Locum community pharmacists’ experiences and perceptions of their work

A thesis submitted to the University of Manchester for the degree of Master of Philosophy in the Faculty of Medical and Human Sciences.

2011

Alison Astles

School of Pharmacy and Pharmaceutical Sciences
# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contents</td>
<td>2</td>
</tr>
<tr>
<td>List of Tables</td>
<td>6</td>
</tr>
<tr>
<td>Abstract</td>
<td>7</td>
</tr>
<tr>
<td>Declaration</td>
<td>8</td>
</tr>
<tr>
<td>Copyright statement</td>
<td>9</td>
</tr>
<tr>
<td>Dedication</td>
<td>10</td>
</tr>
<tr>
<td>1 Introduction</td>
<td>11</td>
</tr>
<tr>
<td>1.1 Background</td>
<td>11</td>
</tr>
<tr>
<td>1.2 Research aim and objectives</td>
<td>11</td>
</tr>
<tr>
<td>1.3 Thesis overview</td>
<td>12</td>
</tr>
<tr>
<td>1.4 Researcher background and interests</td>
<td>13</td>
</tr>
<tr>
<td>2. Literature review</td>
<td>14</td>
</tr>
<tr>
<td>2.1 Introduction</td>
<td>14</td>
</tr>
<tr>
<td>2.2 What is a locum community pharmacist?</td>
<td>14</td>
</tr>
<tr>
<td>2.3 The community pharmacy business environment</td>
<td>16</td>
</tr>
<tr>
<td>2.4 National changes to pharmacy governance structures</td>
<td>17</td>
</tr>
<tr>
<td>2.5 Who works as a locum pharmacist?</td>
<td>18</td>
</tr>
<tr>
<td>2.6 Why do pharmacists work as locums?</td>
<td>20</td>
</tr>
<tr>
<td>2.7 What do locum pharmacists do at work?</td>
<td>21</td>
</tr>
<tr>
<td>2.8 Attitudes to, and performance of, locum community pharmacists</td>
<td>24</td>
</tr>
<tr>
<td>2.9 Workload issues</td>
<td>25</td>
</tr>
<tr>
<td>2.10 What causes stress at work?</td>
<td>26</td>
</tr>
<tr>
<td>2.11 Comparisons with locum work in other professions</td>
<td>29</td>
</tr>
<tr>
<td>2.11.1 Doctors</td>
<td>29</td>
</tr>
<tr>
<td>2.11.2 Nurses</td>
<td>33</td>
</tr>
<tr>
<td>2.12 Conclusion</td>
<td>35</td>
</tr>
<tr>
<td>2.12.1 Research aim and objectives</td>
<td>36</td>
</tr>
<tr>
<td>3 Methodology</td>
<td>37</td>
</tr>
<tr>
<td>3.1 Choice of research method</td>
<td>37</td>
</tr>
<tr>
<td>3.2 Sample</td>
<td>39</td>
</tr>
<tr>
<td>3.2.1 Sampling process</td>
<td>39</td>
</tr>
<tr>
<td>3.3 Interview process</td>
<td>41</td>
</tr>
<tr>
<td>3.3.1 Interview guide development</td>
<td>41</td>
</tr>
</tbody>
</table>
3.3.2 Arranging the interview ......................................................... 42
3.3.3 Conducting the interview .................................................. 43
3.4. Data saturation ................................................................. 45
3.5 Analysis .............................................................................. 45
  3.5.1 Transcription ............................................................... 45
  3.5.2 Sorting data into themes ............................................... 46
3.6 Quality considerations ...................................................... 48
  3.6.1 Researcher bias ............................................................. 48
  3.6.2 Collusion between researcher and interviewee ............... 48
3.7 Validity .............................................................................. 49
3.8 Reliability .......................................................................... 50
3.9 Ethical considerations ....................................................... 50
4 Results .................................................................................. 52
  4.1 Demographics and characteristics of the sample .............. 52
    4.1.1 Discussion on characteristics of the study sample ....... 53
  4.2 Motivation for undertaking locum work ......................... 54
    4.2.1 Keeping up to date ....................................................... 55
    4.2.2 Not wanting to work for a company ............................ 55
    4.2.3 Not wanting to be a manager ...................................... 56
    4.2.4 Having a clinical focus ............................................... 57
    4.2.5 Contact with others .................................................... 57
    4.2.6 Flexibility ................................................................. 58
    4.2.7 Financial benefits ....................................................... 58
    4.2.8 Variety ....................................................................... 59
    4.2.9 Being able to say no to work ...................................... 59
    4.2.10 Contribution of locuming to other jobs .................... 60
  4.3 The locum in the professional context of pharmacy ........ 60
    4.3.1 Continuing professional development (CPD) ............... 60
    4.3.2 Revalidation ............................................................... 63
    4.3.3 Responsible pharmacist ............................................... 64
  4.4 Staff .................................................................................. 65
    4.4.1 Why are staff members important to locums? ............ 65
    4.4.2 Staff resource and availability ..................................... 67
    4.4.3 Good staff ................................................................. 68
    4.4.4 Poor quality staff ....................................................... 69
    4.4.5 Working and interacting with staff ............................. 70
  4.5 Delivery of advanced and enhanced pharmacy services ..... 73
5.2 Study strengths and limitations ................................................................. 114
5.3 Future direction ....................................................................................... 116
References .................................................................................................... 118
Appendices .................................................................................................... 125
Appendix 1: Pharmacy contractual framework ............................................ 125
Appendix 2: Responsible pharmacist ............................................................ 128
Appendix 3: Interview Guide ........................................................................ 131
Appendix 4: Introductory letter .................................................................... 134
Appendix 5: Consent form .......................................................................... 135
Appendix 6: Information sheet for participants ............................................ 136

