

PFIZER PRODUCTS

## SPGC continues to oppose Pfizer's distribution proposal

From Mr A. MacKinnon,  
MRPharmS

The Scottish Pharmaceutical General Council met once again with representatives from Pfizer on 11 December to express its strong dissatisfaction at Pfizer's proposal to distribute its medicines in the UK through one single wholesaler. Unfortunately Pfizer was unable to give the SPGC reassurances on any of the issues that were raised.

As a result of this meeting, the SPGC would like to reiterate that its position on this matter is unchanged and remains as detailed in previous press statements. It has now issued a new press statement making it quite clear that it is totally opposed to Pfizer's new distribution model and continues to maintain that this model will be hugely detrimental to the current wholesaler network.

Despite Pfizer's previous assurances that this initiative would be cost neutral to the NHS, the SPGC believes it is now clearly apparent that this proposal will have significant increased costs for the NHS in Scotland.

The SPGC maintains that such a distribution model would also result in significant administrative burdens for community pharmacy contractors and their staff, thereby reducing their ability to deliver the levels of pharmaceutical care to Scotland's patients as envisaged within the new Scottish Pharmaceutical Care Services contract.

The SPGC therefore will continue to urge Scottish MSPs,

MPs and the Scottish Executive Health Department to review fully this proposal by Pfizer with the utmost urgency.

To that effect, the SPGC will also continue to encourage and recommend that all community pharmacists in Scotland make appropriate representation to their MSP and MP regarding Pfizer's proposal and its detrimental implications for patient care in Scotland.

### Alex MacKinnon

Head of Parliamentary and Corporate Affairs  
The Scottish Pharmaceutical General Council

## Saving money?

From Mr J. L. Woodward,  
MRPharmS

I find Brian Curwain's letter (*PJ*, 11 November, p574) disturbing in as much as that all he is interested in is saving millions of pounds for the tax payer, the quality of life for patients evidently being of little consideration for him. Have we really obtained sufficient evidence to show that the lifespan of those patients changed from atorvastatin to simvastatin will not be decreased or affected in any way?

He is also asking community pharmacists to do his job for him. Unfortunately we have neither the time nor the ammunition that he has at our disposal. We do not have a prescribing incentive scheme at our fingertips whereby we can say "Hi doc, why not change all your patients from atorvastatin to simvastatin and I will see that you get an extra £3,000 a year. Yes we have changed the deal. Last time we saw you, you will remember

that we were offering additional payments if you increased your level of generic dispensing. And, by the way, do not forget our Quality Outcome Framework scheme whereby you can earn up to a maximum of 1,050 points, thus increasing your income by £15,000 to £20,000 per annum when you meet the targets you will be set."

Could you see me saying to old Miss Jones, who I know to have 11 items on her monthly prescription, "look, Miss Jones, you bring all your prescription items to me every month and I will give you a 10 per cent discount on everything you purchase from my pharmacy"?

### John Woodward

Stafford

Dr CURWAIN replies: I am sorry that Mr Woodward found my letter disturbing. I can give my assurance that, as a pharmacist, my aim is to ensure that all patients within my primary care trust area receive first-class therapy and that all prescribers are properly advised as to the underlying clinical science. As a servant of the NHS, I clearly have to act in accordance with the aims and priorities of my primary care trust. If my employer's wishes were to come into irresolvable conflict with my ethical duties as a pharmacist, I would resign without hesitation. My pledge to prescribers has always been, and remains, that the medicines management team will never recommend an inferior product in order to save money. No change we propose results in a reduced quality of treatment, based on the scientific evidence. Patients always have the chance to opt out of a medication change and, anyway, we painstakingly screen out those for

whom the medical records suggest the switch would be inappropriate. In a recent programme in one surgery, over 300 patients were changed and just 11 rang my office as invited to discuss it after reading the letter we sent them. Of these, only one ultimately said that he would prefer not to change and we respected his decision. We have generated evidence locally that patients' cholesterol levels are not adversely affected by the change in medication. There is no evidence that changing statins has an adverse effect on lifespan and there is no anecdotal data that I am aware of to lead one to generate such a hypothesis.

For the record, we paid our GPs nothing to make this change; they are not averse to prescribing cost-effectively. We do, where needed, assist them with the work involved. I was not asking community pharmacists to do my work for me but I do encourage them, along with GPs and other contractors, to act in a corporate way with respect to the priorities of the primary care trust with whom they contract. Our GPs have not had a prescribing incentive scheme for the last couple of years, but they can see the benefit to their local health economy of saving money where possible as this may permit service developments for which there would otherwise be no funding.

### Broad spectrum

The Broad Spectrum feature is open to any reader. Contributions of around 1,100 words commenting on topical issues should be sent to graeme.smith@pharmj.org.uk for consideration

## Letters to the editor

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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.

