

■ WHITE PAPER

Teaching pharmacies are a crucial innovation

From Professor S. Dhillon, MRPharmS, and others

We applaud England's chief pharmaceutical officer Keith Ridge and his team for achieving publication of an undoubtedly visionary pharmacy White Paper. This is an exciting development for the profession and very timely given the ongoing changes at the Royal Pharmaceutical Society and in the wider NHS.

We endorse the call for schools of pharmacy, contractors and pharmacy organisations to come together at a local level to translate the White Paper's priorities into actions.

It is clear there are a number of challenges, not the least of which is the need to influence NHS commissioning processes. This requires negotiation with practice-based commissioners to enable implementation of improvements in access to healthcare and to enhance the management of long-term conditions.

Key elements of the new White paper will require joined up work and local collaborations. Locally in Hertfordshire we welcome this, and have piloted a new model for a teaching community pharmacy which benefits both academia and practice. Our model, developed over the past two years, has included supporting community pharmacists as placement trainers, implementing new service models such as community pharmacy diabetes programmes, providing targeted education and setting up a research infrastructure to evaluate the impact of the model.

It is clear to us from this joint work that development of the model to date has relied upon vision and goodwill and that an injection of appropriately targeted resources will be crucial if the model is to be rolled out. If this is enabled, we are confident that by mobilising local expertise we can translate policy from paper into action.

The opportunities to embed and enhance pharmacy education presaged by chapter 7 of the White Paper will be critical if pharmacists are to deliver the vision. We must build upon the established postgraduate educational framework at certificate and diploma level to provide a platform of short courses through innovative blended learning technologies to advance clinical skills training and

development. At the University of Hertfordshire, the school of pharmacy is engaging with the Higher Education Funding Council for England blended learning fund which the university has acquired to work closely with stakeholders in both hospital and community on such developments. These will be reflected in our short course portfolio to meet stakeholder needs.

We are sure that the Joint Programmes Board (chapter 7, p91) will bring together the specific strengths of all schools of pharmacy to support the much needed advanced education and training framework.

In addition, now is the time to advance discussions with local deaneries to implement interprofessional learning in key priority areas such as patient safety and the management of long-term conditions. The creation of our new leadership body is another exciting development and has a clear mandate from the department to take pharmacy forward in the 21st century.

**Soraya Dhillon
Stephen Curtis**

School of Pharmacy, University of Hertfordshire

Graham Phillips

Manor Pharmacy Group (a University of Hertfordshire Associate Teaching Community Pharmacy), and member of the Royal Pharmaceutical Society's Council

■ COMMUNITY PHARMACY

Excessive workload

From Mr M. Koziol, MRPharmS

Many letters have recently expressed alarm about excessive workload and insufficient staffing levels, particularly in community pharmacies.

Andrew Jukes (*PJ*, 15 March, p305) alluded to the fact that the Pharmacists' Defence Association has done work on this subject. The PDA has produced a policy document and has proposed a relatively simple quality management system as a practical solution. However, for this practical solution to work, it would require the regulatory support of the Royal Pharmaceutical Society.

Despite numerous meetings with the PDA over more than two years, the Society's directorate of practice and quality improvement has failed to act, claiming there is insufficient evidence that staffing

levels and excessive workloads are a problem in community pharmacy.

I hope that the director of practice and quality improvement has been reading his *Journal* these past few weeks for, if he has, then perhaps he can be persuaded to change his mind.

Any pharmacist or employer interested in the details of the PDA's proposal on how to create a staffing level policy for a pharmacy can find this at www.the-pda.org.

Mark Koziol
*Chairman
Pharmacists' Defence Association*

DAVID PRUCE, director of practice and quality improvement, Royal Pharmaceutical Society, responds: We were aware of the concerns of members regarding excessive workload and poor staffing levels when the code of ethics and standards was redrafted. The professional standards for pharmacists and pharmacy technicians in positions of authority therefore deals specifically with this.

These standards say that pharmacists and pharmacy technicians in positions of authority must ensure that "appropriate policies for the number and required experience levels of staff for the business or department(s) they manage are in place and are made known to relevant staff".

