

■ SAFETY

**Risk management**

From Mr A. J. Jukes, MRPharmS

It is a requirement for us all under the "Standards of professional performance" in the Code of Ethics to be concerned primarily for the wellbeing and safety of patients and the public. However, I think across the broad area of services in community and hospital pharmacy, this is becoming an increasingly difficult concept to adhere to.

There is a multitude of diverse processes affecting the ability of hospital and community pharmacies to manage their workloads effectively and safely, and it is time that someone started to look seriously at how such factors are putting patients at risk and do something to effect some change.

In the hospital sector there may be miscommunication within the system that means that pharmacists spend a lot of time contacting prescribers and wards for details that should be mandatory on prescriptions. The turnover of patients is high and there is only a short time to complete a large number of discharge prescriptions with little communication from wards. Hence these prescriptions are not being processed with maximal efficiency.

Financial pressures have caused a fall in staffing levels and this is definitely impacting on effective risk management, despite systems being in place. Colleagues have mentioned that they have had to cover 30 beds in 20 minutes in some hospitals and I would question whether a pharmacist's eyes have time to focus on the ink let alone provide pharmaceutical care in that time. The whole system is at breaking point but the impact on a pharmacist being able to give good quality care and follow the standards of professional performance is questionable.

In the community sector, the introduction of new service provision, increased prescription volume and an ever-demanding public mean that pharmacists can be divided between tasks which increases the risk of them making a mistake.

In both sectors there needs to be a rethink and honest assessment of whether we are compromising patient safety. The low staffing, lack of sufficient work breaks and lack of time to do tasks properly against higher patient demand is an accident waiting to happen. I applaud the Pharmacists' Defence Association for its work on work

breaks and support staff but there needs to be more done to address these issues because they are impacting directly on the risk management of processes affecting patients and our "standards of professional performance".

I realise some of the solutions are complex and involve government-directed organisation of health care trusts and retail service contracts but, surely as a profession we need to do our part in responding to these increasing pressures in order to achieve safe working practices.

**Andrew Jukes**  
 Brighton

■ SUBSCRIPTIONS

**Athens password is key**

From Mr S. R. Whelan, MRPharmS

I would like to add to Bob Dunkley's letter (*PJ*, 17 February, pg187) regarding subscriptions to major medical journals. I, too, access the major journals such as the *BMJ* as part of my continuing professional development. Not only does this give me access to a wide range of original research papers but also an opportunity to see practice issues from the viewpoint of other health professionals.

The expense of this may be less than Mr Dunkley realises. By registering for an Athens password through the NHS electronic library for health, full access to many of the major journals can be obtained (*BMJ*, *JAMA*, *Lancet*, etc).

Registration for an Athens password can be made at [www.library.nhs.uk/athens](http://www.library.nhs.uk/athens). This service is made available to those

professionals working in the NHS and we, as community pharmacists, providing ever-expanding, front-line services, should use resources such as this to provide first-class patient services.

**Sean R. Whelan**  
 Skipton, North Yorkshire

■ COMMUNITY CONTRACT

**We are good value**

From Mr C. Morris, MRPharmS

I refer to the article regarding the review of the new contract by the Department of Health (*PJ*, 10 February, p154). I feel slightly worried that the emphasis being made is to show what good value pharmacists could be to beleaguered primary care trusts. Of course we are good value: we have had to do more work (eg, medicines use reviews) just to get the money that we received before and PCTs, that I am aware of, laugh at the idea of pharmacists providing extra services since they have no money to pay for them.

I agree that we could prove a cost efficient asset to the NHS. After all, if pharmacists can keep their heads above water on the amount that they are paid then they should be able to sort out ways to save their PCTs a lot of money. Maybe this time we could get paid for any extra little jobs that might get added to the contract?

These views are my own and not those of the English Pharmacy Board, but I will be suggesting that this DoH review should be one of the EPB's priorities.

**Chris Morris**  
 Newquay, Cornwall

**Letters to the editor**

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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.

■ STATINS

## Switching is based on evidence

From Dr B. P. Curwain,  
MRPharmS

I would like to reply to some points made by John Woodward (*PJ*, 17 February, p188). Of course I am interested in saving money, not so much for the taxpayer, as Mr Woodward suggests, but so that it can be reinvested by the primary care trust into other local health services for which there is a clear need. There is currently a debate over whether the extra investment made by our Government in the NHS is actually resulting in better health care. Thus, measures that increase the efficiency with which all care, including medicines use, is delivered, are both timely and important. I repeat that we have never, and would never, recommend switching medicines if there has been, or was, any decent scientific evidence that it would lead to poorer care. I can reassure him that many of these decisions no longer lie in the hands of PCTs since we now have a set of national indicators, backed and researched

by the central NHS, called "Better care better value". The use of low acquisition cost statins included in this set and PCTs will be assessed on their performance. The National Prescribing Centre is producing a "toolkit" to help PCTs make the change.

Mr Woodward implies that to do anything that is against the wishes of consultant cardiologists (in North Staffordshire) is wrong. He also asks why I do not leave these decisions in the hands of health care professionals. My medicines management colleagues and I are health care professionals and, in this case, the relevant expertise is in the interpretation of the evidence base. Being a specialist physician or surgeon is no guarantee that one has this skill. There is, after all, the first law of expertise which states that for each expert, there is an equal and opposite expert. My own experience is that the views of consultants in, eg, Bournemouth, Southampton and Salisbury hospitals will not always coincide. That is why we rely on expert appraisals of the evidence, written by highly trained and skilled NHS personnel. Our local district prescribing committee, consisting

largely of health professionals from four pre-October 2006 PCTs, two major hospitals and the mental health trust, makes such decisions based on the best evidence available.

There is of course a hierarchy of evidence that determines the weight that it is given. At the top of this is a meta-analysis of well-conducted randomised controlled trials. A single letter to *The Lancet* would carry much less weight. It is also worth remembering that many doctors in secondary care have significant relationships with the pharmaceutical industry, receiving support for research and clinical work, as well as funding to attend international conferences. There is nothing wrong with this as long as it is transparent and all possible conflicts of interest are declared, especially when attending prescribing committee meetings or publishing letters and articles. The industry spends a lot of money supporting opinion-leading clinicians and it would, in my opinion, be naive to imagine that it is done entirely out of altruism.

**Brian Curwain**  
Chief Pharmacist  
Hampshire PCT (West)

■ RETENTION FEES

## Rubbing salt in the wound

From Mrs M. J. Bradley, MRPharmS

I am writing in support of Clare Mackie and her colleagues (*PJ*, 17 February, p190). I am also writing on my own behalf as a supplementary prescriber to ask the Royal Pharmaceutical Society to reconsider the extra fees allocated to pharmacists on the prescribing register.

I have not heard of one prescribing pharmacist who has received a pay rise as a result of their hard-won qualification, mainly undertaken in their own time. In fact, due to the vagaries of Agenda for Change, I have had a pay cut of about £144 per annum.

To ask me to pay extra on top of everything else is just rubbing salt in the wound and sometimes I wonder why I am bothering to undertake the independent prescribing conversion course in case I am asked to pay even more in the future.

**Marian Bradley**  
Sutton Coldfield, West Midlands

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