Money is not everything
From Dr C. F. Green, MRPharmS

Regarding the letter “Did we make the right career choice” (PJ, 16 October 2010, p438), James Richardson makes some useful points, for example, the imposition of the responsible pharmacist legislation on hospital pharmacy was clearly a farce, but the issue pays deserve more exploration.

Before Agenda for Change, the 2004-05 Whitley Council pharmacy pay structure ran from £19,000 for an A grade to £35,000 for an H grade. From April 2005, Agenda for Change pay ran from £22,000 to £36,000, with other benefits such as a reduced working week and better annual leave. Most pharmacists working on Whitley bands A-C could earn from £19,000–£30,000 while, post-Agenda for Change, bands 6–7 could earn £22,000–£36,000.

Most pharmacists working up to D and E grades in hospital would have earnt up to £35,000 or £35,000, respectively, and, post-Agenda for Change, pharmacists working on a band 8a or 8b could earn up to £41,000 or £50,000, respectively. Once 8c pharmacists reach the top half of their band, they would be earning more than a chief pharmacist had under Whitley arrangements. So, it is clear that, although likely reductions in on-call payments will be painful, pharmacists’ pay generally offers, at worst, a modest improvement before the Agenda for Change process was introduced and, at best, significantly increased financial rewards.

Personally, I left community pharmacy to work in hospital pharmacy, taking a 30 per cent pay cut in the process and losing more income than the on-call payments are now. Much as I respect my community colleagues, I have never regretted this. Hospital pharmacy offers a far greater clinical focus than community pharmacy and, to date, I have had a richly diverse and satisfying career. The opportunity to contribute to and to see the impact that medicines have on patients in the acute setting is rewarding. To work with leading-edge and experienced clinical practitioners and increasingly complex medicines and regimens in a multidisciplinary setting is a stimulating and exciting opportunity. To learn from colleagues, medical and nursing staff, patients and from postgraduate courses means that hospital pharmacy offers an environment where learning is a daily rather than “lifelong” event.

Clinical pharmacy has paid for such speculatively low and possibly have to increase the pay of some of these rates are an insult (experiencing this). Secondly, most other professions are not thinking that there are many more serious and ethical implications to this. First, it could be setting a trend for falling pay rates (while most other professions are not experiencing this). Secondly, some of these rates are an insult to any pharmacist, and I would discourage them from working for such speculatively low and advantage-taking rates, so as not to lower the value of the profession in the medium- to long-term.

Finally, I believe that locum agencies should act responsibly to promote the value of pharmacists and any professionals they represent. There are far too many agencies fighting for too few positions, so I advise desperate pharmacists to take an employed position at a non-discounted rate rather than have their bluff called by a locum agency that is willing to supply those hospitals that are unable to spend wisely and maintain relevant budgets, and provide an adequate pharmacy service.

I accept that these are hard times, but hard times should promote efficiency through good management and not set a precedent for lowering the value of professional services. This type of labour market stressor can impact negatively on thousands of people for far longer than a few years of incompetent management by a few. The pharmacy profession will emerge stronger when the economy recovers if this is lobbyed for, and I certainly lobby for a strong pharmacy profession.

Ben Marks
London

LOCUMS

Hospital locum market in free fall
From Mr B. J. Marks, MRPharmS

In recent months we have seen many changes to the demands made on the pharmacy workforce. I have recently seen positions advertised by locum agencies that are almost 40 per cent lower than they were a couple of years ago. I can appreciate that this reflects primary care trust and hospital budgetary constraints, but I also think that there are many more serious and ethical implications to this.

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Ben Marks
London

Threats to the status quo are very real
From Mr P. A. N. Johnstone, MRPharmS

You report that over half of primary care pharmacists expect to work for GP consortia (PJ, 2 October 2010, p363). I would advise against complacency on a number of grounds.

The publication of the White Paper is exposing opinions from some GPs that question the value and future of medicines management services. Others see an opportunity to recompense at reduced cost or to bring in new providers that will deliver the commissioners’ requirements rather than continue with the historical approach. Potential new providers are gathering. Some are in the private sector but others are from within the NHS in both secondary and primary care.

Many primary care pharmacists are going to have to bid to continue providing a service. They might want to...
consider developing a business approach that they can deploy that demonstrates their value and protects themselves from decommisioning or takeover — potentially by erstwhile colleagues, since the threats to the status quo are very real.

Peter Johnstone
General Manager
Liverpool Health Care PBC Consortium

The Royal Pharmaceutical Society ought to be congratulated on reaching this stage in its evolution. I now think it is time to ask the following questions: when and where will annual general meetings be held; and what will replace the branch representatives’ meeting that gave ordinary members of the RPS a chance to influence the workings of the RPS?

I believe that it is important that members have a right to meet and debate topics that will be important to the profession’s future.

