Pharmacies could not function without locums

From Miss J. E. Cronin, MRPharmS

I think that the Broad spectrum (PJ, 15 May 2010, p474) and Leading article (ibid, p466) about locum pharmacists were unfair and inaccurate.

It may be the case that the 2008 workforce census reported that 23.1 per cent of all respondents worked as community pharmacy locums, but did this figure take into account that a significant proportion of these will be regular locums who work for the same company on the same day or every day of the week? They are not transient workers. These pharmacists should really be classed as employees. The fact that they are classed as locums is beneficial for companies because they do not have the same rights as employees. Also, they can be dismissed at any time and do not have to be paid sick and holiday pay, etc.

The idea that independent pharmacies could work together and develop staff “banks” to provide employed pharmacists is a ludicrous idea that was just developed because the authors think locum pharmacists are not “economically sustainable” and this will save the contractors money.

As a locum, I might only work one or two days a year in independent pharmacies. It works out cheaper for them to pay my locum fees rather than have me as an employee because they would then have to pay sick pay, holiday pay, employer’s national insurance, potentially maternity pay, registration fees, etc. It is expensive to take on an employee.

You state that you have anecdotal evidence that some pharmacists choose to work as career locums because they earn more money. So what? Would it be a big sin if pharmacists wanted to earn a decent wage to support their families?

I doubt, however, that many pharmacists choose to be locums for financial reasons. I do not think the remuneration is high. In my case, my fees have been frozen for two years now because large multiples and agencies will not raise them and some supermarkets’ rates are rock bottom. This, combined with rising petrol and food prices, means I have been watching the pennies lately. Also, out of my locum fee, I have to pay tax and national insurance, and I often do not get travel expenses paid for journeys under 40 miles.

Pharmacists often become locums because they are treated unfairly as employees (eg, put under excessive pressure to do medicines use reviews, forced to attend training days, have a day off etc). Many can end up with a poor work-life balance, so it is not surprising that becoming a locum is an attractive option.

The Broad spectrum suggests that permanently employed pharmacists are safer because locums are often driving long distances and working long days. There is no evidence to suggest that locum pharmacists are any less safe than employees. Locums have the choice of where they want to work. For example, I will not take a job where I have to drive long distances, work long days, etc. When I was employed as a relief pharmacist for a multiple, I had no control over my working life. I was told which stores to cover and often had Sam start times, long drives, long days, late finishes and no lunch breaks.

It is an insult to suggest that locum pharmacists do not have the same training and professional development as employed pharmacists. As a professional, I undertake continuing professional development and fund my own training. For example, I am accredited to do MURs.

The final insult was the statement that there is “something rotten in the state of locum pharmacy”. As a locum, I know I provide an excellent service, sometimes at short notice for a fairly low rate of pay. I am cheaper in most cases than an employee since I do not get sick pay, holiday pay, etc. I and others like me provide an invaluable service to pharmacy that enables employed pharmacists to have a day off, attend training days, have a day off sick when needed, and have the time to conduct MURs and other services. Pharmacists simply could not function without us.

Julie Cronin
Lichfield, Staffordshire

Not responsible for low uptake of services

From Miss J. Richardson, MRPharmS

I believe there are other reasons for the low provision of enhanced and advanced services other than too much reliance on locum pharmacists. First, as things stand at present, every prescription dispensed in a community pharmacy must have input from a pharmacist at some stage in the procedure. Secondly, a prescriber can arrive in a community pharmacy at any time during opening hours.

Once pharmacists start a consultation, it is not appropriate for them to be disturbed. So what happens when a mother with a sick child brings a prescription for dispensing? The mother wants the medicines as soon as possible so that she can take the child home, but the pharmacist will not be available for, say, 30 minutes. Another patient would like his medicines dispensed now so that he can catch a bus in 15 minutes’ time. The potential scenarios are endless.

Once a pharmacist has finished the consultation, he or she then has to catch up with whatever has been dispensed while he or she has been occupied. This can be stressful, with patients complaining that they have had to wait, and can result in errors as the pharmacist rushes the checking process.

Employing a locum to cover the dispensing tasks would free the regular pharmacist to carry out other services but there are cost implications. The NHS is under financial pressure at the moment and this situation is unlikely to improve in the near future.

As things stand, I do not think locum pharmacists are responsible for the low uptake of extra services.

Joan Richardson
Walsall

What exactly is rotten in locum pharmacy?