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■ FITNESS TO PRACTISE

## Unreasonable expectations

From Mr P. F. Murphy,  
MRPharmS

I now find myself writing to this column a second time — different topic but the same theme; the impossible situation community pharmacists are in. My first letter (*PJ*, 25 February, p230) concerned monitored dosage systems. With these we are liable to be sued for placing medicines within a compliance aid against the manufacturer's advice, the flip side being that we might be sued for not providing support to the disabled; we are also without any useful guidance to help us determine who is actually disabled.

Now it appears that we are to be sued for dispensing a prescription comfortably within the usual dosage range on the basis we need to ensure "the prescribed medicine is suitable for the patient" (*PJ*, 18 November, p595). My interpretation of assessing suitability covers ensuring that amoxicillin capsules are not prescribed to an 18-month-old and

such like. Anyone who spends any length of time at the dispensary bench would surely agree that our liability has to end at pharmaceutically assessing each prescription to ensure it is within the usual dose range, free from significant interactions and presented in a form that is appropriate to the patients' circumstances. These pharmacists will also agree at the absurdity of communicating with the GP every time there is a dose change in order to establish intention. Pharmacists often make valuable interventions of this sort but it is a giant leap to suggest that this is the "achievable norm".

To reach this standard of care would require a massive investment in terms of pharmacy's access to personal medical information and the time to be able to scrutinise routinely each prescription to the required level. The question I would like answered is was the view of the Royal Pharmaceutical Society sought by the judge in reaching this decision? Either the Society (or its point of view) was ignored, which should surely be investigated, or the Society was in agreement with this ruling. Should this be the case, I feel it would be

significantly out of kilter with the views of its membership.

The claimant is obviously an intelligent and motivated individual with a head for figures. Surely some of the responsibility must rest with the patient for not realising the significance of one tablet being suddenly replaced by two? No wonder I get leaflets about stress with the *PJ*.

### Paul Murphy

Wallasey,  
Wirral

■ THE PROFESSION

## We do not need to invent new roles

From Mrs D. Drury,  
MRPharmS

Most pharmacists have noted that there has been a lot of focus on regulation at the Royal Pharmaceutical Society. Hopefully, the formation of the national boards should mean a transition to professional leadership. We need to examine workload, and be in a position to help pharmacists to meet the requirements, in which

ever field of work they practise. The question needs to be asked: how many support staff can be supervised per pharmacist? There must be sensible discussion about lunch breaks and breaks during long working days. Let us go back to part-time or low income fees, for pharmacists that can only work a few hours a week. That would allow us home visits, appointments with primary care trusts, or surgeries, or whatever the new health demands are. We would also be retaining highly educated staff.

We need funding for pharmacists to undertake continuing professional development and further courses. It is absurd that we have to work longer hours than many other professionals and then to do continuing professional development in our limited leisure time. We need well trained medicines counter assistants, dispensers and technicians; they also are having to spend many hours of private time in study. This is just not sustainable and no wonder we are all fed up with the current state of affairs.

We do not need to invent new roles. The public love us and we are one of the only instant services in

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health care on the high street. We want pharmacists in pharmacies and have to say no to the daft idea of remote supervision or delegating to non-pharmacists. The public expect better of us and quite rightly. They should have this access to the highly qualified graduates in pharmacy that we are turning out. We need some overlap of pharmacists in our community pharmacies and must put pressure where needed to achieve this. Our services are both timely and cost efficient which comes about from being private contractors to the NHS. Other areas of the NHS have had managers of this, that and the other and it has only led to overspending and wastage. They need to take the lead from us.

Fees for pharmacists need to be pegged and we cannot be expected to subsidise other registrants. Support staff were to be regulated only and pay a regulatory fee whereas pharmacists are members of the Society and are both regulated and professionally represented. Pharmacists are now paying three times the technician fee for ultimately the same service.

#### **Dorothy Drury**

*Member of Council  
Royal Pharmaceutical Society  
English National Board Election  
Candidate*

#### ■ RURAL PRACTICE

### **Dispensing doctors should employ pharmacists**

From Mr J. D. Thomas, MRPharmS

The dubious practices of dispensing doctors as discovered recently by Neville Cameron (*PJ*, 25 November, p636) are not new to some rural community pharmacies, as they know too well that they have been in existence

since the inception of the NHS in 1947. The regulations then applied to real rurality but have not been modernised to apply to the present creeping urbanisation of most "rural" villages.

In the early days of the NHS, rural doctors did actually dispense themselves, but with the vast expansion of the numbers of so-called rural patients, and the increase in modern clinical and diagnostic procedures, they now do not dispense. The change from single-handed rural practices to the multi-partnership, means that these rural practices provide a supply-only function for NHS prescription medicines operating a Monday to Friday weekday office hours service. I personally happen to be on a rural doctor's list, but after much difficulty and pressure, I am on their prescribing and not dispensing list. Having been told that the book-keeper checks the prescriptions, need I say more?

