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PSNC CONFERENCE

Disappointed with PJ coverage

From Mrs S. J. Gidley, MRPharmS

As a "media tart" I was pleased with the *PJ's* coverage of the Pharmaceutical Services Negotiating Committee's conference (*PJ*, 4 November, p555) on a personal level, but it might surprise cynics to know that politicians also have one eye on the bigger picture.

It was therefore disappointing to note that many of the sessions, particularly those highlighting how pharmacists can make a difference at a grass roots level, were not covered. Michael Holden, chief officer of Hampshire and Isle of Wight Local Pharmaceutical Committee, for example, described how he had engaged with local opinion formers, which held important lessons for everybody.

A small proportion of the membership left the conference better informed on issues such as sexual health services, long-term conditions, devising an urgent care scheme and providing an anticoagulant monitoring service. It is a shame, however, that all of this was not communicated to the wider membership.

When I first qualified in 1979 clinical input into *The Journal* was as a drop in the ocean. We have come a long way and clinical input has improved immensely but is it not time that *The Journal* recognised the reality of community practice and provided us with real examples of how to provide new services and rise to the challenge of practice-based commissioning? At a time when the profession faces both huge challenges and huge opportunities, the *PJ* should be our standard bearer. I really must congratulate the PSNC on an excellent conference which would have been worthy of a *PJ* supplement. At a time when the whole profession needs to be better informed on best practice what better than the *PJ* to showcase the profession and provide a practical focus?

Sandra Gidley
Member of Parliament

New services are regularly covered in **News features** and **Visions**. The report of the PSNC community pharmacy conference aimed to focus on issues new to our readers. We were only able to send one journalist to the conference, so it was not possible to cover the whole day, since sets of breakout sessions ran concurrently. Readers interested in finding out about sessions not covered by *The Journal* can access all the presentations via the PSNC website (www.psnc.org.uk). — EDITOR

NHS FRAUD

Shoot first, ask questions afterwards

From Mr M. E. James, FRPharmS

No one condones fraud on the NHS and one can sympathise with the efforts of Jim Gee, director of the NHS Counter Fraud Service, and his staff. However, the "Citizens Advice Bureau social policy bulletin" regularly reports cases where heavy fines have been levied on people who have made what appears to be an honest error, either in completing the form on the back of the prescription, or in understanding the regulations. Colleagues should be aware that it would appear that the Counter Fraud Services policy is to shoot first and ask questions afterwards.

Miall E. James
Colchester, Essex

DARREN ALDRICH, from corporate affairs at the NHS Counter Fraud and Security Management Service, responds: The purpose of the penalty charge is to deter the incorrect or deliberate evasion of prescription charges by patients, which costs the NHS some £47m each year. The penalty charge is one of a series of measures that the NHS Counter Fraud and Security Management Service introduced to tackle patient evasion of NHS costs. This has contributed towards a reduction in losses to pharmaceutical fraud of approximately £70m per year — money that otherwise would have been lost and is now being used for the benefit of the NHS.

The process is governed by the NHS (Penalty Charge) Regulations 1999 and has been the responsibility of primary care trusts since 1 April 2005. NHS CFSMS has issued guidance to PCTs on managing the penalty charge process and this explains valid defenses and easements that can be applied.

The regulations clearly state that a patient is not liable to pay a penalty charge if they can show that they did not act wrongfully or with any lack of care in respect to the payment in question and that a lack of understanding of the law is not sufficient on its own to provide a valid defence.

Although we appreciate honest errors can take place in completing a prescription, it remains the responsibility of the patient to complete the prescription correctly and ascertain whether they should or should not pay the charge.

Further information and a copy of the guidance can be found at www.cfsms.nhs.uk.

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Letters to the editor

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Letters are accepted for publication on the understanding that they have not appeared anywhere, including electronic media, previously. If the issue is of such significance that the correspondent has simultaneously submitted the letter elsewhere, it is the responsibility of the correspondent to inform *The Journal* at the time.

Letters that are critical of individuals, organisations or companies may be sent to the person or body concerned so that they are given a simultaneous right of reply. In these instances, the authors' identities will not be disclosed until publication, and publication will usually be delayed.

Anonymity will only be accepted in exceptional circumstances. These circumstances will be at the discretion of the editor and the decision made in consultation with the correspondent.

THE PROFESSION

Master's degree corresponds to level of academic achievement

From Mr D. Day

Dan Lee makes some interesting points about the award of an MPharm for a first degree (*PJ*, 11 November, p573). However, master's degrees are not just about "original research and writing up of a thesis". They range from intensely practical courses through to more conventional written research submissions; the MPharm is in the middle of that spectrum. There are a number of four-year integrated master's degrees in the UK, in chemistry and engineering among other faculties, and other health care regulators are looking to the MPharm as a model for their own primary qualification because they recognise that students are actually graduating with master's level knowledge and skills. Pharmacy is in good academic company and, in awarding MPharm degrees, universities are recognising the proper level of academic achievement of pharmacy students.

