LOCUM PHARMACY

New Year's resolution

From Mr P. A. Quinlan, MRPharmS

If contractors are unable to provide a full pharmaceutical service to the public because pharmacists will not work for them for low pay rates, then their dispensing contracts should be rescinded and awarded to contractors who will provide a full service. I have no doubt that there are many employers who will offer the appropriate pay and conditions to attract staff to provide such a service. The practice, for example, of faxing prescriptions from one pharmacy to another for dispensing should only be used in emergency conditions and should never be the norm. The public have the right to be able to have prescriptions dispensed at the pharmacy where they are presented.

All pharmacists undertaking locum duties should provide a professional service. The idea of the "token pharmacist" sitting in the corner of the dispensary reading the newspaper and taking little part in pharmaceutical activities should be a thing of the past.

Perhaps all pharmacists undertaking professional community locum duties should make a new year's resolution to charge a minimum of £20 per hour for their services. To do less would demean both themselves and the profession. I am sure that responsible employers will be pleased to pay these rates to ensure that their pharmacies are run in a proper and professional way.

Paul Quinlan
Stoke-on-Trent

Multiples should stop buying pharmacies

From Mr A. O. Agbejule, MRPharmS

Perhaps if primary care trusts would take more seriously the closure of pharmacies because of lack of pharmacists, then, and only then, will the managers of the large multiples decide to pay locums their true worth (*PJ*, 30 November 2002, p773). My question is, why buy more pharmacies when you cannot even manage to ensure regular pharmacist cover for the ones that you already have? The multiples should stop acquiring pharmacies if they cannot get adequate staff cover.

I am quite sure there are many young and able pharmacists who would like to buy their own pharmacies but cannot afford to do so because they have to compete with the big multiples. Maybe when the new pharmacy contract comes out, these issues will be addressed. I suggest that continuation of the dispensing contract might be linked to reliability — in terms of always being open for business when needed.

Adewale Agbejule
Saxmundham, Suffolk

Unfair to undervalue professional persons

From Mrs E. M. Nowell

What is a locum worth? What kind of a question is that? Why not ask how long is a piece of string? Conversely, we could ask how important is the main cog in a piece of machinery, and what would be the cost should that machinery grind to a halt and business and goodwill are lost?

Locums have always kept, and are keeping, open many pharmacies. Some proprietors would never have a holiday without the services of a locum.

Locums often go out at short notice, travelling greater distances than is the norm. They step into the breach and take on the duties required, often without adequate and experienced staffing levels, deal with "backlogs", work without lunch or tea-breaks and often without prompt payment.

It is a mistake and unfair to undervalue professional persons. To suggest an hourly rate that was insufficient two years ago (considering what tradesmen charge) is nothing other than an insult.

Through an agency, hourly rates and expenses are negotiated between all parties and agreed upon before the work is undertaken.

"Ripping off" is not acceptable to ourselves or our customers, but a decent rate of remuneration is required to enable us to "keep the show on the road".

All parties are working towards the same goal, ie, the agency supplies the locum, who keeps the business open and which enables the public to receive the service they require and to which they are entitled.

The mood seems to be that £19 per hour for weekdays and £20 per hour minimum on Saturdays is a more realistic figure. "Emergencies" naturally command rather more.

All locums known to my agency and my staff are greatly respected and held in high regard. We know their worth; perhaps others have yet to learn.

E. M. (Judy) Nowell
Proprietor
The Locum Agency, Bradford

ADVICE FOR CORRESPONDENTS

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.* 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.

PERIOD-OF-TREATMENT FEE

Decision needs to be revisited

From Mr E. A. Goran, MRPharmS

Today, I received a prescription for 120 days' supply of furosemide 20mg. Admittedly, 120 days' worth is unusual in my pharmacy, but 112- and 100-day periods are not infrequent, while 84 days is very much the standard. Currently my net ingredient cost is over £15 per item, roughly 50 per cent above the national average. Given this background, I would suspect that my gross profit margin on NHS dispensing is unlikely to be as high as 10 per cent.