These modern urbanised rural patients are thus being denied the benefits of a full pharmaceutical service as provided by both rural and urban community pharmacists. My local village pharmacy is only 300 yards from the surgery and every visiting patient has to pass it twice. Incidentally this pharmacy dispenses virtually the same number of prescriptions as the doctors' surgery.

Over 11 per cent of the total NHS drugs bill is spent with these rural doctors, which in reality means that tax payers, in general, and community pharmacy, in particular, are being deprived of funding to provide, enhance and develop the full pharmaceutical service and all its innovative new nuances.

In order that tax payers should receive value for money in the provision and supply of pharmaceutical services, it is my humble opinion that all rural GP practices that dispense, should

employ a registered pharmacist and the dispensing area be subject to the full vigour and scrutiny of the Factory and Shops Act, and Environmental Health and Safety rules, which already apply to all community pharmacies, which dispense the vast majority of the nation's NHS prescriptions.

#### **David Thomas**

*Patshull,  
Shropshire*

RICHARD WEST, chairman of the Dispensing Doctors Association, responds: I am disappointed by the tone of recent letters to *The Pharmaceutical Journal*. I believe that the professions had moved on and were now trying to work together to improve the service for all of our patients. It was only last month that Sue Sharpe, chief executive of the Pharmaceutical Services Negotiating Committee was warmly welcomed at the Dispensing Doctors Association's annual conference, where she gave the keynote address about working together.

There is no doubt that both professions have a small number among them who do not provide the level of service that we would all like, but the vast majority provide a service which is safe, convenient and cost effective to both the NHS and patients. We can all find anecdotes of this poor service, but this is not helpful in trying to improve the service. It is important that we all acknowledge the different strengths and weakness that both professions have and look to maximise the strengths and minimise the weaknesses.

I am aware that there are a growing number of dispensing practices that employ a pharmacist for the skills that they bring to improve patient care. This is around the whole area of medicines

management not just dispensing. The pharmacist is a valued member of the team.

It is important that both pharmacists and dispensing doctors ensure that people who perform medicines management tasks have the required competencies. The person's title is less important than their competency in performing these tasks. The new dispensing quality scheme has tried to make this process more open to external scrutiny than before. We need to recognise that with the changing NHS, there are tasks that were the sole preserve of doctors that are now being competently performed by others, including pharmacists. It is important that we have objective rather than subjective standards for competencies.

There are no special dispensations for dispensing practices with regard to health and safety regulations. The same standards apply to dispensaries and pharmacies.

Although it would be nice to think that if money is removed from one service it will be invested into another, my experience tells me that this does not happen. There is a lot of evidence that dispensing subsidises rural medical practice. If dispensing were removed then other medical services would suffer. The reconfiguration of rural services is worthy of debate but is a complex jigsaw. It is important we do not destroy the things we are trying to improve.

I am hopeful that both professions can move on from any past differences and try to work together to improve the patient experience wherever that is.

#### **Telephone number**

All correspondents should supply a daytime telephone number, in case we need to contact them urgently

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## ■ RETENTION FEES

**Supplementary prescriber fee**

From Mr R. Thompson, MRPharmS

I write to echo David Miller's comments (*PJ*, 9 December, p690) about the £35 annual retention fee for supplementary prescribers being a "kick in the teeth for those who have endeavoured to take the profession forward by additional study and practice".

Having qualified as a supplementary prescriber (SP) in September 2004, I gladly paid the £35 fee to have my entry on the Register annotated. I recall then that the fee was to be a one-off payment.

I have since practised as an SP for the past two years without being asked for an annual retention fee. That is until now. It seems that the Society has decided to move the goalposts without informing us beforehand, which seems a little underhand.

To my dismay, the letter asking for an SP retention fee blames things such as:

- Administration of the Register
- Preparation and updating of the curriculum for SP and independent prescribing
- Accreditation of university providers for SP and independent prescribing training for the costs

Is it not reasonable for these costs to be absorbed in my £283 annual pharmacist retention fee (a 6 per cent increase on last year's £267 fee)? It seems that I am paying for independent prescribing before I have even decided whether or not to complete the qualification.

All this from a Society that was of no help when I inquired about suitable additional indemnity insurance to cover me while working as an SP, yet would be quick to report me to the Statutory Committee in the case of an error. Will the Society rethink its decision?

**Richard Thompson**

*Chester-le-Street, County Durham*

**One-off fee**

From Mrs K. A. Liddell, MRPharmS

I have just received a fee demand for £35 to retain the annotation "SP" after my name on the Royal Pharmaceutical Society's Register.