Word count excluding appendices: 46,416
List of Tables
Table 1 Job titles used in community pharmacy.................................................. 15
Table 2 Demographics and characteristics of interviewees.................................. 52

Table 1 Job titles used in community pharmacy.................................................. 15
Table 2 Demographics and characteristics of interviewees.................................. 52
Abstract

University of Manchester Alison Astles
Degree title: Master of Philosophy (MPhil)
Locum community pharmacists’ experiences and perceptions of their work
2011

Previous work has examined motivations for undertaking locum work, and the demographics of locum community pharmacists, but little is known of the experiences they encounter during their work. This study aims to explore locum community pharmacists’ experiences and perceptions of their work. It encompasses the work pressures that affect locum community pharmacists, their views of their role and how they perceive others’ attitudes towards locum pharmacists.

Method
Twelve semi structured interviews were conducted with locum community pharmacists identified from the Royal Pharmaceutical Society of Great Britain registered pharmacist database. Interviews were conducted face to face and via telephone, during May to September 2010. Participants were sampled to create diversity of age, gender and geographical location in England. Interviews were audio-recorded, transcribed and thematically analysed using Nvivo software.

Outcomes
Interviewees revealed a range of motivations for working as a locum, which corroborated previous work and also emphasised considerable dissatisfaction with the employed environment. Interactions with staff were explored, describing the induction role of staff, and the importance of staff local knowledge. The physical environment of the pharmacy was identified as being important, with consideration of available space, organisation and distractions. Interviewees had mixed views on access to continuing professional development, but there appeared to be general acceptance of it as part of pharmacy practice. They expressed views that the responsible pharmacist regulations had little impact on their practice, that it gave them a tool to improve facilities, and that it could in theory present barriers to working safely as a locum. Interviewees described participation in pharmacy advanced and enhanced services, giving reasons for their participation or lack of it. Stresses of the locum pharmacy environment focused on lack of continuity and unfamiliarity with the environment. Participants considered that perceptions of and attitudes of others to locum pharmacists were neutral overall. Locum quality was described in terms of professional engagement and conscientiousness.

Conclusion
The study corroborates previous research into locum community pharmacy, and provides some additional insights. It reveals locum community pharmacy as a positive career choice for some pharmacists, and highlights some of the issues of employed status that motivate pharmacists to work as a locum. The large size of the locum community pharmacy workforce means that this sector cannot be ignored in either motivational or quality terms.. Further investigation into those quality issues would be beneficial.
Declaration

No portion of the work referred to in this thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.
Copyright statement

i. The author of this thesis (including any appendices and/or schedules to this thesis) owns certain copyright or related rights in it (the “Copyright”) and she has given The University of Manchester certain rights to use such Copyright, including for administrative purposes.

ii. Copies of this thesis, either in full or in extracts and whether in hard or electronic copy, may be made only in accordance with the Copyright, Designs and Patents Act 1988 (as amended) and regulations issued under it or, where appropriate, in accordance with licensing agreements which the University has from time to time. This page must form part of any such copies made.

iii. The ownership of certain Copyright, patents, designs, trade marks and other intellectual property (the “Intellectual Property”) and any reproductions of copyright works in the thesis, for example graphs and tables (“Reproductions”), which may be described in this thesis, may not be owned by the author and may be owned by third parties. Such Intellectual Property and Reproductions cannot and must not be made available for use without the prior written permission of the owner(s) of the relevant Intellectual Property and/or Reproductions.

iv. Further information on the conditions under which disclosure, publication and commercialisation of this thesis, the Copyright and any Intellectual Property and/or Reproductions described in it may take place is available in the University IP Policy (see http://www.campus.manchester.ac.uk/medialibrary/policies/intellectual-property.pdf), in any relevant Thesis restriction declarations deposited in the University Library, The University Library’s regulations (see http://www.manchester.ac.uk/library/aboutus/regulations) and in The University’s policy on presentation of Theses.
Dedication

Sincere thanks are due to the locum pharmacists who volunteered to be interviewed for this research, and to my supervisors Professor Karen Hassell and Dr Sheena Johnson for their interest and support.

Thanks are due to the Pharmacy Practice Research Trust for their funding support for this work.

Thanks as ever to my family for their support during this work.
1 Introduction

This section provides the background and rationale for the study, and describes the aim and objectives for the research. It also provides a description of the background and interests of the researcher.

1.1 Background

Locum community pharmacists comprise approximately one third of the community pharmacy workforce in the UK (Seston and Hassell, 2009). There is some suggestion and anecdote that the quality of service provided by locum pharmacists may be poorer than that provided by employed or contractor pharmacists (Badwal, 2008), and that service delivery may be compromised by having such a large section of the community pharmacy workforce employed as locums (Latif and Boardman, 2008). Conversely, a substantial locum population may provide flexibility to the workforce, and so contribute to effective service delivery.

There has been much discussion in the pharmacy press over recent years about levels of stress in the pharmacy workforce (Donyai and Denicolo, 2009), which is of relevance to the locum pharmacist population. Locum pharmacists may use their locum status as a route to avoiding some stressors, or the locum experience itself may add other stressors to the working situation.

This thesis aims to explore these issues and contribute to the baseline knowledge of the locum community pharmacy workforce. This will be achieved by analysing the views of locum pharmacists, obtained during semi-structured interviews with the researcher.

1.2 Research aim and objectives

The research aim of this study is to explore locum community pharmacists’ experiences and perceptions of their work.