Today, also, I have read of the Pharmaceutical Services Negotiating Committee's decision to bow to Department of Health pressure to waive the period-of-treatment fee for the remainder of the financial year. I say "decision", but my understanding from the article is that this was decided by officers within the PSNC without debate or even comment by the rest of the committee. Let it be clear that this fee gives some small degree of recompense to those contractors who through no fault of their own are seriously disadvantaged by the current remuneration system. Thus the PSNC has agreed to further disadvantage one particular section of contractors.

It is unfair that volume increases over and above those predicted and driven largely by the Government's targets are not paid for in full and the PSNC needs to address this issue. However, penalising one particular section of contractors who are already disadvantaged is equally unfair and this decision needs to be revisited.

Elliot Goran
Badger Hill Pharmacy
York

Stabbed in the back

From Mr T. O. Tasker, MRPharmS

I must protest about the removal of the period-of-treatment fee (*PJ*, 14 December 2002, p835). I have a small, semi-rural pharmacy whose main

doctor issues three-month prescriptions for most of his patients. My profit margin is tight given the extra stock I must carry and, since my business is small, there are no generous wholesaler discounts. Because prescriptions are being reduced, there is no 6 per cent rise in prescription numbers, so no fee rise next year. My only compensation is the period-of-treatment fee. Now it is to be cut for the rest of this financial year to settle an overpayment I have never seen. How is this fair?

I feel like I have been stabbed in the back by my own negotiating committee. I might as well close down now if it were not for the welfare of my customers.

Tim Tasker
Ilkley, West Yorkshire

COMMUNITY PHARMACY

An urgent need to act creatively

From Dr B. P. Curwain, MRPharmS

Both Peter Cattee and Mike Bland have made many good points (*PJ*, 14 December 2002, pp844–5) in their replies to my letter (*PJ*, 30 November 2002, p779). I am not calling for large amounts of pharmacist time to be based in medical practice but until community pharmacists can access the whole patient record, and until pharmacies are generally suitable for private consultations, the surgery is more appropriate for some functions. It is precisely because I am worried about the continued provision of services from community pharmacies that I wrote in the first place.

All of us in the New Forest medicines management team regularly visit our community pharmacies. Some of us do locum work, and we are well aware how painfully stretched the service is in terms of pharmacists and support staff. Robust technician-led dispensing and checking systems can be developed, although not overnight. Evidence from hospital pharmacy (eg, Winchester) suggests that technicians are more accurate dispensers than pharmacists. As more pharmaceutical and medicines management input occurs in NHS surgeries, perhaps there will be some who argue that the need for pharmacist input in the pharmacy is reduced. This is why we must find ways to facilitate our community colleagues' participation in activities such as review, repeat dispensing and domiciliary visits.

As Mike Bland points out, there are disadvantages in having a pharmacy open without a pharmacist present. It is also debatable how "present" a pharmacist would be if he or she had just begun a 20-minute medication review in a private area. Thus, if we seek to provide a truly modern community pharmacy service, we do need to think a bit laterally. In some urban areas, fewer, larger pharmacies with two pharmacists on the staff would ease many of the problems; and in rural areas, like the New Forest, there are probably some pharmacies that could open shorter hours, allowing the pharmacist to do some work elsewhere.

I agree wholeheartedly about the urgent need for a new contract although I doubt that significant new money will be on the table. The Government wants to re-engineer the service and will probably only offer limited extra funding. I do not support this but am trying to understand the world as it is. It is because of the value I place on community pharmacy services that I see an urgent need to act creatively, before things go wrong.

Brian Curwain
Christchurch, Dorset

REPEAT PRESCRIBING

Projects in the north east

From Mr P. J. Hopley, MRPharmS

Your readers may be interested in repeat prescriptions following the designation of pathfinder sites (*PJ*, 12 October 2002, p513) and subsequent agreement by the Pharmaceutical Services Negotiating Committee of funding arrangements. A project funded by a Health Action Zone Fellowship grant has looked at increasing access to repeat medicines by coronary heart disease patients as part of wider service development in line with both "Pharmacy in the future" and the national service framework.