I paid the fee when I qualified as a prescriber mid-way through this year, on the understanding that it would be a one-off payment. Less than six months later it appears I have to pay a further £35. As I am presently a non-practising SP I see no benefit in paying this fee at present. The letter I received from the Society did not state what the potential consequences of non-payment would be. I certainly would not like to incur the type of financial repercussions imposed on those who fail to pay their registration fees on time. Could someone please clarify the situation for me? Is there any incentive to pay now, or should I wait until I am going to use the qualification? Bearing in mind that I have to pay the fee myself, and that even when I am using the qualification, I will not be paid extra, my preference would be to keep my money until I have no choice but to pay.

**Karen Liddell**

*Glasgow*

PETER WILSON, head of the postregistration division at the Royal Pharmaceutical Society, responds: The fee for annotation of the Register for a supplementary prescriber was originally set as a one-off payment of £35. At that time we realised that independent prescribing was likely to be introduced and the regulation of prescribing by pharmacists would be subject to development. The Council considered the introduction of fees for independent prescribing earlier this year and decided to amend the fee for an annotation from a single to an annual payment. The first annual retention payment for prescribing annotations takes effect in the current retention fee round. It has always been the case that members who pay an annual registration fee in-year have to pay the full annual retention fee when this falls due at the end of the year.

We are currently working on new rules under the Section 60 Order to cover continuing professional development and annotations for advanced practice, including prescribing. These rules will include provision for non-payment of fees and also the requirements for return to practice (including prescribing practice) after a break in practice. Drafts of the rules will be made available for consultation before they are introduced. While a policy on pharmacist prescribers who fail to pay the annual annotation fee has yet to be agreed, the preferred solution in this case is for the

pharmacist to contact the registration division of the Society and ask for their annotation to be removed rather than allow their annotation to lapse.

## ■ THE SOCIETY

**Now is not the time to disengage**

From Mrs D. M. Eustace, MRPharmS

It would be understandable if many pharmacists were to disengage from any debate about the profession at the moment. With the pressure of increasing prescription volume in the community, Agenda for Change, public and political expectations and decreasing resources, it is easy to see why morale could be dwindling. Indeed the Royal Pharmaceutical Society's own research on workforce satisfaction, and reported at BPC 2006, shows that this is a reality.

The new English National Board will give pharmacists new impetus to press the case for pharmacists' contribution to the local health economy. Key answers here are independent prescribing, pharmacists with special interests and pharmacists' representation on both primary care and strategic health authority boards.

As a grass roots pharmacist, working in both in community, primary care and as a member of a primary care trust professional executive committee, I can see at first hand both the problems and potential solutions.

Under the "old" ways of commissioning services, primary care organisations have fallen into ever deepening financial difficulty. We all recognise the need to use other health care professionals — not just GPs — to provide essential services, either through redesigning existing, or through development of new, services. This will help balance the books as well as providing the best essential services for any local area. Pharmacists should be an integral part of this new method of commissioning in primary care, from prescribing through to delivery. The board must provide a strong voice for the varying sectors of our profession.

To minimise the threats and maximise the opportunities it is imperative that members remain involved with the future of their professional body.

Within the next few months, and following a thorough review of relevant issues, the Council will finally make a decision whether or

not the Society should split. However, it is the members who must enjoy the final say. We, the members of the Society must remain engaged with the debate to ensure that the right decision is reached for the future of our Society.

Pharmacy is at a critical point in its history. There are many decisions to be made, but each individual pharmacist must take responsibility for the future of our profession, and remain engaged. Let us not abdicate our responsibility to own our own future. Now is not the time to disengage.

**Davan Eustace**

*Member of the Royal Pharmaceutical Society's Council  
English National Board Election  
Candidate*

**How many fellows have we lost?**

From Dr W. F. H. McLean, FRPharmS

I was saddened to read that the Royal Pharmaceutical Society may be "deprived of the company" of yet another distinguished, erudite supporter of the profession (Bruce Rhodes, *PJ*, 11 November, p574). In the same issue (p576), the "Workforce update" does not detail the number of fellows who have left the Register in each of the listed years (2003–06). Can these figures be made available, please, so that the membership can make a more informed judgement on the effects of the Society's Council policies over recent years?

**W. F. H. McLean**

*Waterlooville, Hampshire*

ANDREW GARDNER, head of registration at the Royal Pharmaceutical Society, responds: The number of fellows on the Register is usually published as part of the "Annual registrar's report", sent to all registered members and fellows. Over the past few years the reports show a steady decline in the number of fellows at about 10 per cent per year.

The total number of fellows reported as no longer on the Register includes those who die or who are removed from the Register. The figures for those who are recorded as having left the Register voluntarily are: 1 January to 31 December 2003, 19; 2004, 47; 2005, 81; and 2006 (to date), 59.

There are 711 fellows on the Register to date.