The document goes on to say that these people must ensure that, "working conditions and practices are lawful and resources, facilities and equipment enable staff to provide services to professionally accepted standards".

It also states: "Staff are able and

encouraged to take appropriate rest breaks. When agreeing working hours and rest breaks with employees you must take into account legislative requirements, individual requirements for breaks and the needs of patients."

We make it clear that a failure to adhere to the standards could result in a complaint being made against an individual.

A disciplinary case against a superintendent, a pharmacy owner or a manager requires evidence that can be presented to the Investigating and Disciplinary Committees. We have asked the PDA to share any specific examples that it has with us that could result in a disciplinary case.

The PDA has produced a policy statement suggesting that each pharmacy should have a satisfactory staffing level policy agreed in an open and transparent manner. We endorse this and, indeed, the standards above require that such policies are in place.

We have some concerns about the tool advocated by the PDA in its policy document. While it attempts to measure workload, it does not provide a means of relating this information to appropriate staffing levels. We would need to be sure that the tool is valid and usable before we could recommend it to the profession.

If readers have developed a validated tool that can be used to assess workload and appropriate staffing levels, please share it with us. We are keen to work with any professional colleagues on ways in which the requirements of the code of ethics can be fulfilled. Please contact david.pruce@rpsgb.org.

Letters to the editor

Letters are welcome from all readers. 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 and registered pharmacy technician correspondents should supply their membership numbers, and a contact telephone number should always be given.

All letters are considered on their merit and 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. Further to a recommendation by the Journal Oversight Board (*PJ*, 1 March 2008, p244), pharmacists and pharmacy technicians whose names appear on the non-practising part of the relevant register are asked to make their status known.

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.

■ DOMAIN NAMES

Rival bought domains with pharmacy name

From Mr A. K. Jhalley, MRPharmS

As an independent pharmacy contractor, I intended to advertise my services on the internet through creating my own website. On trying to purchase a suitable domain name, I found, to my astonishment, that a local contractor had purchased six domain names with the name of my pharmacy. Is it unethical to purchase domain names of local contractors in an attempt to prevent them from opening up their own website?

Ashok Jhalley

Morecambe Bay Chemist,
Morecambe Bay,
Lancashire

JEREMY HOLMES, Chief Executive and Registrar, Royal Pharmaceutical Society, replies: Disputes regarding internet domain names can be resolved in a number of ways. For instance, the aggrieved party may decide to contact the legal owner of the

domain name in an attempt to resolve the dispute by way of a negotiated settlement. Alternatively, an individual may consider legal action or the use of domain name arbitration proceedings.

Nominet and ICANN, for example, both operate domain name dispute resolution services. Information about these organisations is available on the web.

The Society is of the view that the registration of domain names in the circumstances outlined does not breach guidance in "Medicines, ethics and practice — a guide for pharmacists and pharmacy technicians".

■ MINOR AILMENT SERVICE

Pharmacists have role as clinical practitioners

From Mr A. I. Mackinnon,
MRPharmS

I have followed with interest the letters responding to Nadim Ali's letter (*PJ*, 8 March, p273) headed "medicines shopping list" and have been encouraged by many of the responses.

I would like to emphasise the original vision and policy intention behind the introduction of the minor ailment service (MAS) in Scotland. This core pharmaceutical care service was introduced to support the provision of direct pharmaceutical care on the NHS by community pharmacists to members of the public presenting with common illnesses and who are exempt from paying prescription charges. Improving access to consultations, advice and medicines for common illnesses was one of the key objectives.

The vision for this service has a number of important elements — namely, improving access to NHS services, highlighting community pharmacy as a first port of call for common illnesses, helping to address health inequalities and allowing community pharmacists to prescribe for minor ailments.

The focus of the service is the consultation itself, allowing the community pharmacist to give advice, treat if appropriate or refer the patient to another practitioner where required.

