

■ WHITE PAPER

Council motion

From Mr J. Gentle, MRPharmS, and Mr A. C. Gush, MRPharmS

The following motion has been submitted for debate at the May Council meeting: "This Council believes that as soon as possible the Society should begin a process to enable it to recognise affiliate bodies whose members benefit from paid services agreed to be provided by the Society."

We hope that the debate will take place in the public part of the meeting and will ask for a named vote so that the members will be able to see how each Council member has voted.

We have been prompted by recent letters from Council members in *The Journal*, suggesting that there are different views on this matter and that a debate is in progress. There is a feeling that this should be conducted openly and that pharmacists have a right to know which Council member believes in which position. The aim will be to reassure the membership that the Council has their interests at heart and that pharmacists will retain the pre-eminent role in any body akin to a royal college.

The relationship with support staff will need to be arranged in the longer term and the solution is not clear cut but, along with other non-pharmacists, it is hoped that a close working relationship will be established so that on many policy issues, a united front can be developed.

A royal college-type body would want to include professionals in the pharmaceutical sciences when developing policy and an inclusive approach will be

sought, but the post-nominal MRCPPharm, for example, should be reserved for pharmacists.

While the Council will lead on developing such policies, the membership will have the final say on composition of the college.

John Gentle
Andrew Gush
Members of Council
Royal Pharmaceutical Society

What is going on?

From Mr B. J. Clarke, MRPharmS

I am extremely concerned that both undue speed and a high level of secrecy are being imposed with regard to the formation of the new pharmacy bodies. What is the reason? Why is so much pressure being put on the Royal Pharmaceutical Society to act so quickly? Why are Council members not being allowed to discuss openly matters arising from the White Paper until they are given clearance by the Department of Health?

The changes that are being undertaken will have significant effects for both patients and the profession. It is essential that the new structures are properly thought out. This can only be achieved if there is free, frank and open consultation and discussion. This will take time and surely it is much more important that this is done properly than that it is done quickly. At the March Council meeting, Bob Michell expressed eloquently the dangers of haste by looking at the track record of the Department of Health (*PJ*, 14 April, p436). Bad decisions made now could have serious consequences for the future of pharmacy.

The new regulatory body will undoubtedly have to conform with government requirements. Nevertheless the Society has a great deal of experience and expertise in this area and it is surely in the public interest that such experience and expertise is fully used. This will take time.

If there is too much pressure for speed then errors and omissions are more likely to occur. The way that pharmacy is regulated will have many consequences, both professional and financial, and it is extremely important that there should be openness about what is being proposed so that a proper discussion can take place.

My particular concern is with regard to the new body to represent pharmacists, that is being referred to as a royal college-type body. In my view it is absolutely essential that every member of the profession has the opportunity to have access to all the information available. Council members should be free to discuss openly all such matters. Only then are we, the members of the profession, able to make appropriate comments and draw proper conclusions. Why is there any need for secrecy? What is it that we are not to be told and why? What has the Department got in mind?

I would strongly urge all pharmacists, whatever their views on the Society, to get involved. So-called consultation that is really only about explaining decisions that have already been made is of no use.

We need to take part in the process from the beginning; we must be allowed to decide the sort of body that we want.

Barry J. Clarke
Epworth, Doncaster

GRAHAM PHILLIPS, member of the Royal Pharmaceutical Society's Council, responds: Mr Clarke is right to call for all members of the Society to take part in the debate about the future of the profession and the proposed royal college-type body that may result from the recent White Paper on health regulation.

To that end the Society is making plans to stimulate debate and seek views from each and every member. These plans include speaking at branch meetings, a special section on the Society's website (where we plan to post a short questionnaire), regular e-mail alerts to the 20,000-plus members who have signed up to the myRPSGB section of the website, updates through regular briefings

for the press by the President and a series of road shows around the country for members.

Last week, I addressed a meeting of approaching 100 members at a west London branch meeting, and the overwhelming feeling about the changes proposed in the White Paper was positive. The General Pharmaceutical Council is not something that is open to debate. It is government policy and, therefore, out of the profession's hands. But we do have the opportunity for a truly open debate about how we establish our own professional body in the form of a royal college and there is plenty of time for this.