Five pharmacies and three medical practices in South Shields, Gateshead and Northumberland are involved. To date, 100 patients are enrolled and supplies of approximately 400 prescription items have been made over periods of up to five months.

In South Shields, the pharmacy is within the health centre building and a cable extension has been made to the GP practice EMIS computer system for access by the pharmacist. In Gateshead, a transmitter/aerial system has been installed to link the pharmacy situated across the road from the health centre, although some technical problems are being experienced with this. In Northumberland, paper communication is used by the three pharmacies that serve the local community. A half-day training session was attended by pharmacists, dispensary staff, the practice manager and a general practitioner.

It is too early for a formal evaluation, but two main subjective observations can be made. First, there has been an increase in team working among and between the GPs and pharmacists involved where previously, in some cases, little contact existed. Secondly, many patients have reacted in low-key manner, giving an impression that obtaining repeat medicines directly from a pharmacy is an obvious thing to do and is only common sense.

I would be pleased to supply further information on the scheme upon request and to refer where appropriate to the individual pharmacists and practice managers involved.

Peter Hopley
Newcastle upon Tyne
(e-mail hopleypharm@compuserve.com)

WHOLESALING

Payment rules should be changed

From Mr S. Dunn

The report from the recent GHP Procurement and Distribution Interest Group symposium, highlighted the presentation by Kurt Salmon Associates of the first phase of the NHS Purchasing and Supplies Authority (PASA) commissioned Pharmaceutical Supply Chain Project (*PJ*, 23 November 2002, p758). This initiative is a welcome and vital first step in improving the supply chain of pharmaceutical delivery to hospitals. The report mirrors and adds to valuable messages that came out of "A spoonful of sugar" last December and "Procurement and supply" in May.

For many years wholesalers have invested heavily in infrastructure to improve the supply chain, with the aim of helping drive a more efficient delivery of medicines to patients. Such developments include e-commerce order systems, twice-daily delivery, and increasing breadth of stock holding. More recently some wholesalers have begun to develop and pilot a ward box assembly service.

Twice daily delivery is well established and has since become the norm in our industry. This efficient supply chain that wholesalers operate in hospitals benefits immensely from synergies with the retail pharmacy supply chain. Wholesalers are eager to accommodate the needs of hospitals, but the introduction of new night-time, weekly, or emergency delivery services would be costly and would have to be paid for somewhere along the line.

The current Government rules on payments — allowing hospitals to pay an invoice only when all items have been reconciled — imposes an enormous financial burden on wholesalers. Lifting that rule would have an instantaneous benefit to wholesalers and their relationships with hospitals.

Our members recognise the importance of working with the National Health Service to ensure greater supply chain efficiencies by reducing the number of suppliers, and improving the level of e-commerce utilisation.

Wholesalers have for many years been moving towards greater relationships with hospitals. Maybe now that the value they add to the supply chain has been recognised and acknowledged they will be able to move forward in further developing a partnership approach. This strategic option, outlined in the report, is by far the more realistic and achievable of the three.

We look forward to hearing a response to this report from hospitals, and to seeing the next step from the PASA.

Steve Dunn
Chairman
British Association of Pharmaceutical Wholesalers

PI INSURANCE

Some may want own indemnity insurance

From Mr J. D'Arcy, MRPharmS

I write to clarify the benefits offered by the National Pharmaceutical Association following Mark Koziol's letter of 14 December 2002 (p844).

The indemnity and defence benefits provided by the NPA extend not only to our members but also to anyone employed or engaged by our members. Our benefits therefore extend to managers, locums and other pharmacy support staff.