Damian Day
Head of Accreditation
Royal Pharmaceutical Society

PFIZER PRODUCTS

Scheme likely to work in opposite way

From Mr R. A. Jephson, MRPharmS

Have I missed something in the fine words that have emanated from Pfizer extolling the virtues of its distribution scheme? Pfizer has stated that the scheme is being put in place to protect the integrity of its prescription medicines. But how will this scheme prevent the legitimate trade of pharmaceutical products entering the UK as parallel imports? How will this scheme prevent the infiltration of this legitimate trade by counterfeit products? Pfizer products are well represented in the lists of those suppliers.

In short, the scheme will not prevent infiltration, but is in fact more likely to be the catalyst to the proliferation of this type of activity which is, of course, the exact opposite to that from which Pfizer hopes to protect patients.

Ray Jephson
Swindon

100-HOUR EXEMPTION

Not to worry

From Mr A. Harwood

I write in response to some of the letters about the 100-hour control-of-entry exemption. I do not think contractors should worry a great deal about the 100-hour contracts.

A 100-hour pharmacy is going to create a wage bill in excess of £15,000 a month. Based on this, the pharmacy needs to be dispensing approximately 6,000 items or more each month just to break even, inclusive of all other costs. Along with this, people will need to consider the safety aspect of being open so late, especially in areas where crime rates might be higher. I speak from experience as I considered a couple of 100-hour contracts and have rigorously annualised the numbers.

Andrew Harwood
Hampton Hill,
Middlesex

SECTION 60 ORDER

Why the New Zealand model will not work in Great Britain

From Dr. D. J. Temple, FRPharmS

The news feature on the Pharmaceutical Society of New Zealand (*PJ*, 28 October, p509) highlighted the success of the role split that was forced upon that body two years ago and asks whether the same could happen in Great Britain. I believe an important factor in the British scene has not been considered by your reporter, that is, the influence of the NHS as the major employer (either directly or indirectly) of most health care professionals in this country.

Since the late 1960s, via various NHS Acts, successive UK governments have accepted their responsibility to maintain the competence of health care professionals through the provision of continuing education. Hence pharmacists and others have become used to free continuing education offered by the Centre for Postgraduate Pharmacy Education and similar organisations within the NHS.

This is clearly not the case in New Zealand, where the Pharmaceutical Society had established itself in the 1990s as a major provider of continuing education through its subsidiary body, the New Zealand College of Pharmacists. Currently, membership of the PSNZ brings automatic membership of the college and the obvious benefit of access to quality continuing education courses. This is generating income for the PSNZ in a way that would be difficult to for the Royal Pharmaceutical Society to achieve here.

"Pharmacy self care" is another example of the PSNZ seizing an opportunity to provide (for an up-front fee) quality materials and full support to pharmacists seeking to offer a service to their clientele. This, again, was developed in the previous decade but it is still a viable and tangible benefit for members of the PSNZ.

The analogous "Pharmacy healthcare scheme" in the UK relied totally on NHS funding to provide a "free" supply of leaflets to community pharmacies, but largely lacked the additional training and support provided at cost in New Zealand. Pharmacists in Great Britain now expect to source leaflets via their primary care organisations, leaving the Society out of the loop.

There are other examples of the PSNZ developing practical solutions in support of their members before the split, which encouraged 90 per cent of its members to retain their membership. In the UK other bodies have filled these gaps. This throws into question the percentage of pharmacists who would voluntarily retain membership of the professional arm of the Society, should it decide to split along the same lines as the PSNZ.

David J. Temple
Welsh School of Pharmacy, Cardiff

REGISTRATION

Fitness-to-practise declaration

From Mr D. I. Simpson, FRPharmS

In *The Journal's* report of the October meeting of the Royal Pharmaceutical Society's Council (*PJ*, October 21, p491), it is said: "The Council noted that the completion of a fitness-to-practise declaration [when renewing registration] is currently required under the terms of the Society's Charter." I was at the meeting, and I do not recall the Council doing any such thing, although I acknowledge that memory can play tricks with one.

Be that as it may, I would be glad if I could be directed to precisely which part of the Charter sets out in terms the requirement to complete the declaration.

Douglas Simpson
Member of Council
Royal Pharmaceutical Society

In our report of the October Council meeting, a statement that the completion of a fitness-to-practise declaration when renewing one's registration "is currently required under the terms of the Society's Charter" (*PJ*, October 21, p491) was not meant to imply that the Charter itself includes a specific requirement for a declaration to be completed. What the Council was told was that the Society "relies on its Charter to request the completion of the annual retention declaration by members".

We understand the retention fee declaration form has been designed to enable the Society to fulfil its legal obligations under the Charter. — EDITOR.

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