Melwyn Smith
Hull

HOWARD DUFF, director for England, Royal Pharmaceutical Society, responds: The RPS is in the process of setting the date for the AGM in 2011. It will be sometime in June.

The format of AGMs will be decided by the executive group in December. We hope that the AGM next year will have a fresh new feel and format that is appropriate to our board structure and, as well as the usual items, we will communicate with members about our work nationally and regionally.

In 2009, we announced that there would be no plans for a branch and regional secretaries’ meeting or a branch representatives’ meeting in 2010 as we concentrated our efforts on setting up and developing transitional committees for the emerging local practice forums.

This work has progressed well and we are pleased that we now have 40 LPF steering committees set up out of a total of 48.

The RPS will continue to provide meeting opportunities and events to share new ideas and general progress, as well as listen to members’ feedback. To this effect, the LPSs may be invited to nominate and send representatives to centrally held meetings, the dates and frequency of which are yet to be determined.

Members are encouraged, via their LPSs, to raise issues of concern or submit policy ideas forward to their appropriate board for consideration. The boards are there to listen to members’ views and LPSs are becoming increasingly important because they represent members locally. We are currently finalising LPS governance arrangements and the expectation is that we will have a national meeting for representatives from LPSs in 2011. We are also working on a mechanism that will be ready by 2011, whereby issues that LPSs consider to be important will be able to be raised through the appropriate national boards.

See Professional matters p474.

EDITOR.

RPS needs to tread new ground

From Mr M. W. Jackson, MRPharmS

While rummaging through some old journals, I came across the P-journal issue 19 September 2009, which advertised the position within the Royal Pharmaceutical Society for head of corporate communications. One of the roles was “to raise the awareness and understanding of the public in the professional and expert role that pharmacists play in delivering healthcare in Great Britain” and “to act as spokesperson in all public relation matters”. Has all this been forthcoming from the successful candidate?

The lack of PR in pharmacy has been my bête noire since I qualified in 1953. PR has been our weak link over the years and a professional approach to it has been sadly lacking in my view, making the public and politicians unaware of our value in relation to what we are qualified to offer.

We have an excellent journal that presents a professional approach to ourselves and members of the public. At least once a month the media refer to the RPS and the medicines featuring an RPS pharmacist spokesman. Other stories last weekend on high cost medicines (News of the World) and codine (The Independent) also feature quotes from pharmacists.

On the topic of substance misuse, my colleagues in Scotland took the opportunity to explain the role of pharmacists — what we do now and what more we can do — on Radio 5 Live and BBC online when this topic was brought up by Scottish politicians earlier this month.

Using the media to take forward campaigns is a new feature of the RPS’s work and Mr Patel works closely with Charles Willis, head of public affairs, to make sure we present consistent messages to the media, politicians and the public.

For example, recently Mr Patel was able to talk about the benefits of original pack dispensing during an interview with a European broadcaster before decisions affecting medicines packaging by the Council of Europe.

I am glad Mr Jackson enjoyed “Victorian pharmacy”, a programme that, in my view, has not have been made without the expert knowledge that resides at RPS. We are now in early discussion with producers about other pharmacy-related programmes.

We are committed to working with the profession to show its expertise directly and we have seen success in this approach, too. Working with the profession to make sure pharmacists feel confident about engaging with the media and making RPS the place for journalists to come when looking for experts on medicines goes hand-in-hand. We are working hard to achieve both.

FROM PJ ONLINE

Rehearsed answers

I think that a significant number of people have now memorised the symptoms of conjunctivitis and simply rattle them off at the pharmacy to obtain chloramphenicol. I have even had people coming in purchasing the drops for others with a note that lists the answers to all my questions before I have had the opportunity to ask them. It is now a well rehearsed procedure with many people and, if I refuse to supply, I will get abused.

For this reason, I am against further prescription-only to pharmacy medicine switches of any antibiotics. This is unfortunate since I believe I am competent with supplying them to treat minor bacterial infections.

The only way around this is if a pharmacist writes out a prescription for such a supply, which must be obtained from another pharmacy.

Adnan Mir, Bradford

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Letters
Letters

We all deserve respect
From Miss N.J. Kernaghan

My response to the letter from R. A. Jephson (PJ, 25 September 2010, p331) is that his reference to technicians is derogatory, antiquated and unprofessional. Fortunately, our pharmacists are from the 21st century and they recognise the valued support we offer along with mutual respect.

Although we do not have degrees in pharmacy — which we acknowledge — we do have qualifications pertinent to our role and for which we undertake an intensive two years of training to complete. In many cases, with experience, we acquire just as much knowledge as some practising pharmacists, certainly in their early years. Many of us, too, have gained long and devoted service to the profession (myself 26 years so far).