If the column inches in *The Journal* and other pharmacy publications are anything to go by, there has been a lot of information — but maybe not as much as we would all have liked — about White Paper developments in the public domain. Abiding by government confidentiality rules is just something we have to live with. By convention, advice to ministers is confidential, and it was the Government, not the Society, which set the timetable. The Council has shared what it has been able to within the limits of these restrictions, while trying to advance the interests of members and the profession as a whole.

Finally, I cannot overemphasise the opportunity afforded by modern technology for every member to take part in this debate. Readers who have not already done so, are invited to sign up to myRPSGB at: <https://my.rpsgb.org/login/>

Let us have a party that reflects and supports all of us

From Mrs J. Maiden,
RegPharmTech

The following is my reply to Jonathan Buisson's invitation to the royal college party for pharmacy (*PJ*, 28 April, p484): Thank you for the invitation. I am bringing a Party Seven and a few bottles of Babycham for colleagues like Andrew Gush, who think "we both have key and distinct roles within pharmacy" (*PJ*, 28 April, p485). I could reminisce with them, about when pharmacy was clear cut and they guarded the nitrazepam while I wielded a mean spatula.

Life, however, seems to have moved on. Looking around today, most jobs within our profession blur the boundaries of what was previously another's. Evolution, by

Letters for publication can be posted, faxed, or sent by e-mail to letters@pharmj.org.uk and should not normally be of more than 400 words and should cover one topic only. *The Journal* reserves the right to abridge letters and to edit them for clarity and style. Pharmacist correspondents should supply their membership numbers and a contact telephone number should always be given. Women correspondents should specify a preferred title otherwise "Ms" will be used.

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.

definition, will not end so let us have a party that reflects and supports all of us.

Juliet Maiden
Stafford

Blind acceptance of a royal college-type body

From Mr W. A. Baker, MRPharmS

The Royal Pharmaceutical Society as presently constituted has, broadly, five main areas of activity: regulatory, educational, publishing, professional (representing the views and interests of pharmacists) and looking after the health and welfare of pharmacists and their dependants. In recent years, the Society has put almost all its efforts into the first two of these activities — this is a reason why the Society is so unpopular with so many members and why members are not happy to pay so much in fees.



Telephone number

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

Now, the Government, in its wisdom, has decided that the regulation of pharmacists should be given to a new body, a General Pharmaceutical Council. This is the prerogative of Government and, presumably, legislation to effect this will be promulgated. The White Paper also suggests that a new royal college type body should be set up. Unless the Government intends to set this up through legislation (which appears not to be the case), why has it made recommendations regarding the future of what is left of the Society? Surely this should be left to the members of the Society to decide.

I note that the President has written that the Council has pledged to work with other pharmacy bodies to help to create a royal college for the pharmacy profession (*PJ*, 14 April, p417). This is in advance of discussions by its members at a general meeting. What seems to have happened is a blind acceptance that if the Government wants a royal college-type body it must be obeyed, even if we disagree.

Why do we need a such a body when we already have the Society? Surely it is not being proposed that this should co-exist with the new

body? The most logical way forward surely is to maintain the Society (including its assets), and just strip out the regulatory aspects. This in fact could be a great opportunity for the profession; we should then be able to oppose excessive legislation that is against the interests of pharmacists, spend more time on promoting the profession, and better look after any pharmacist who is ill or in trouble.

A college would be difficult and troublesome to set up and almost certainly be more interested in education rather than in looking after interests, professional and personal, of pharmacists. Pharmacy technicians already have their own association looking after their interests so should this should not present a problem.

Long live the Royal Pharmaceutical Society!

Arthur Baker
Stockport, Cheshire



E-mail

E-mail correspondents are asked to give a full postal address or membership number

■ MURS

It does not take a £25 MUR to identify problem

From Dr J. A. Harding, MRPharmS

I read the letter from David Jenkins (*PJ*, 28 April, p486) with interest. I suggest to Dr Jenkins that it does not need a medicines use review costing £25 to identify that Patient B, who had been taking clopidogrel and aspirin for three years, may be at serious risk of a gastric bleed. Responsibility for prescribing rests with the prescriber, but I believe that a pharmacist who dispenses such a combination without consideration of the appropriateness of the drugs is not acting in the patient's best interest and may indeed be contributing to a potential patient safety incident.

Essential service 1 is designed to improve quality of the dispensing service and reduce risks to patients. Let this be used to best advantage and all will benefit.