From Mr S. J. Hadley, MRPharmS

I am writing with regard to the Broad spectrum (PJ, 15 May 2010, p474) and your Leading article about it entitled “Something rotten” (ibid, p466).

The Broad spectrum is written by a professional pharmacy adviser and a senior information analyst. Its main thrust seems to be that many pharmacists work as locums, that this is a bad thing and that research should be undertaken to find out why. Whatever its merits or otherwise, The Journal is perfectly correct to publish such an article. However, the reason for my letter is to question some of your comments.

You say: “In a provocative but well informed Broad spectrum piece, the writers imply that the fact that nearly a quarter of pharmacists working in the community are locums has meant that the community pharmacy role has not developed to its full potential.” In calling the article “well informed”, are you in agreement with their assertion that locum pharmacists are the ones to blame for the community role not having developed to its full potential?

You later say: “With apologies to Shakespeare, something is rotten in the state of locum pharmacy.” We have all heard horror stories about bad locums, but I consider that most of us do a good job...
Locum pharmacists are not expensive

From Mr C. O. Agomo, MRPharmS

The Broad spectrum on the locum pharmacy workforce (PJ, 15 May 2010, p474) made an interesting read. The reasons why many pharmacists choose to work as locums can be found in the numerous letters published in the past few weeks in the PJ. These include unbearable pressures from employers, lack of autonomy for community pharmacists and the lack of control that community pharmacists have over the work they do.

In my Continuing professional development article “Understanding what motivates staff” (PJ, 3 May 2008, p545), I mentioned a study that showed community pharmacy ownership is the top ambition among pharmacy students. Perhaps UK employers and policy makers could introduce the concept of franchising or other ownership or partnership arrangements, as seen in the US and Canada, as a method to motivate and strengthen commitment.

Additionally, there have been several letters from pharmacists recently who have decided to leave the profession either voluntarily or otherwise. Before we focus on locum community pharmacists and how the pharmacy workforce planning, it would be best to find out why such a huge number of pharmacists are leaving the profession and, of course, the impact it has on workforce planning.

One needs to work in community pharmacy practice to find out for oneself why a quarter of the profession will either choose to work as locums or throw in the towel.

Finally, before we conclude on the impact of locums on workforce planning, it is also important not to ignore recent increases in the number of pharmacy schools and the enlargement of the EU. I am aware that, last year, one of the large multiples was only able to offer full-time community pharmacist employment to 60 per cent of its former preregistration trainees. Most pharmacists not employed by this multiple might be surviving through occasional locum work. Is it therefore possible to suggest that we have so many locum community pharmacists due to lack of jobs and over-saturation of the market? Locum agencies can help confirm the situation.

I think we should consider merging some of the pharmacy schools or consider lowering the intake capacity of some of these schools (which is likely to happen anyway, due to decreased funding from the Government).

Chijioke O. Agomo
Community pharmacist
London

Too many assumptions

From Mr K. S. Golding, MRPharmS

I have to admit that I come from a time when my training involved making suppositories who fitting trusses, and where computers filled entire rooms. After a long career in management, I now work as a locum for personal reasons.

The basis of research in the Broad spectrum on the locum pharmacy workforce (PJ, 15 May 2010, p474) is a response to a workforce census, which is a flawed argument statistically.

Should we not be taking steps to reduce our dependence on locums? Absolutely not. What we should be doing is something completely different. The article asks lots of interesting but one-sided questions. Of course employers would prefer a more controllable, trainable, flexible and permanent workforce. Of course it is more difficult to deliver every service when the predicted seismic change happens. But are the authors making too many assumptions about locum pharmacists’ skills?

Mind you, now that the article has appeared and has even prompted a mention on the front cover, I think a lot of money will be put into practice-based research, which will undoubtedly prove the case. In 10 years’ time, there will be total discrimination resulting in a new locum pharmaceutical society.

In order to keep the cynics at bay, I would welcome a personal investment to improve my knowledge and skills from those who would support me. Somehow, I cannot see that happening either, and like the authors, I shall now retire to “la la land”.

Keith S. Golding
Dagenham, Essex

Letters

We should focus on medicines adherence

From Miss B. E. Pawulska, MRPharmS

I was interested in Tristan Learoyd’s suggestion (PJ, 8 May 2010, p447) that pharmaceutical selection be shifted to pharmacy. I would say it is already there. Pharmacists from secondary and primary care work collaboratively to develop, update and implement local drug formularies, which are a powerful tool to inform selection.