Mr Koziol places great emphasis in his letter on out of court settlements and implies that such settlements are unusual and are synonymous with a tainting of professional reputation. In fact, going to court is an extremely expensive last resort and so few cases get there. The vast majority of cases settled out of court are clear cut: the pharmacist is at fault and a settlement follows an admission of liability. We look to settle these cases quickly because delay would do a huge disservice to an injured patient. Moreover, anything other than a speedy settlement will see the profession as being reluctant to face up to its responsibilities.

In cases where liability is an issue we will defend but, like any professional indemnity insurer, we need to take a view on the economics of running a case to trial. In most cases, it would be a poor use of precious resources and likely to lead to unnecessary stress for the affected pharmacist to drag out a case where there are not good prospects of success. There would also be a risk of a claimant involving the media, and potential damage to a pharmacist's reputation if it appeared we were dragging our feet over settlement. In those cases where liability is disputed, we would need to consider whether settling out of court is an appropriate way forward. But where this happens cases will always be settled on an ex gratia basis with no admission of liability.

There will always be cases where the professional reputation of an NPA member, an individual pharmacist or the profession is at stake. But where an issue is of sufficient importance we will take a case all the way. As an example I refer to one of our current cases which involves a coroner's inquest where certain findings, criticisms and observations were made against a pharmacist and a pharmacy company which were, in our view, wrong and unfair. In seeking a judicial review of the coroner's decision we are supporting both the member and the individual pharmacist and seeking to uphold the status of the profession.

Mr Koziol also makes reference to the conflict of interest where employer-led indemnity benefits are offered alongside an employee/engagee package. Where such conflicts arise they are easily managed in practice. However, in the event of there being any dispute between the employer and employee/engagee that cannot be resolved, we will ensure that each is provided with separate representation.

However, in this increasingly litigious and claim-conscious world, we recognise that some pharmacists will want the added security of their own indemnity insurance. This is, of course, their prerogative and many of them have already approached the NPA for an individual policy. In recognition of this demand we now offer, through an NPA subsidiary, an individual pharmacist indemnity package.

John D'Arcy
Chief Executive
National Pharmaceutical Association

GENETIC RESEARCH

Information disclosed only with informed consent

From Mr K. K. Cheeseman

Your meeting report on the Genetics and Law conference (*PJ*, 7 December 2002, p822) reports me as saying: "... it is not usual for drug companies to disclose genetic information, and in most cases this would only be done with informed consent".

Lest there be any misunderstanding, I would like to make clear that disclosure of genetic information would only ever be done with the informed consent of the subject. This is certainly the policy of AstraZeneca and I believe it to represent the common standard in the industry. It is important that participants in genetic research are not led to believe that the research sponsors may disclose genetic information without their consent.

Kevin Cheeseman
Director of development pharmacogenetics
AstraZeneca

PILS

Putting the PIL debate into perspective

From Mr D. K. Page, MRPharmS

With respect to the letter from G. J. Weaver, and the response from Stephen Lutener (*PJ*, 23 November 2002, p744) it is worth putting the whole debate in perspective. The requirement to supply printed patient information, and incidentally to supply appropriate external labelling on the container, was enshrined in a directive from the European Commission relating to consumer information and patient safety. This directive applies to all medicinal products placed for sale, including on prescription. (Since there was a similar directive to enforce the listing of contents and nutritional value of packaged foods, it seems fair that the customer/patient should know something about their medicines.) It was the choice of the pharmaceutical industry, as a whole, to implement Unit Pack Dispensing, using the EC Directive as a lever to achieve a cherished aim. (Unit Pack Dispensing is not the only solution to the requirements of the directive, but it is the most elegant.)

Given that the directive dates from 1992, that there was supposed to be a five-year implementation period, which the Medicines Control Agency managed to comply with, the question now sits as to why full implementation regarding labelling and printed information did not occur on 1 January 1999? It is too easy to say because the Department of Health and others did not come to an agreement regarding reimbursement rules so many years ago. It was known that not every product was available in treatment packs at that stage. There probably was not sufficient impetus to resolve the matter then. The question remains as to why after a further three years that "loose pack" bulk tablets are still available and that, where there is a choice, contractors are not buying sealed unit packs.