Jenifer Harding
Assistant Director Medicines
Management
Sandwell Primary Care Trust

■ MURS

We probably all do MURs to a level we are comfortable with

From Mr P. Melnick, MRPharmS

I read David Jenkins's letter (*PJ*, 28 April, p486) with particular interest because I have been in similar situations.

At first sight, I would support his view that in the strictest sense one could not comment about Patient B who had been taking clopidogrel and aspirin for three years because it would be beyond the scope of a medicines use review. But what if the patient subsequently had a haemorrhage? Could we be sued for failing to flag up a potential problem? Are there not parallels here with the Migril case? And what if we had raised the issue with the prescriber previously but that fact had not been recorded either at the surgery of the pharmacy?

I suspect that we probably all do MURs to a level we are comfortable with and I have previously approached this problem more obliquely by noting on the MUR form that I had counselled the patient to report any unexplained bruising, stomach pain or black stools promptly.

Perry Melnick
Ilford, Essex

■ DISPENSING ERRORS

Society's new criteria brought into question

From Mr P. Walton, MRPharmS

I read with renewed concern the criteria that the Royal Pharmaceutical Society's Council has agreed for dealing with one-off dispensing errors (*PJ*, 14 April, p435). Are there any full-time practising pharmacists (especially in a busy pharmacy) who can hold up their hands and volunteer that they have only ever been responsible for a single error or less in three years? I suspect that there would be no pharmacist who could and, if my suspicions are correct and pharmacists tell the truth, they could put themselves and their careers immediately at risk by logging errors.

The criteria with respect to misconduct need to be looked at in conjunction with the criteria for criminal proceedings, and guidelines make little sense if errors that are not looked at by the

Statutory Committee are then looked at in a criminal context.

Asking pharmacy personnel to complete logs is effectively asking them to incriminate themselves, which in most circumstances would be inadvisable. There seems to be no exemption from referral for misconduct even when the prime cause of the error is well known or has previously been reported and is correctable but has not been corrected. Earlier this year, I wrote a letter to *The Journal* regarding decriminalisation (13 January, p47) in which I asked "What use is reporting dispensing errors if nothing is then done?". The content would still be true if I had written it today.

I have heard of a company disciplining a member of staff who reported minor errors where there was a well known cause, even though the error had been corrected before the medicine was being dispensed. (It was in the protocol that such potential errors were reported.) The error was taking from shelves boxes that looked similar but contained different medicines.

Nobody seems to want to take pharmaceutical companies to task for their desire to have a unified image, colour scheme and logo on their product. Yet this a contributory factor in dispensing errors and has caused concern for many years. Of course a pharmacy company sees logs of errors and can dismiss or otherwise punish personnel, even when its own actions or negligence may have contributed to the errors.

There is nothing in the Society's criteria stating staff have to log preconditions likely to cause error but which have not resulted in actual error. How many pharmacists have walked into intolerable dispensing conditions, and possibly even complained about the conditions to the company (with risk to their own job) — without a log of the complaint having to be made? What is needed is an independent complaints body that employees can use to protect themselves from the actions of their employers, otherwise the employers could effectively deal with logged problems and potential problems by removing or otherwise demoting any member of staff who reports or complains.

I suspect that the criteria for misconduct were devised by pharmacists who do little dispensing themselves and so are unlikely to be at the receiving end of any consequences. For the reasons elucidated above these

criteria represent the antithesis of the no-blame or fair-blame culture.

Philip Walton
Manchester

The Royal Pharmaceutical Society declined an invitation to respond.
— EDITOR.

■ CHEMOTHERAPY

More and more cancer patients are likely to receive chemotherapy outside hospitals

From Mr T. R. Root, MRPharmS, and Mr A. L. West, MRPharmS

We note the letter from John Murphy (*PJ*, 21 April, p457) drawing attention to two deaths after misinterpretation of the Z-DEX protocol for the treatment of myeloma led to three patients being prescribed a four-fold overdose of idarubicin.

It is, of course, of great concern that an error of this sort, which is well documented, not least as the cause of the much publicised death of Betsy Lehman, a reporter on the *Boston Globe*, who died at the Dana Faber Cancer Institute in the US in 1994, has occurred again not once but three times.

Our main point in writing, however, is to draw the attention of colleagues to the work of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD). This is an independent organisation mandated by the Department of Health and the General Medical Council to review clinical practice in the NHS and independent health care sectors and to make recommendations for improving quality of care. More information can be found at www.ncepod.org.uk.