Is Dr Learoyd suggesting that pharmaceutical selection be carried out by employees of multiples, and possibly subject to the influence of commercial interests? I am not convinced that this is the way ahead for pharmacy.

I have an alternative proposition for the future of pharmacy. Rather than spend time duplicating or replacing work that is already carried out by other healthcare professionals, why not put our broad expertise into a hugely neglected area of medicines adherence?

Millions are spent on studies to determine which medicines have the best evidence and which should be chosen for routine prescribing, but little or no effort is made to ensure patients are happy to take them. It is recognised that adherence to long-term treatment is poor. Pharmacists in hospital and community are in the best position to influence this. Patients are often more willing to be frank with their pharmacist about their medicines, and pharmacists can give practical, understandable advice and information. In the community, we have medicines use reviews and prescription interventions as a tool for delivering this type of care.

I believe this is the real specialty of pharmacists and a future the new professional body needs to promote.

Barbara Pawulska
Brighton

Blogs on PJ Online

You can read regular contributions from a number of bloggers on PJ Online.

In addition to The Journal’s regular contributors Bytander, Didapper, Footler, Glow-worm, Hourglass and Prosperk, we have contributions from Jim Hutchins, who operates a pharmacy at Golborne Festival, and from pharmacy students across Britain.
The medical profession is not interested
From Mr D. Wood, MRPharmS
I wish to take issue with your Leading article (PJ, 8 May 2010, p449). I am a retired pharmacist who, at the start of my career, worked in hospitals and then later had chemist shops in the Barnsley area. I have to say that, on the whole, the medical profession is not interested in developing relationships as you suggest.
As a profession, pharmacy needs to have some self-confidence. I developed this position gradually over the years and the result was that my business got better the more I did this. I was not particularly popular with the local doctors but I could not care less. My customers seemed to like my approach, which is what mattered to me.
In my experience, trying to get too close to the doctors was a dangerous thing for pharmacists. Professional but at arms’ length was my approach. I saw some local pharmacists come to grief when they adopted your suggested attitude.
Donald Wood
Barnsley, South Yorkshire

Widening provision has little impact on pregnancy rates
From Mr P. Gornall, MRPharmS
I am sorry that Paul Hardy (PJ, 15 May 2010, p475) finds my categorisation of UK teenage pregnancy rates as “appalling” to be glib. I am familiar with the article by Lawlor and Shaw1 to which he refers. This article argues that, rather than compare UK rates with just those in western Europe, figures for less developed countries and also for New Zealand and the US should be taken into account.
First, comparing the UK with less developed countries is not, in my opinion, “like for like” because different cultural precedents apply. Similarly, the rates in New Zealand are (according to New Zealand government statistics) skewed by the rates in native Maori teenagers. When these are factored out, the rates in New Zealand are actually quite low.
This leaves us with the case of the US as a like-for-like comparator. In my view, the fact that UK figures are second only to the US (leaving out New Zealand) in the developed world can only be described as appalling, given that the US suffers from the greatest social inequality in the western industrialised world. This is borne out by the significantly higher rates in African American and Hispanic American teenagers as compared with European American teenagers.
Mr Hardy also relies on the above article to assert that UK teenage pregnancy rates have not really changed over the past 50 years. This actually supports my point that widening the provision of emergency hormonal contraception over the past 12 years has made little impact on the rates.

References

NEW PROFESSIONAL BODY
Repeated absences
From Mr P. G. Pate, FRPharmS
Further to previous correspondence (PJ, 24 April 2010, p395, and 8 May 2010, p449) regarding board meetings, I wrote to the country directors for each national pharmacy board asking for information on members’ attendance.
On examination of information received for England, work appears to be progressing well except one new board member, Graeme Stafford, is notable by his absence from any board meeting to date and this includes induction meeting for new members. From approved minutes of the first board meeting, it would also appear that no apologies for his absence were given.
I am particularly disappointed to learn of such repeated absence since Mr Stafford went to great lengths to canvass support for the election of himself and other candidates on a “Stop remote supervision” ticket. Such effort included personal e-mails to members who had signed the petition to criminalise dispensing errors (how these were secured is another issue that warrants examination). It is surprising therefore that, following such effort to get elected, Mr Stafford has not attended any meetings and, on at least one
occasionally, appears not even to have given any apologies for absence.