The MAS is an element of a much larger vision which, if we deliver, will position community pharmacists as clinical practitioners,

as public health practitioners and as prescribers. Positioning the patient at the centre of the pharmacy contract and delivering the pharmaceutical care the patient requires will allow community pharmacists to play an important role in improving the health of Scotland's people and then just maybe the true value of community pharmacy will be recognised by Government and rewarded and remunerated appropriately.

The MAS is not about fulfilling a medicines shopping list. It is about taking a step into pharmacy's future and grasping an opportunity. It is about using our expertise and clinical skills to improve patient care and reduce health inequalities and maybe, too, there is something in there about proving our worth.

The benefits of this core service are well recognised and, over the coming months, Community Pharmacy Scotland will explore the implications and opportunities for the service afforded by the phased abolition of prescription charges in Scotland.

Alex Mackinnon

Head of Corporate Affairs,
Community Pharmacy Scotland

Advertisement

■ ELECTRONIC PRESCRIPTIONS

Evaluate before roll-out

From Mr M. Bennett, FRPharmS

As someone who has eagerly embraced new technology throughout my career I find it rather uncomfortable to be writing what may appear to be a Luddite reaction to the electronic prescription service (EPS).

Last month, the Pharmaceutical Services Negotiating Committee distributed its guidance for contractors, which provides an excellent overview and I urge everyone to read it carefully. It can be downloaded it from the website at www.psn.org.uk.

Readers might then like to consider how this complicated system will work in a busy pharmacy, given the potential for the whole operation to come to an abrupt halt should a connection go down or power be lost. Finally, they can contemplate the benefits for all concerned and weigh this against the cost, potential disruption and the inevitable problems caused when patients are unable to obtain their medicines.

Before we rush, lemming-like, over the cliff can we have a properly evaluated trial in one primary care trust — preferably not mine — and only when all the problems are resolved consider rolling it out.

Martin Bennett

Managing Director
Associated Chemists (Wicker) Ltd,
Sheffield

■ HOSPITAL PHARMACY

Work together to raise standards

From Mr S. J. May, MRPharmS,
and Mrs C. Quinn, MRPharmS

We agree with the concerns raised by Llewellyn Baker about the often poor quality of communication between primary and secondary care at both hospital admission and discharge (*PJ*, 8 March, p275). He rightly states that many hospitals have taken significant steps to improve discharge communication.

Locally, Sherwood Forest Hospitals NHS Foundation Trust has developed an electronic discharge communication system that ensures legibility and enforces provision of some important information, such as medication changes and allergies. Feedback from both secondary and primary care has been extremely positive.

We have audited notes accompanying patients on admission to hospital from primary care and these, disappointingly, showed poor adherence to our expected standards. Working with primary care colleagues in North Nottinghamshire we have developed a proforma for completion by the admitting GP that will, likewise, help improve clarity and accuracy of information presented on admission to hospital. This can be generated electronically from the practice's computer system or paper copies can be completed by hand in the case of domiciliary visits. The new system is to be piloted in the near future.

Partnership working between primary and secondary care colleagues is essential to enable such improvements for the benefit of patients. We are sure similar strategies have taken place elsewhere in the UK; but if motivation is required, our early experience shows this initiative is helping to break down some of the barriers to effective communication across the interface, which can only have positive benefits for patient care.

Steve May

Chief Pharmacist,
Sherwood Forest Hospitals NHS
Foundation Trust

Cathy Quinn

Nottinghamshire Teaching Primary
Care Trust

■ PROCUREMENT

Instant magnesium sulphate infusion bags

From Mr U. M. Chouhan, MRPharmS

Magnesium sulphate infusion has many therapeutic indications, including arrhythmia, hypomagnesaemia and eclampsia. However, when it comes to prescribing the drug the doses are expressed differently. For arrhythmia, the British National Formulary (number 54) states the dose in millimoles while for prevention of seizures in eclampsia the dose is given in grams.

The matter is further complicated because the ampoules are labelled as a percentage of magnesium sulphate. Consequently, it is not surprising

that errors in calculation occur. In addition, preparation of infusions in clinical areas is a major contributor in incorrect dosing as exemplified by preparation of opiates and acetylcysteine.