We particularly want to take this opportunity to highlight that NCEPOD is presently conducting a study into cancer chemotherapy-related deaths in England and Wales. From its inception in 1990, NCEPOD's focus has been on surgery: it has not previously studied medical treatments and hence has not worked directly with pharmacy staff. During the course of planning and launching the chemotherapy study earlier this year, it has become apparent to us that many pharmacists are unaware of NCEPOD and its important role and we believe it is important to try to remedy this.

We would also like to draw attention to a collaborative project due to be initiated soon between the National Patient Safety Agency and the DoH Cancer Action Team on managing the risks of cancer chemotherapy. The recent publication of the "Safety first" and "Safety in doses" reports, establishment of the National Patient Safety Forum and of strategic health authority-based patient safety action teams, have all raised the stakes for the patient safety agenda in general and for medicines safety in particular.

Changing models of care mean that in the near future more and more cancer patients are likely to receive anticancer treatment, including cytotoxic chemotherapy, outside hospitals, on which almost all of our current risk management strategies for these treatments are based. The pace of innovation and development of new treatments means that more anticancer medicines will be given orally and over many months or years; some may well, in due course, be prescribed by GPs and dispensed by community pharmacists.

If these new models of care are to be achieved safely it is essential that all pharmacists are aware of the issues involved and are actively engaged in the risk management agenda. Effective engagement must be based on a comprehensive awareness, knowledge and understanding of the wider patient safety agenda and all its stakeholders.

Tim Root
Specialist Pharmacist, Clinical Governance and Technical Services Chelsea and Westminster Hospital
Tony West
Chief Pharmacist Guy's and St Thomas's Foundation Trust, London

■ MEDICATION REVIEW

Pharmacists can potentially prevent hospital admissions

From Mrs C. A. Brown, MRPharmS

In response to the results of the POLYMED trial (*PJ*, 7 April, p387), which showed no clear health gain, no difference in hospital or care home admission but a slight decrease in the mean number of prescriptions per patient, I would like to describe a domiciliary clinical medication review service undertaken in a practice in South Huddersfield

which, in contrast, showed clear health gains.

This was a service to housebound patients. Most were over 75 years of age, and many had multiple conditions and complex needs. The objectives of the service were to improve patients' understanding of their medicines, to increase adherence and compliance, to optimise the medication prescribed in a cost-effective manner and to reduce waste. The patients for review were selected by GPs and the pharmacist had full access to patients' notes.

The reviews were face-to-face clinical medication reviews; a holistic review of the patient, drawing together medication (including over-the-counter medicines and homeopathic and herbal medicines) prescribed by a variety of practitioners, and incorporating lifestyle and social issues in relation to his or her medical conditions. On returning to the surgery, patients discussed the reviews with their GPs and suggestions were actioned. The pharmacist entered the medication review in the patient's electronic notes.

One hundred and seventy-five patients were reviewed annually. Outcomes were measured by classifying the medication changes, noting referrals, and costing increase and decrease of prescribing.

An average of three clinically significant interventions were made per patient and over 95 per cent of changes were accepted by the GPs. There was a net reduction in cost of medication. A panel of GPs critically assessed a cohort of 32 patients and, in their opinion, six potential admissions had been prevented, the annual medication costs saved were £2,956 and the cost of medication initiated was £2,177.

Taking into account potential admissions and GP time saved, reduction in medication costs and pharmacist time the overall cost saved per domiciliary visit was £536.

Feedback from questionnaires to patients and GPs showed great enthusiasm for the service. The initial objectives of the service were met but there was a secondary outcome of potentially avoiding hospital admissions, which is now a key objective in practice-based commissioning. The service required the clinical pharmacist to be integrated within the existing medication review system and involved building relationships with a range of other health professionals.

The ideal requirements for a pharmacist medication review to be clinically effective are a face-to-face review with the patient and full access to the patient records. The pharmacist should have appropriate clinical training and be working within an integrated medication review system with other health professionals.

Use of a clinical pharmacist for domiciliary medication review maximises the use of skill mix within the primary care team and improves health outcomes for elderly patients with long-term conditions.