The objectives to deliver this aim are:

1. To describe the work pressures that affect locum community pharmacists
2. To explore locum community pharmacists’ views of their role
   a. Their views on their local working situation
b. Their views on changes in national policy on their role
3. To explore locums' perceptions of others' attitudes towards locums

1.3 Thesis overview

The thesis describes the process of undertaking this research study. The literature review describes the current body of knowledge about locum community pharmacy, and acknowledges the dearth of peer-reviewed papers and a significant dependence upon ‘grey’ literature of comment and opinion in the pharmacy press. The literature review encompasses current information on the roles, motivations and demographics of the locum community pharmacy workforce, explores stresses in community pharmacy and explores some comparisons with locum workers in other healthcare professions.

The method chapter describes the theoretical approach to the research, and provides detail on how the research was undertaken, including the sampling, interview process, data analysis and consideration of quality issues. The results chapter provides a detailed account of the results, and is divided and subdivided into the themes identified in the research analysis. The discussion chapter summarises and contextualises these findings.

Throughout the document, certain conventions are used for referring to locum community pharmacists and their working environment. These conventions are taken from the language used by the research participants, and also by the literature. These conventions are described here:

- Locum – noun to describe a locum community pharmacist
- Locuming – verb to describe working as a locum community pharmacist
- Booking – a confirmed contract between a locum and a community pharmacy
- Sector – used to describe an area of pharmacy practice, such as hospital pharmacy, community pharmacy or industrial pharmacy
- Cross-sector working – pharmacists working in more than one sector of pharmacy practice
1.4 Researcher background and interests

Alison Astles has been a UK registered pharmacist since 1988. She has worked in community and primary care pharmacy, and briefly as a hospital pharmacist. She has worked as a locum community pharmacist throughout her career, and has a particular interest in community pharmacy service commissioning and quality management. This study is her first submission for a research degree.
2. Literature review

2.1 Introduction

It is recognised that there is little published literature on the locum community pharmacy workforce in the UK (John and Turner, 2010). Two key studies have however, provided some background to the locum population (Hassell and Shann, 2003), (Shann and Hassell, 2006). This review sets out to identify current knowledge of the locum, in terms of their demographics, their motivations for locum work, what tasks locum pharmacists undertake, the work pressures they experience, the attitudes of other pharmacists and pharmacy staff, how locums adapt to the varied environments in which they work and if this adaption involves any risk or benefits to patient safety. It also provides some comparisons with locum work in other healthcare professions.

The following databases were searched as part of the literature review: Embase Ovid, Embase Elsevier, International Pharmaceutical Abstracts, PubMed and e-PIC. The databases were chosen for their coverage of pharmaceutical issues, including news and opinion. Search terms used included ‘locum’, ‘pharmac*', ‘community’, ‘nurse’, ‘doctor’, ‘general practitioner’, ‘non-principal’, ‘workforce’, ‘bank’, ‘agency’. Searches covered the period January 1990-October 2010, selected as providing a reasonable period of time for relevant information to be uncovered, but sufficiently recent for that information to be relevant to current pharmacy practice.

In addition, other pharmacy journals, magazines and web-based discussion forums (‘grey’ literature) were reviewed for relevant articles and comment about locum community pharmacy issues. These were identified through the personal knowledge of the researcher and using cross-references from other sources. Journals were hand-searched at the John Rylands University of Manchester library where online resources did not exist (back to January 1990). The grey literature uncovered tended to be documents retrieved from organisation websites and pharmacy magazines.

2.2 What is a locum community pharmacist?

The term ‘locum’ in relation to community pharmacy covers a wide variety of different working situations. The defining criterion may be that the pharmacist has self-employed status (as defined by HM Revenue and Customs (HMRC, 2009)) but even this is open
to legal dispute, as revealed when a locum community pharmacist was able to claim holiday pay from an employer (Anon, 2005a). This definition of being self employed was taken for this study. Beyond that there is a wide range of patterns of work. A locum may work in one pharmacy for many years, effectively providing the service of an employed manager. At the other extreme, a locum may work in a pharmacy for one day, or a few hours, and never visit there again. Locum pharmacists may work on an occasional basis, one or two days a month, or full time (or more) hours per week. Symonds (2000) describes the great variation in working patterns of part time pharmacists, and Seston and Hassell (2009) demonstrate a sample of the range of working options available to locum pharmacists. Table 1 shows descriptions of some of the range of job titles and employment options available in community pharmacy.

Table 1 Job titles used in community pharmacy

<table>
<thead>
<tr>
<th>Job title</th>
<th>Employment status</th>
<th>What they do</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy manager Community pharmacist</td>
<td>Employed</td>
<td>Work full or part time in one pharmacy. Managerial and clinical roles.</td>
<td></td>
</tr>
<tr>
<td>Second pharmacist</td>
<td>Employed</td>
<td>Work full or part time in one pharmacy. Clinical roles.</td>
<td></td>
</tr>
<tr>
<td>Superintendent pharmacist</td>
<td>Employed or self employed</td>
<td>Has overall responsibility for pharmacy standards and policies over one or several pharmacies</td>
<td></td>
</tr>
<tr>
<td>Relief pharmacist</td>
<td>Employed</td>
<td>Work full or part time in different pharmacies within the same company. Clinical roles, some managerial.</td>
<td></td>
</tr>
<tr>
<td>Long term locum pharmacist</td>
<td>Self employed</td>
<td>Work full or part time in one pharmacy only. Managerial and clinical roles.</td>
<td>HMRC may argue this is not self employment.</td>
</tr>
<tr>
<td>Locum pharmacist</td>
<td>Self employed</td>
<td>Work for short periods in different pharmacies. Clinical roles.</td>
<td>HMRC would class this as self employment.</td>
</tr>
<tr>
<td>Responsible</td>
<td>Employed or self employed</td>
<td>The pharmacist in All pharmacies have</td>
<td></td>
</tr>
</tbody>
</table>
2.3 The community pharmacy business environment

In order to put the research subject into context, it is relevant to describe the business environment that community pharmacy operates within. Community pharmacies are contractors to the NHS and operate as private businesses. The community pharmacy contractual framework is described in Appendix 1. At September 1 2010, the Royal Pharmaceutical Society of Great Britain reported 11,089 registered pharmacy premises in England (Anon, 2010a).