I believe members were hopeful that those they have elected would be truly committed. In other organisations with which I have been involved, when a committee member misses three consecutive meetings without adequate explanation, he or she is deemed to have voluntarily resigned. Perhaps Mr Staff should consider his position?

R. G. Pate

Graeme Stafford, member, English Pharmacy Board, responds:

Meetings, especially in London, are expensive. The way I do my thinking, planning, co-operating and influencing costs little.

My decriminalisation of dispensing errors petition was set aside while I was in France, monitored from the cafe of the MS Dana Sirena while crossing from Esbjerg to Harwich and cost nothing but my time to set up. Look at the effect that it has had.

I hope the majority of members will, in future, judge me on results and not on how many times I have given any apologies for absence.

I found the
currently paid to the Royal
Pharmaceutical Society. Instead, we
see a 7.5 per cent increase, way above any reasonable calculation to cover inflation.

It appears this has done the new professional body no favours. As it declared its fees first (£192), I would assume it had taken into account some sort of estimate of what fee the regulator might decide to charge. The cost of regulation could have been deduced to a reasonably high level of accuracy, one would have thought, from those privy to this information of how the money was spent at Lambeth.

Unfortunately, the fall out could be reduced membership of the professional body. Many pharmacists who would have willingly joined the new professional body on the basis of an equivalent yearly combined subscription may now decide against it. Some may not join because they feel they have been misled.

Registration is compulsory to practise so it is the voluntary part of this dual subscription that may well suffer. This is a great shame since a lot of people have put enormous time and effort into extolling the virtues and benefits of the professional body to potential members.

Chris Toothill

Barry Wienholdt

Delivery of my pharmacy ambitions

From Mr A. J. T. Low, MRPharmS

Didapper’s piece (PJ, 22 May 2010, p515) on the nightingale and its famous song made me recall the poem “Ode to a nightingale” by John Keats, who was also an apothecary.

On the level of the literary connection, there is a notable novel called ‘Tender is the night’ by F. Scott Fitzgerald. The title comes from a line in Keats’s poem. The book is a loosely autobiographical rendering of the sad waste caused by the schizophrenia suffered by Fitzgerald’s wife Zelda. When one considers the song bird “pouring its soul abroad” and when one remembers the poor husband “withdrawing his soul” because of his wife’s disturbing “episodes”, one begins to get an inkling of what it must be like for people, including our pharmacy colleagues in psychiatry, who deal with the emotional trauma of mental illness.

People with mental illness may be “sacrifice visitors” to community pharmacies, like the nightingale to southern England, but people with schizophrenia warrant the attention of pharmacists, who should do what they can. I recommend the DVD “Schizophrenia: cancer of the spirit”, with psychiatrist Peter Maddocks. Work like that will certainly help sufferers of this cruel condition and empower their voice and cause — beleaguered souls as they often are.

Andrew Low

Middlesbrough

Letters

No mention of the newer specialties

From Mrs C. L. Cooke, MRPharmS

I found the Leading article in The Pharmaceutical Journal (8 May 2010, p440) to be rather disappointing. Pharmacy is, indeed, increasingly a versatile profession (although I believe medicine definitely outstrips us), so why list hospital, community and the laboratory bench, which have all been around for many years, without mentioning the newer specialties?

GP practice support and clinical pharmacists, pharmaceutical advisers, secure environment specialists (prisons, immigration centres, secure hospitals, police custody, etc) are also carving out and developing innovative roles and promoting pharmacists as the experts on medicines. Multi-disciplinary working is essential because influencing other healthcare professionals and care partners is key to these roles.

The way to earn the confidence of the medical profession, patients and, indeed, anyone is to be good at your job, understand exactly what value pharmacists can provide and do so. We need to ensure that all pharmacists meet this standard.

Cathy Cooke

Clevedon, Avon

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BOOTS

Delivery of my pharmacy ambitions

From Mr B. Wienholdt, MRPharmS

In response to a question about restructuring its area management, a Boots spokeswoman commented that it was all “about investment in the pharmacy agenda and to accelerate the delivery of our pharmacy ambitions” (PJ, 22 May 2010, p494).

As a retired pharmacist, the only difficulty I can recall in accelerating the delivery of my pharmacy ambitions was when the Benylin Winchester was slow to pour on a cold morning!

Barry Wienholdt

Knutsford, Cheshire