Carole Brown

*Domiciliary Review Pharmacist
Calderdale Primary Care Trust*

■ PFIZER

A word of warning

From Mr P. R. Rodwell, MRPharmS

A word of warning to your readers: find out your Pfizer credit limit. If pharmacists overspend their limit Pfizer will put their accounts on hold without warning.

This happened to me over Easter while I was away and could not be resolved for the best part of 10 days. Fortunately UniChem (my primary wholesaler) was able to find a solution of sorts. Cash flow and funds are not an issue.

As for Pfizer, it did not want to know. It does have a monopoly I suppose.

Paul Rodwell

*Wallingford,
Oxfordshire*

DAVID WATSON, head of trade at Pfizer, responds: Pfizer's new distribution arrangement has been designed to be as simple and straightforward as possible. We have a responsibility to make sure that our prescription medicines are being distributed in the correct manner and sold according to our terms and conditions. As part of the development of our new arrangement, we will do our best to notify customers directly in the event of there being any credit issues. These scenarios are rare. If we think there is a legitimate reason to put an account on hold, we will aim to resolve the issue and reinstate the account as quickly as possible. We are committed to ensuring the best possible service to our customers. Pharmacists who would like to speak to Pfizer about any aspect of the service can call the Pfizer team on 0845 6088866.

Correction

The second sentence of the third paragraph of Carole Browne's letter (p524-5) should read: "On returning to the surgery, pharmacists discussed the reviews with the GP and suggestions were actioned."

■ LOCUM PHARMACY

Signing standard operating procedures could affect locums' pockets

From Mr A. Matalia, MRPharmS

In response to Peter Bremner's letter (*PJ*, 21 April, p458), signing standard operating procedures may well compromise a locum's deemed employment status and could increase his or her tax liability. One needs to consider tax legislation known as IR35. This is a mechanism by which HM Revenue & Customs (HMRC) closed a loophole that enabled many contractors and freelance professionals (particularly in IT) to avoid paying large amounts of tax and national insurance.

Before IR35, such workers would use personal service companies, partnerships and composite companies (referred to as "intermediaries") to reduce their tax and national insurance contribution liabilities. Some companies invoice on behalf of locums for a 5 per cent cut of their income. Locums become

employees of the umbrella company and, as well as paying less national insurance, can take advantage of "unreceipted dispensations", enabling them to claim food expenses of around £6,000 a year (in addition to mileage expenses and other expenses), which means they do not pay tax on £6,000 of their income.

In addition, workers who owned their own companies were allowed to receive payments from clients direct to the company. Company profits could be distributed as dividends, which are not subject to national insurance contributions. Workers could also save tax by splitting ownership of the company with family members in order to place income in lower tax bands.

IR35 deemed that, if an intermediary was used and the employment relationship between the worker and his client would have normally been direct employment, the worker would be classed as a deemed employee of the business for tax purposes and should pay tax and national insurance like any other employee. There have been battles between contractors and HMRC over what

constitutes a real business. Vital aspects have been mutuality of obligation, control of the worker and substitution (where the locum can send someone else to do a job in his place). By signing an SOP one could argue that a pharmacist agrees to work in a particular manner. This could be construed as control and render the locum an employee.

Besides, why should a locum have to sign an SOP? If someone requests he read it, he may well do so. Is a pharmacist's word that the SOP has been read not good enough? Is he not supposed to be a "professional"? To protect their self-employed status locums should never agree to comply with SOPs or sign a statement that they have read them.

Some believe that locum pharmacists should be deemed employees: they cannot, generally, determine hours of work and they seldom use their own tools. If they have a genuine right of substitution, is it ever invoked? Is the way locums work different to employed pharmacists? What are the distinguishing factors? I have read arguments that locums should only dispense and provide professional advice — they should

not cash-up, prepare end of month paperwork or replenish stock for these are activities of employees.

In reality, locums tend to work to the protocols of each pharmacy they visit. Thus, they submit to an element of control and HMRC could, under IR35, argue they are deemed employees for tax purposes. A locum should take professional advice before signing an SOP.

A. Matalia
Coventry

Ownership change?

Transferring the ownership of a registered pharmacy premises? Remember that you have a legal obligation to update the Royal Pharmaceutical Society. Contact the Society's registration section (tel 020 7572 2322; e-mail registration@rpsgb.org) for an application form or download a form from the registration section of the Society's website (www.rpsgb.org/pdfs/reg_premB.pdf).

Advertisement