Pharmacies may be owned by individuals or large corporations. Large groups are known as ‘multiples’ and smaller businesses as ‘independents’. Rather confusingly, middle-sized businesses can be known as ‘independent multiples’. The Independent Pharmacy Federation claims to represent independent pharmacies and says it has 800 members (presumably individuals, but this is not clear) (Anon, 2009c). It does not specify the definition of an independent on its website, the membership criteria area is still under construction. There has been a trend over the last couple of decades of fewer independent pharmacies, as the larger chains purchase the smaller businesses (Bush et al., 2009). There are two main trade bodies representing multiple businesses. The Association of Independent Multiples (2009) represents community pharmacy companies with between five and three hundred branch pharmacies. The Company Chemists Association (CCA, 2009) represents larger companies with more than three hundred branches nationally. A trend in recent years has been the growth of pharmacies located in supermarkets. These are commonly open long hours, and tend to be pharmacies from multiple pharmacy chains, though not exclusively. Changes in 2005 to control of entry regulations for pharmacies (Anon, 2005b) resulted in an increase in the number of ‘100-hour’ pharmacies, that is, pharmacies with opening hours of 100 hours or longer per week. It can be speculated that this change may have some impact on locum community pharmacists, in terms of shift working and job opportunities.

Within the national community pharmacy contractual framework there are additional (advanced and enhanced) services beyond the essential core pharmacy role (these are described in Appendix 1). The one national advanced service is the medicines use review (MUR), where pharmacists discuss a patient’s medicines with them, to ensure...
that patients know what their medicines are for and how to use them. Enhanced services are locally commissioned by the local NHS Primary Care Trust according to local need. Examples of enhanced services include provision of emergency hormonal contraception free to clients, minor ailments services where treatments for minor illnesses are available via the NHS from pharmacies, instead of attending the GP surgery, and supervised methadone consumption for substance misuse clients.

2.4 National changes to pharmacy governance structures

During 2010, the Royal Pharmaceutical Society of Great Britain (RPSGB) demerged into two organisations, the General Pharmaceutical Council (GPhC) and a professional leadership body (Royal Pharmaceutical Society). This is in line with Government policy and has created a clear split between regulation of the profession (GPhC) and professional leadership and support, to avoid any conflict of interest. Registration with the GPhC will be mandatory to practise as a pharmacist, but member of the professional leadership body will be voluntary. The current local RPSGB branch structure that supports pharmacists professionally in their localities is being dissolved, and new ‘local practice forum’ structures are being created to provide local support, particularly continuing professional development (CPD) activities. The new GPhC regulator is also bringing in new professional standards, and a process of revalidation will be initiated by 2012. Revalidation will involve some process of assessment of competence to continue to practice as a pharmacist.

This package of changes may impact on the professional working lives of locum community pharmacists. It has been noted that locum professionals find it more difficult to engage in CPD opportunities than those within organisational structures (GMC, 2004). A voluntary professional leadership body combined with new professional standards and requirements for revalidation may make the locum pharmacist environment more complex in the future. The GPhC has acknowledged that locum pharmacists have their own particular professional issues that will be have to be addressed (Anon, 2009b). A research objective will be to examine locum pharmacists’ awareness of these changes, and explore their perceptions of how these changes may impact on their working lives.

The Medicines Act 1968 states that to lawfully conduct a community pharmacy business, there must be a pharmacist in personal control of that pharmacy. Primary legislation of the Health Act 2006 introduced some changes to the 1968 Act, in that the
term ‘personal control’ was replaced with the concept of the ‘responsible pharmacist’, so every pharmacy must have a named responsible pharmacist whilst it is operating. If more than one pharmacist is present (pharmacies that have a second pharmacist), then only one may be the responsible pharmacist at any one time. The duty of the responsible pharmacist is to ensure safe and effective practice in the pharmacy and this is a statutory duty. In effect, the responsible pharmacist has to ensure that the systems and procedures in that pharmacy are of a sufficient standard to provide a safe pharmaceutical service. The responsible pharmacist regulations came into force on October 1 2009. They cover pharmacy procedures, records and pharmacist absence from the pharmacy and are described in Appendix 2: Responsible pharmacist.

It is possible that having a statutory responsibility as a responsible pharmacist has had an impact on the nature of locum community pharmacy work. Whilst locum pharmacists report having to be adaptable and responsive to each new environment they work in, the new regulations appear to formalise that initial review of the capacity of the pharmacy to operate safely into a statutory responsibility, which may have changed the nature of the locum pharmacist’s interaction with the pharmacy. One comment letter (Kemp, 2008) mentions ‘pre-flight checks’, analogous to an airline pilot, as the initial process that will determine whether a pharmacy opens or closes in a morning. Whilst community pharmacy locums have been noted to ‘vote with their feet’ and not return to an understaffed or badly run pharmacy, this new statutory responsibility may mean that locums will need to be more immediately proactive about quality issues. It also remains to be seen if this task is actually within the capacity of a locum pharmacist, for example, assessing staff competence and capacity. Ashcroft et al (2005) note that locum pharmacists felt they were not well placed to review pharmacy safety. The responsible pharmacist role will conceivably also take the locum pharmacist out of a purely clinical role, and into managerial areas. The data collection for this study took place during May to September 2010, approximately six months after this legislative change on October 1 2009. As the responsible pharmacist agenda has now made this balance of roles explicit, research into the nature of the locum pharmacist working experience is highly relevant.