The current situation is far from ideal, and there is a need to resolve this matter for the sake of the patient as well as pharmacy contractors.

There are two interesting points from Mr Weaver's letter. The first is the assertion that prescribers will vigorously defend the right to prescribe part packs. That is not actually a problem, once it is pointed out that the occasions where it is clinically necessary to prescribe a part pack are probably few, and that if that is the case, surely the negotiators can take that on board. There is no problem in defending a right. It is only when the right is unnecessarily asserted that it becomes an issue.

The second point is more interesting, regarding the pack size of Buccastem 3mg tablets. This is probably not the only product where the quantity regularly prescribed is smaller than the usual container. I would suggest that where this is the case, Mr Weaver and other pharmacists lobby the manufacturers concerned in writing, and copy the letters to the Pharmaceutical Services Negotiating Committee, or equivalent body in the home countries, as evidence. If the industry is against copying of leaflets, it could strengthen its case by ensuring that the packs supplied are sufficient for one month's supply, or are in accordance with usual prescribed quantities, with no need to break the seal on the pack, or have to resort to either a photocopier or trying to get a decent copy off the internet. (This latter action assumes that the pharmacist has the time and resources to locate the appropriate information sheet and print it off.)

With respect to Mr Lutener's comments, there are a number of practical issues to be considered. The first is that prescribers, particularly GPs, are not in the habit of memorising pack sizes. The computer system on the GP's desk might prompt a pack size, but he or she is not obliged to follow it. The failure of the industry to agree whether a month is 28 days or 30 days is no assistance to this process. Although there is the facility of the "calendar pack rule" available, it is by no means clear if it is being used to a significant degree. There is also the detail that patients do read what is on their prescription, and if they have paid the charge of £6.20 and receive 28 tablets instead of 30, they are entitled to ask if they are

getting their "money's worth". This matter will have to be addressed in negotiation.

There is one further point that has been raised infrequently. No matter how old pharmacists that are reading this letter might be, I am sure that few, if any, were taught how to count loose tablets as an examined part of the formal training. Although the act of juggling tablets in a counting triangle might be a therapeutic break in the dispensing process, it adds nothing to the safety of the patient. Worse still, noting that not all tablets are film-coated, there is the residual possibility of cross-contamination from a mechanical tablet counting device. Likewise, skill in the use of scissors for modifying blister strips is probably not going to be accepted as a positive part of CPD or effective use of a pharmacist or dispenser's time. The sealed package, with proper external labelling and the leaflet supplied from the manufacturer is a safer option.

Don Page
Edinburgh

PUBLIC HEALTH

Possibility of new CPP faculty

From Dr A. M. Alexander, FRPharmS, and Mr I. G. Simpson, FRPharmS

We are grateful to Dr Terry Maguire for raising the profile of the public health roles of pharmacists (*PJ*, 7 December 2002, p808) and we wish to comment on one particular aspect of his article.

For several months, the College of Pharmacy Practice has been participating in the "quiet debate" about whether or not there should be a specialism of pharmaceutical public health. Having had informal discussions with many of the key players, both in public health and pharmacy, we are now at the stage of proposing to develop a faculty for pharmacists who see themselves as having a public health role, either at an operational or strategic level.

The college established its faculty structure in order to recognise the expertise of pharmacists working as specialists in various aspects of pharmacy practice, and help them develop their aspirations and competencies. The board of our Faculty of Prescribing and Medicines Management has identified the following aims and is developing a range of activities to support them:

- Identify professional standards by defining relevant competencies
- Formally recognise competence, expertise and excellence when achieved
- Provide targeted education and training
- Accredit appropriate training
- Support personal and career development
- Provide peer support and networking
- Provide input into national policy and strategic development
- Support practice research and development
- Promote and share best practice

Our vision is for faculties in other fields of practice, including public health, to develop along similar principles. In the case of public health, this development would raise awareness among pharmacists of their roles in public health, at both policy and practice levels, with the purpose of integrating those roles into the wider public health arena. We therefore think that the faculty would complement the roles of the Faculty of Public Health Medicine, the UK Public Health Association and the Pharmacy Healthcare Scheme, rather than compete with them. To that end, we would see it as a Faculty of Pharmacists in Public Health, rather than a Faculty of Pharmaceutical Public Health, but we recognise that colleagues, both within the college and elsewhere, may wish to debate this further.

