting to coalesce around a new much larger shadow cluster structure. Many uncertainties are emerging, especially about what happens to the differing styles of operation that have been seen at individual PCT level once the mergers become final. The PDA will undertake another survey of its members in the near future to attempt to establish the extent to which the situation has changed and to assist with the strategic and tactical effort to support members.
As this information becomes available, it will also be disseminated via electronic communication.

Working reactively, in certain parts of the country, the PDA Union has worked with primary care pharmacists that have chosen to take matters into their own hands. The PDA Union has supported groups of pharmacists to arrange for them to have formal union consultative rights at PCT reorganisation meetings.

In a more proactive sense, the PDA is using its influence and a number of meetings have been held with relevant national organisations to ensure that the interests of primary care pharmacists are not overlooked. Most recently, the PDA met with representatives of the British Medical Association to discuss the importance of transferring pharmacists' employment rights properly to any new GP-led organisations (see News page 4). More such initiatives are underway.

Members that have general concerns that have not been explored by this feature should make contact in the first instance with their PDA Union primary care pharmacists' membership group representatives (found on **www.pda-union.org**). Those with a specific or technical query relating to this feature or their employment contract or TUPE transfer should contact the PDA office based team on www.the-pda.org.

The PDA will continue to watch the fast changing situation closely, to provide members with support where necessary and to provide information on any developments or arrangements that become available that may be helpful to primary care pharmacists.

WHAT WILL NHS REFORM BRING?

As a primary care pharmacist, you have never yet had to contemplate the phasing out of PCOs. So how can you best protect your interests?

The government's proposals on NHS reform are more far reaching than anyone imagined. Clinical consortia are to take over the roles of PCOs. This has already led to uncertainty as staff contemplate their future. As a union, the PDA will stand by primary care pharmacists who may be affected by any changes.

Handling more than 4,000 incidents each year, the PDA has considerable experience of dealing with often difficult employment situations.

We will do our utmost to ensure that the individual contractual employment rights of members are protected and also, strategically, we will seek to identify and then exploit any new opportunities that may emerge for the benefit of members.

The full extent of what the NHS reform will bring for primary care pharmacists is as yet unknown, but it is inevitable that the process will not be without stress. However, members can be assured that the PDA will do its utmost to ensure that their interests are protected.

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

- ✓ More than £800,000 compensation already secured from employers who have treated pharmacists unfairly or illegally
- ✓ £500,000 worth of Legal Defence Costs insurance
- ✓ £5,000,000 worth of Professional Indemnity Insurance
- ✓ Union membership option available

now more than 19,000 → have you?

~~13,000~~ **pharmacists have already joined the PDA.**

Visit our website: **www.the-pda.org**

Call us: **0121 694 7000**

pda
the pharmacists' defence association

defending your reputation