2.5 Who works as a locum pharmacist?

The Pharmacy Workforce Census 2008 (Seston and Hassell, 2009) indicated that about a quarter of all community pharmacy posts (23.1%) are filled by locum pharmacists and locums pharmacists are also more likely to work part-time than other
working pharmacists. In the census, 6615 pharmacists indicated that they worked in some capacity as a locum community pharmacist, which indicates that 36.9% of the community pharmacy workforce works as a locum.

Of these pharmacists who reported working as a community pharmacy locum, two thirds (66.1%) worked only as a locum. The remaining third also held jobs as community pharmacy managers (32.3%), hospital pharmacists (30.6%), primary care pharmacists (16.2%) or elsewhere (industry, academia or outside pharmacy).

From the census data, slightly more locum community pharmacists were female than male (52.8% versus 47.2%), comparing to the general pharmacist population of 56.9% female versus 43.1% male. Locum community pharmacists were on average slightly older than the general pharmacist population (44 years versus 42 years). Over a third of community locums were over 50 years of age.

From the census data, locum community pharmacists were more likely than employed community pharmacists to work in independent pharmacies or supermarket pharmacies. The authors reflect that this may indicate that independent pharmacies struggle to employ pharmacists, but an alternative view is that the environment is more attractive to locums than multiple pharmacies. It has been proposed that the multiple community pharmacy environment provides reduced opportunities for professional autonomy for the pharmacist (Bush et al., 2009), which may provide a motivation for both working as a locum and working for an independent pharmacy. Additionally, the availability of relief pharmacists within multiple pharmacy organisations (see Table 1) may also be a factor for less locum working. The high proportion of locums in supermarket pharmacies may reflect the long opening hours in these sites.

The proportion of pharmacists having more than one job has increased in recent years (Seston and Hassell, 2009), with more than one in ten pharmacists being employed in more than one sector of pharmacy. Of these pharmacists, many combined locum community pharmacy work with employment in another sector as described above.

The census data (Seston and Hassell, 2009) paints a picture of a very diverse locum workforce, and of a significant proportion of the community pharmacy workforce being locum workers.
2.6 Why do pharmacists work as locums?

Shann and Hassell (2004) described a wide range of motivations for pharmacists choosing to work as locums. The same paper notes that unique personal circumstances were sometimes described by locums as triggers for the move to locum work, but there appeared to be common factors in making this choice. These included the flexibility of the role, to accommodate family commitments but also other working and social opportunities; the financial contribution that locum work provides; social contact was identified particularly by older pharmacists; avoiding management pressures of an employed post; variety; and keeping up to date professionally. Seston and Hassell (2009) indicate that locums have the most satisfaction with their work-life balance, reflecting the flexibility of the role. Shann and Hassell (2004) also note that most locum pharmacists studied provided a range of reasons for their chosen working pattern, it was rarely the case that only one factor was involved.

It may be that some of the reasons why locums work as locums in terms of work life balance, flexibility and choice have been identified, but what specifically do locum pharmacists like about the experience during the working day? Wood (2002) (p102) described his enjoyment of the ‘newness’ of the experience: “I find working in different locations, with different people, to be stimulating. Also working with new systems and experiencing alternative methods of approaching problems is refreshing.”

Symonds (2000) describes gender differences in expression of commitment to the role of locum pharmacist. She describes male locums as expressing commitment in terms of a ‘lifetime commitment’ whereas women tended to focus on the immediate, in terms of ‘helping’ and doing the best job they could in the time they were there. Symonds also describes significant professional commitment amongst part time workers, and also discusses the requirement for flexibility being a significant driver for part time working.

Employers are also recognising the pros and cons of locum working, and using it in their employment and recruitment strategies (Lloydspharmacy, 2008). Lloyds Pharmacy described the pros of locum working as flexibility to choose your working environment, comparing this with cons of financial instability, lack of support, lack of familiarity with company procedures and uncertain travel arrangements to strange pharmacies. It appears that locum pharmacists choose their working patterns for a wide variety of reasons, and that the flexibility of the role is certainly an attraction.
2.7 What do locum pharmacists do at work?

The 2005 Census data (Hassell et al., 2006) reveal that a third of locums work in only one pharmacy during the course of a month, whilst a quarter worked in four or more pharmacies during the course of the month. Symonds (2000) found that a quarter of ‘part time pharmacists’ (62% of whom were locums) worked at short notice.

Beyond the information on working patterns and motivations, it is interesting to speculate what actually happens when a locum goes to work, in terms of the tasks undertaken, tasks not undertaken, roles and responsibilities, relationships and strategies to get through the day (Hassell and Shann, 2003). The little information that is available largely derives from letters in professional journals by pharmacists on locum issues, written opinion pieces by pharmacists and magazine articles (Mason, 2008) on working as a locum. It also derives from pharmacy websites and online chatrooms. Some of this opinion is discussed here to illustrate how locum pharmacists may work and interact.

Symonds (2000) investigated the role of part-time pharmacists (62% of whom described themselves as locums), and tried to discover what they considered their role to be. Roles described generally covered short-term activities, such as checking prescriptions, problem solving, giving advice and overall supervision. Longer term activities, including management issues such as staff training were generally not considered part of the role.