I am not sure what Mr Jephson thinks technicians do on a daily basis, but to enlighten him, we, too, dispense medicines and this may include chemotherapy. We manage the day-to-day operations of dispensaries, production units, medicines management teams (including dealing with patients). We are also at the forefront of electronic prescribing.

My understanding when I joined the "profession" was that we are all valued members of the pharmacy team working for the safety and benefit of patients and all deserving of respect for whatever our role entails. Many pharmacists may find their working lives just that little bit harder without the support of pharmacy technicians, just as we would without the support of our valued pharmacy assistants.

N.J. Kernaghan
Birkenhead,
Wirral

Why should we not be part of the same regulatory body?
From Mrs Elizabeth Fisher

I was appalled when I read the letter from R. A. Jephson (PJ, 25 September 2010, p221) and the comment “unnecessary downgrading of the pharmacy profession when for, some strange reason, technicians were admitted”.

The “strange reason” we were admitted was because of increasing Government pressure (ie, the White Paper “Trust, assurance and safety — the regulation of health professional in the 21st century”) for public protection and patient safety.

I have been a pharmacy technician for over 30 years and worked in hospital pharmacy all that time. I have witnessed the role of technicians develop enormously, especially in the past five to 10 years. Technicians are now expected to fulfil more responsible roles formerly held by pharmacists, particularly in roles with managerial responsibilities (eg, dispensary managers). This was brought about so that pharmacists could focus on clinical roles that involve spending more time on the wards.

Why should we not be part of the same regulatory body? From my experience, the service we provide would not be possible without the co-operation of all grades of pharmacy staff working as a team to provide a safe service to patients.

Elizabeth Fisher
Liverpool

TAMSULOSIN

Men have increased access to treatment with OTC tamsulosin
From Mr R. Rohilla, MRPharmS

I read with interest your News item (PJ, 9 October 2010, p96), which reported on the advice from the Drug and Therapeutics Bulletin that advised pharmacists to refer patients who present with lower urinary tract symptoms (LUTS) and who may benefit from tamsulosin to their GPs for a full clinical assessment to determine whether an over-the-counter supply is necessary.

Pharmacists are highly trained and educated healthcare professionals so are well placed to be responsible for the first-line management of LUTS due to benign prostatic hyperplasia. The pharmacy supply model for OTC tamsulosin stipulates the use of a questionnaire designed especially for pharmacists to evaluate symptoms, medical history, current medicines and potential differential diagnoses, which will help assess a patient’s suitability for the product. Having been trained myself (along with our healthcare assistants), we are confident with supplying this safely.

The OTC tamsulosin protocol also states that men must return to see their pharmacist within two weeks of starting treatment and, if he has experienced no change, or worsening of, symptoms, he is advised to see his GP straight away and not sold further supplies of tamsulosin.

The DTB recommendation failed to recognise that, as a patient population, most men wait for too long before seeking treatment for health problems associated with an enlarged prostate.

The switch of tamsulosin has increased the availability of a proven and safe treatment for a number of men who, in general, do not access healthcare early enough. It also provides an opportunity to increase the number of men entering the healthcare system, which, in turn, may increase screening for other health conditions among this hard-to-reach patient group.

We should be encouraging this group to access healthcare through pharmacy rather than passing them on to GPs.

Raj Rohilla
Richmond Pharmacy
Richmond,
Surrey

Broad spectrum

The Broad Spectrum feature is open to any reader. Contributions of around 1,000 words commenting on topical issues should be sent to graeme.smith@pharmj.org.uk for consideration

Time for maturity

For three years we have had this professional ping-pong and still no resolution. The Transitional Committee was told by Nigel Clarke and several members that [the Royal Pharmaceutical Society] had to be a body that covered the practice of pharmacy (not premises) and that many others were involved in this role as well as pharmacists. It was also made clear that royal colleges allowed for other categories of involvement than membership. Yes, the [RPS] must be controlled by pharmacists but, if we are to be credible and lead the professional practice and research agenda for safe medicines and safe practice, we need wider input from the pharmacy team and the public.

Provided only pharmacists control national boards and have votes in Assembly then why not allow for other non-pharmacists to be added to students and overseas membership groups [expected to be] allowed? Scientist membership will be crucial to our future and they must be able to input views to the Assembly and beyond.

Associate non-voting groups should include registered technicians and those interested in safe medicines use from other professions, industry and public.

It is time for a mature team approach to replace the myopic trade unionist notion of a body purely for pharmacists, which would soon have no role since there are already two such organisations.

Let us look at mature royal colleges and professional bodies like the Royal Society of Chemistry or Institute of Physics and see how they deliver their roles in the public’s interest and who may be part of their organisations and how. Then let us have some sensible proposals and a strategy to take us forward in a way that pharmacists feel in charge, but know they have listened to others first.

Howard McNulty, Glasgow