We would welcome discussion with any readers who would wish to help us to further our aims (e-mail info@collpharm.org.uk).

Angela Alexander
Chairman of Governors

Ian Simpson
Chief Executive
College of Pharmacy Practice

THE PROFESSION

Why did I bother?

From Mr N. J. Oxley, MRPharmS

I am beginning to wonder why I bothered. Five years down the line, after having been promised a rewarding career, I find myself feeling a tad short-changed.

I have been trained to offer my professional opinion on medicines to medical staff and offer patients advice on how best to use their medicines and educate them about their treatment. Why? To have consultants shoot me down and dismiss my advice on ward rounds? To see specialist nurses with no real understanding of drugs and their uses performing the patient educational roles for which I trained? To be torn between a well-paid, mediocre job in community pharmacy or the low-paid, ill-respected service we provide in hospital? Surely not.

I also worry about the future. Nurses and technicians are pushing up, while doctors seem unwilling to move aside and work alongside us. I wonder, will we be cut out of the equation when employers realise that they can pay someone less to do the same job? Will we see mass unemployment in pharmacy?

What happens when we need to re-educate? Many will leave the profession (as many respondents in my undergraduate research project said they would), creating a worse workforce crisis than the one we already have. Perhaps the exodus has already begun?

At this point, some will wake up screaming, in a cold sweat. Alas, this is no nightmare — it is a potential reality.

Neil Oxley,
East Boldon, Tyne and Wear

BRANCH MEETINGS

Sponsorship bias?

From Dr C. F. Green, MRPharmS

Having recently attended two meetings of a local branch in my area, I am concerned about the manner in which the content of the meeting was biased towards the pharmaceutical company sponsoring the evening. The first occasion was reasonably subtle but in the second, the speaker stood at the front of the room, next to the large stand displaying the sponsor's products and the company representative sat in the front row of the audience. The presentation was about an update of some therapeutics guidelines and was well delivered by the speaker. Although the first 20 minutes covered an update of a change in guidelines, the last 20 minutes concentrated on one product alone, which happened to be the product emblazoned across the stand next to him.

I am not against company sponsorship of local branch meetings and understand that the meetings may not happen without this sponsorship, and this is not a criticism of the local branch committee. However, I do not believe that a local branch meeting is a suitable forum for presentations that are clearly influenced by sponsorship and the presence of company representatives.

I am surprised that the current guidelines for local branch meetings are inadequate with regard to this issue and would propose that the Royal Pharmaceutical Society addresses this issue as a matter of principle. Its guidelines should state where promotional material may be sited and should contain advice to speakers on content, perhaps in the format of a standard letter. With pharmacist prescribing just around the corner and an ever increasing number of pharmacists having a direct influence on prescribers and prescribing policy, it is important that the balance of information presented at independent events such as local branch meetings is impartial and well balanced.

Chris Green
Assistant Director of Pharmacy, Clinical Services
Royal Liverpool and Broadgreen University Hospitals NHS Trust

JEAN-PIERRE MOSER, head of public relations and membership, Royal Pharmaceutical Society, replies: Branches may wish to accept sponsorship from commercial companies in the health care sector that are prepared to contribute to the cost of meetings in exchange for an opportunity to promote their products or services at the meeting. This is acceptable provided that branches follow the practice of making it plain to attendees that the meeting has been sponsored and ensure that any promotional material is clearly identified as such. In our experience, branches make every effort to ensure that the educational content of their meetings is both balanced and factual.