Evans (2000) (p186) described some of the attractions for her of working as a locum: “no staff problems. No rota. No company rules and targets to meet”. Brown and Bellaby (2002) mention “dirty work”, meaning non-pharmaceutical tasks such as answering a phone query about a retail item that the pharmacist considers is not part of his locum role.

The Pharmacists’ Defence Association has produced a ‘sample’ locum community pharmacist contract (Anon, 2009a) (p1) which includes the phrase, “[the locum] shall not be required by the Proprietor to perform any duties at the Pharmacy in connection with the running or operation of the Proprietor’s business other than the provision of the Services as a pharmaceutical chemist and matters directly related to the provision of the Services by the Locum”. The contract is merely an example that locums could use, and it is not known to what degree this document is used. It does however appear to highlight the fact that duties undertaken are professional, and not managerial, in nature.
HM Revenue and Customs also has something to say on the tasks that locum pharmacists perform (HMRC, 2009), stating that self employment status is unlikely to be compromised by tasks such as dispensing and sale of medicines, but the pharmacist may be more likely to be considered an employee if they undertake such duties as general supervision of staff, cashing up or ordering of non-pharmacy stock. This reflects the situation where a locum is employed for a long duration in one pharmacy – there is a significant case for classing that as permanent employment (Anon, 2005a).

There is apparently some distinction between the tasks undertaken by locum pharmacists compared to regular pharmacist managers. It appears that the locum role encompasses short term, professional tasks, and excludes staff management and longer term business development roles. Some variability in opinion arises when considering involvement in what might be termed non-professional tasks, such as putting away stock, serving at the till and helping with retail activities. Some opinion suggests that helping put away stock ingratiates the locum with staff, building relationships (Anon, 2008a). Others give counter views that locum pharmacists are paid for their professional input and should restrict their workload to this (Brown and Bellaby, 2002).

Magirr et al (2004) researched the clinical autonomy of community pharmacists, and highlighted how this varied with employment status. Their study found that locum community pharmacists demonstrated the least clinical autonomy when presented with a series of scenarios, compared to employee and contractor community pharmacists. This adds a complexity to the picture of the locum community pharmacist at work, in terms of the roles that they undertake and also in terms of their motivations for undertaking locum work.

As described in section 2.3 and appendix 1, the community pharmacy contractual framework comprises essential, advanced and enhanced services.

The MUR advanced service requires accreditation of the pharmacist and pharmacy. Enhanced services typically (though not always) require some accreditation of the pharmacist before the service can be undertaken. Accreditation is via the local Primary Care Trust.

It has been proposed that locum community pharmacists may be less engaged in delivery of advanced and enhanced services (John and Turner, 2010). The availability of locum community pharmacists to provide dispensing services may aid other pharmacists in delivery of other professional services has also been mooted (Hassell
One comment on this issue focused on locum delivery of the medicines use review (MUR) advanced service (Schofield, 2009). Schofield notes that it is for the locum to decide whether an MUR is an appropriate activity from two points of view: if it is clinically appropriate for that particular patient, and also if it can be safely accommodated within the working practices of that pharmacy at that time. He relates this to the responsible pharmacist agenda (see below), where the pharmacist has a duty to ensure that the total pharmaceutical service provided is operating safely. It is clear from the comments and discussion that the independence and professional autonomy of the locum pharmacist are very important aspects of the role. Employee pharmacists have reported pressure from employers to deliver MURs (Yuen, 2009), and it is this type of management pressure and targets that locums claim being self-employed protects them from.

The debate on tasks that locum pharmacists should undertake has a financial as well as professional component. Where services bring in extra payments to the pharmacy (advanced and enhanced pharmacy services – see Appendix 1), locums may choose not undertake these advanced and enhanced services, even though they may be capable and accredited for them (Schofield, 2009), (Latif and Boardman, 2008). Locums are usually paid per hour, and usually do not receive additional payments for providing extra services. Anecdotally, some pharmacy companies do incentivise locums to provide advanced and enhanced services, by giving the locum an extra payment. In general however, published comment (Matalia, 2009) indicates that locums may not wish to provide additional services for no extra remuneration. This reflects the fact that locum pharmacists are small businesses, and consider the financial aspects of their work as well as the professional aspects. It also brings in issues of duty to the pharmacy business they are working for, both in a professional and financial context. Comment from Phillips (2009) (p483) support this decision-making in relation to roles, where Phillips suggests that pharmacists undertake locum roles so they do not have to “jump through… contractual hoops” for little or no reward.

There appears to be little information in the literature on safety issues in relation to locum community pharmacy. However, there are suggestions that the nature of the work does introduce some risk. Wood (2002) (p102) raises issues relating to communication methods between one working day and the next: “lengthy messages being left, and the hope that this will be enough”. This implies that there is risk attached to faulty or inadequate communication between pharmacists working on different days. This issue of potentially compromised patient safety is an important justification for further research into locum community pharmacy.
Evans (2000) (p186) described difficulties with “the strange pharmacy [with] no dispenser or staff member familiar with the computer”. She also tells of difficulties working in pharmacies that have a different locum every day, with resultant communication problems, and chaotic situations resulting from inadequate systems that are “fraught with danger”.