The National Patient Safety Agency patient safety alert 20 issued in March 2007 recommends that a risk assessment of each injectable product be done together with the clinical area it is prepared in. Based on the risk assessment, the Welsh Aseptic Services and Production Pharmacists Group gave a high score for magnesium sulphate, suggesting there is a high risk that it could cause harm.

To overcome the problem, the pharmacy at Glan Clwyd Hospital has provided ready-to-use intravenous infusion bags since 2004, containing 80mmol (20g) of magnesium sulphate in 250ml sodium chloride 0.9 per cent. The bags are produced commercially and have a shelf-life of 18 months. Our commitment is to purchase the whole batch over the 18 months. However, due to increased production costs the price of the next batch will more than double.

The cost of each bag can be reduced by increasing the batch size. Our current usage level means the whole batch cannot be used within its shelf-life. At a batch size of 2,960 bags, the cost per bag would be £2.95 plus VAT. Glan Clwyd Hospital would use about 1,000 bags per year.

If there is a trust that would be interested in committing to purchase the balance of the prepared batch directly from the company, it can contact me at uttam.chouhan@cd-tr.wales.nhs.uk.

Uttam M. Chouhan

Principal Pharmacist (Clinical Services),
Glan Clwyd Hospital,
Rhyl, Denbighshire

■ EUTHANASIA

Hard cases always make bad law

From Mrs M. M. Mortimer,
MRPharmS

I am sorry for the wife of Bob Michell (*PJ*, 8 March, p272), but, as always, hard cases make bad law.

Hospital staff told me, on two occasions, that my husband would not live, so I was grateful when they persisted in their efforts to revive him, giving him seven years of reasonable life and enabling our children to know they had a father.

In more than 40 years of pharmacy and 15 years of hospital ministry, I have seen many people who have lived a reasonable life against all predictions.

The only thing that protects us from being terminated by mistake or design, particularly as we get older, is a complete ban on the taking of life, without which I would be afraid to trust myself to the medics.

In any case, what is this article doing in *The Journal*, which is supposed to deal with pharmaceutical matters?

Monica Mortimer

Enfield, Middlesex

■ COUNCIL ELECTION

Alliance Boots takeover at Lambeth?

From Mr N. Baumber, FRPharmS

With the Royal Pharmaceutical Society Council election looming, may I remind pharmacists that the Society exists to represent their interests and not those of organisations that want to wield power and influence by claiming that they pay the membership fees of their pharmacy staff.

We have seen in the past year a frightening level of consolidation and commercial influence in community pharmacy from the amalgamation of retail and wholesale chains in the Alliance Boots organisation. Have we forgotten the advantage taken of us so recently by partnership in the Pfizer Solus scheme, and the damage caused by it to our distribution channels?

There are already two Alliance Boots pharmacists, Steve Churton and Jonathan Buisson, on the Society's Council, while Paul Bennett, also a senior Alliance Boots employee, chairs the English Pharmacy Board.

In what one can only assume to be a deliberate tactical move, Mr Buisson has chosen to stand not for Council but for the English National Board instead. It seems to me that this paves the way for Nanette Kerr, a new Boots candidate, to take a place on Council.

Might this give Boots undue political influence on the current Council and boards if all four are elected? And might it attempt to bring this to bear as the new professional body is shaped?

Noel Baumber

Grantham, Lincolnshire

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

■ HEALTH AND SAFETY

Improve pharmacists' working conditions

From Mrs L. K. Gilpin, MRPharmS

We have all had days when everything goes wrong — the train is crowded, the coffee is spilled, the prescriptions come in bunches rather than a steady stream, the urgent medicine fails to arrive even though it has been promised and someone is off sick. That is life. We cope. A certain amount of stress is good for us. It keeps us on our toes, we know we are alive and, at the end of the day, the relaxation is all the sweeter because of it. But unrelenting stress is different. The kind that wears us down day after day is all too frequent now for pharmacists, who have little control over their working conditions.

In a recent *Chemist & Druggist* survey, 80 per cent of community locum pharmacists and 76 per cent of community employee pharmacists expected their stress levels to be higher in 12 months time — and this from a pretty high baseline already.