It is clear that locum pharmacists make judgements about the standards within the pharmacy they are working at. ‘Locum’ (2001) anonymously described many examples of poor practice that s/he has identified whilst working as a locum pharmacist, including poor physical conditions and equipment, but does not state what action might be taken by the locum. Similarly, Schmidt (2007) notes that, as a locum, he finds practice that he considers not be up to standard, but again does not report what action can be taken. Shann and Hassell (2004) (p8) describe ‘dubious practices and whistleblowing’, where locum pharmacists identified pharmacies they perceived as having poor practices in place. The paper reports that locum pharmacists often ‘voted with their feet’ by choosing not to work in the pharmacy again, rather than report the issue to try and improve the situation. The Royal Pharmaceutical Society of Great Britain (RPSGB) has produced a guidance factsheet (RPSGB, 2007) on working as, and employing, a locum pharmacist that states locum pharmacists have a professional responsibility to whistleblows poor practices, rather than doing nothing at the time and choosing not to return to the pharmacy. Similarly, employers of locums (for example, the pharmacy owner or locum agency) who raise cause for concern are advised to report this, rather than merely not book that person again.

2.8 Attitudes to, and performance of, locum community pharmacists

There is anecdote and opinion in the pharmacy literature that locums have a ‘bad press’, in that they are considered less competent and professionally committed than employed pharmacists (Badwal, 2008). This study examines this issue to some degree, in that it explores locum community pharmacists’ perceptions of others think of them. To support exploration of this issue, some of this press and literature opinion is described here.

A public consultation document on the Draft Pharmacy Order 2009 by the Scottish Government and the Department of Health (Anon, 2009e) asked opinions on pharmacy of members of the public recruited from NHS local involvement networks. The discussions revealed some impressions of locum pharmacists, “the use of locums
which made the service less personal and specialised, and this also removed continuity of care” (p7). The same consultation also revealed some public attitudes about the competency of locums, “I would like to know if they [pharmacist] have just been doing locum work” (p9), implying this is a less competent role. The consultation document concludes that a clear and consistent strategy is required on the issue of employing locums. Shann and Hassell (2006) describe some locums perceiving negative attitudes from staff and patients because they are ‘only a locum’.

One paper examining a performance issue did analyse any difference in counselling patients on their medicines between locum and other pharmacists (Aslanpour, 1997). This study examined rates of verbal counselling with dispensed medicines and found that the rate of involvement in counselling was not affected by the employment status of the pharmacist – locums did as much, or as little, as other pharmacists. Another study found that locum pharmacists were less likely than other community pharmacists to undertake medicines use reviews (Latif and Boardman, 2008). However, as discussed in Section Error! Reference source not found., there may be other reasons for this apparent non-engagement with MURs than competency. Some locum pharmacists themselves recognise that their image is a problem, and have vigorously defended their competency (Anon, 2008c). There is therefore an impression from published comments that locum pharmacists are not as competent as other community pharmacists but there is very little published evidence on competency of locums. Whilst a study of competency is outside the scope of this work, attitudes and impressions of locums, from the locum point of view, is worthy of further research.

2.9 Workload issues

There is considerable debate about work pressures and stress within the pharmacy profession (Donyai and Denicolo, 2009). Recent survey work undertaken by the Pharmacists’ Defence Association (PDA) (Anon, 2009f) has highlighted significant levels of workplace stress amongst pharmacists. Gilpin (2009) describes how to work as a locum pharmacist is “to gamble daily with workplace stress”. Gilpin highlights lack of preparation by the pharmacy for the arrival of a locum, unfamiliarity with working practices and understaffing as contributing to locum workplace stress. Online discussion following this article (Anon, 2009h) raised comment on “incompetent, overpaid and lazy locums”, in contrast to the idea of the overworked professional locum. The stresses experienced by locum community pharmacists will be explored as part of this study.
Bond et al (2008) surveyed the types of pressures experienced by community pharmacists (of whom circa 32% were self-employed). Stressors included paperwork, insufficient time, CPD/training, patient demands, long working hours, work/life balance, professional isolation, insufficient resources and business versus professional conflicts. McCann et al (2009) found that the top three job situations that caused stress to community pharmacists were being interrupted, excessive and increased workloads and not having enough staff. The same study also found little evidence of a difference in mean stress scores between contractor pharmacists and employee, employee managers or locum pharmacists (locum pharmacists were not analysed separately from other employee pharmacists, which provides a justification for this further research into locum workplaces stresses).

2.10 What causes stress at work?

There are a number of factors that contribute to stress in general working environments (Cooper and Cartwright, 1996). Cooper and Cartwright note ‘factors intrinsic to the job’, such as poor physical working conditions, working unsociable hours or shiftwork, work overload and underload, repetitive and understimulating work, poorly designed working environment, physical danger, and person-job mismatch. Work overload can be described as ‘quantitative’, where there is too much work, and ‘qualitative’, where the work is too challenging for the person. Person-job mismatch relates to jobs which don’t match the skills or expectations of the person undertaking the work.

Other work stressors relate to the worker’s role in the organisation – role ambiguity, where the person is not sure of their role or objectives; role conflict, where the person has to do work that they do not believe in, or feel uncomfortable about; and responsibility, for other people and work items (Cooper and Cartwright, 1996). Cooper and Cartwright (1996) describe relationships at work as potential stressors, particularly mistrust of co-workers. They also discuss career development and job security, organisational culture and the home/work interface.