Companies with non-pharmacist area managers seem to be among the worst offenders, insisting that a certain number of medicines use reviews be performed whether appropriate or not and "If you don't get that number done today, then just get double done tomorrow".

With the move away from dispensing to other services, the locum or employee is having to do everything they have previously done and everything else on top, often with inadequate and poorly trained staff. These poor conditions of work cannot continue to go unchallenged. They can lead to errors that ruin lives.

I want the new professional body to concern itself with the working conditions and the health and safety of pharmacists. I want it to be proactive and not just wait for a whistleblower to sacrifice his or her own future for the sake of others.

I want there to be, if necessary, a way of reporting anonymously — even through a third party to alert the professional body to where it should shine a light to expose unsafe working practices and put an end to them.

Now that would be a professional body worth joining.

Lindsey Gilpin

New Malden, Surrey
English Pharmacy Board Election
Candidate

■ THE SOCIETY

A chance to influence new legislation

From Mr M. K. Astbury, MRPharmS

Beware! Following the explosion of new universities we will be pumping out pharmacists by the bucket load. Beware! In the next couple of years the regulations on supervision will be changed.

Some are pushing strongly for community pharmacies without pharmacists. When I point out they are doing this against the will of most pharmacists they claim they are doing this for the good of pharmacy and that the rank and file do not always know what is good for them.

We need people on the Royal Pharmaceutical Society's Council who will see the trip wires and fight for pharmacists. I have been doing this and intend to continue. I will endeavour to ensure that all pharmacists get a chance to influence any new legislation.

Beware! Pharmacist unemployment is possible. If we end up with more pharmacists than jobs the multiples will pay us as little as they can.

If a pharmacist has a professional disagreement with an employer it can be hard to maintain professional integrity when he knows he can be replaced by someone who will play ball.

An example in which coalface pharmacists have been effective is that, had I, as Joe Bloggs's pharmacist, not been on the Royal Pharmaceutical Society's Council during the past few years, then pharmacy medicines would probably now be on self-selection. This would have been disastrous for pharmacists and pharmacy. The Council was advised "we must do this to comply with competition law". In conjunction with some other Council members of conviction we staved off disaster.

At Council we should be using our influence to reduce sweat shop pharmacies and reduce the workload heaped on pharmacists, in all sectors, while elevating us in the public's eye to GP status.

Martin Astbury

Community Pharmacist
Chester
Council Election Candidate



Telephone number

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

Why I am missing the happy days of the Society

From Mr J. M. Brunt, MRPharmS

I endorse wholeheartedly the sentiments of past president John E. Balmford, whom I knew from my days as a Pharmaceutical Society Council member some 25 years ago. I, too, wonder where the Society is heading and why I still pay my retention fee.

Time was when pharmacists worked for pharmacists and made the decisions that only pharmacists can make and the officers employed at Lambeth, all experts in their field, had their fingers on the pulse.

Today, pharmacists work in ever increasing numbers for grocers, which may enhance the image of a supermarket but does little for the status of pharmacy.

When I hung up my self-employed boots at the age of 54 I refused to work for these people and I cringe nowadays at what my brethren have to put up with.

During my time on the Council the profession enforced its code of ethics fairly and standards were kept high, unlike today, when multiples appear to be powerful enough to probe everything and do as they wish, often riding roughshod over professional employees.

In the 1980s, some of us stood for Council because we saw the Society as a somewhat out-of-touch ivory tower. We quickly learnt otherwise and I remember standing up in the Council chamber one day talking about the reality of working in a busy pharmacy where we are dispensing over 3,000 prescriptions a month.

Hopkin Maddock got to his feet and admonished me for being greedy for single handedly supervising that volume. I hate to think what his feelings are now when my local pharmacist is responsible for 17,000 prescriptions.

At my first Council finance committee meeting, when the agenda item was next year's retention fees, I recall Mr Balmford casually suggesting a nominal figure which went through on the nod.

That was how things used to be done. There were people on the staff who were expert in different disciplines. They gave advice, but pharmacists made the decisions.

Mike Brunt

Thetford,
Norfolk