The Department of Health has provided some guidance on managing workplace stress (DoH, 2009). This includes a list of major causes of work related stress, based on responses from doctors and nurses. The major causes of work stress listed in the Department of Health document include:

- Erosion of autonomy or lack of control over work life balance
- Rigidity of the hierarchy
• Doing tasks below grade
• Lack of the right tools to do the job
• Increase in patients’ expectations
• Increase in administrative duties
• Lack of coherence in organisational structures and procedures
• Isolation from other team members
• Colleagues not understanding each other’s roles and competencies
• Lack of management support

In relation to locum community pharmacy, it can be speculated that many of these stressors may be present in the working environment. Community pharmacy is a physically demanding job, physical conditions are not always ideal, and commonly out of control of the locum pharmacist. The role is professionally isolated, with pharmacists usually working with no other pharmacists present. Pharmacists may be called upon to do tasks they consider outside their professional remit (“dirty work” (Brown and Bellaby, 2002)). For locum pharmacists, unfamiliar computer systems may hinder effective working (poor tools) and policies and procedures are likely to vary in different pharmacies. It may be that locum community pharmacists are more likely to work unsociable hours than other pharmacists, though this is not known. The nature of community pharmacy dispensing work can require long periods of repetitive checking work, yet demands constant high concentration levels. Role conflict may appear as a stressor when tasks are required that do not meet the professional or moral inclinations of the locum pharmacist, for example, sales of homeopathy products, or emergency hormonal contraception. Mistrust of colleagues, or not understanding colleagues’ roles and competencies, as a stressor may relate to a locum’s unfamiliarity with staff competency. This is balanced against the need to rely on other staff’s performance, for example, working with accredited checking technicians. Whilst examples may be considered for these areas, it is not known whether locums do experience these stressors, or others.

Willett and Cooper (1996) describe four major factors in community pharmacy workload stress: daily demands of the job and dealing with patients, the professional role, counter prescribing and time pressures. Whilst the community pharmacy role has changed considerably since the introduction of the new contractual framework in 2005, this study from 1996 does seem to mirror the experiences of later work. The study also highlights that younger pharmacists working for large multiple companies, are most dissatisfied with their roles. Since that time, the number of pharmacies that are part of large multiple companies has grown significantly. Cooper also describes the changing
nature of the twenty-first century workplace (Cooper, 2002a), with a movement towards a ‘short term contract’ culture, with more portfolio and project-based working. This results in greater independence and control for workers, but less job security.

The parallels with community pharmacy and locum working with respect to a short term contract culture are difficult to work through. Community pharmacy is essentially a long term, stable business. A pharmacist must always be present for the business to operate, so there is no ‘downtime’ when pharmacists are not required. Pharmacy employment does not demonstrate the peaks and troughs of seasonal or periodic activity that would lend itself to temporary working, it is a continuous activity. However, some drivers or incentives must exist to stimulate such a significant proportion of the community pharmacy workforce to work as locums. One can speculate that the pharmacy workforce has changed as a result of the behaviour and desires of individual pharmacists, rather than from business forces. It may be that given that there is low unemployment amongst pharmacists (Anon, 2009g), locum pharmacists see a positive balance between the independence and control that locum work offers them, versus job security. Whilst the motivations of individuals to work as a locum have been explored to some extent (Shann and Hassell, 2006), the external factors that create those behaviours within individuals have not been researched. What is it about the structures and business models of community pharmacy that have driven the creation of a substantial locum pharmacy workforce? There is some opinion (John and Turner, 2010) that the nature of pharmacy employment is a significant disincentive to being employed, and that the extent of locum working is a direct result of the NHS and its contractors being ‘bad employers’. Thus, whilst increased locum working may mirror global trends for increased outsourcing and portfolio working, there are likely to be other factors within the pharmacy business environment that also play a part in the desire to be a locum.

Workplace stress has been a topic of discussion within the pharmacy profession. Following a news feature in the Pharmaceutical Journal in 2009 that commented on the approach of the profession to stress issues (Cree, 2009), online discussion of the feature (Anon, 2009h) discussed that telephone calls made to the ‘Listening Friends’ Pharmacist Support service mainly came from younger employees of large multiple pharmacy companies, with a smaller proportion from independent pharmacies or smaller multiple companies. It was stated that fewer calls to the service are received from proprietor and locum pharmacists. The online discussion (Anon, 2009h) speculates that this “may indicate that their [proprietors and locum pharmacists] stress levels are lower since they can exert a greater degree of control over their working lives”.

28
Hassell et al (2006) surveyed pharmacists’ job satisfaction on a range of factors. Locum pharmacists yielded higher satisfaction scores for the following factors than other types of pharmacist: ‘physical working conditions’, ‘colleagues and fellow workers’, ‘amount of variety in job’ and ‘patient contact’. In contrast, locum pharmacists were amongst the most likely of community pharmacists to consider reducing their hours or leaving the profession. It may be that becoming a locum pharmacist was in some cases a first step to making a bigger life change. Alternatively, it could be that those who choose to work as a locum are in some way more inclined to take risk than those who choose a more secure employed role.

In conclusion, it appears there are many factors in the community pharmacy working environment that may contribute to work stress. Locum pharmacists may be choosing their work practices and environments to reduce stress upon themselves, which has a consequent impact on the shape of the community pharmacy workforce, resulting in the significant proportion of the workforce that works as a locum. Locum pharmacists’ experiences of stress at work, and how that impacts on their working strategies, is therefore a useful focus for research.

2.11 Comparisons with locum work in other professions

Other healthcare professions in the UK also operate using locum workers. Shann and Hassell (2004) describe comparisons with doctors and nurses, and note that these provide reasonable comparators for pharmacy locum working. Comparisons with these other locum workforces may provide some useful parallels with the locum community pharmacy workforce, and may also provide some differences, reflecting the varied roles of health professionals, and also the different contractual and employment frameworks within which the profession practises. Other health professional groups, such as dentists and optometrists, may also provide useful comparators, but general practitioners and nurses were selected as they represent the largest healthcare worker populations and consequently have reasonable workforce literature for examination.

2.11.1 Doctors

There appears to be a greater volume of literature on locum doctors than pharmacy, principally around workforce planning. This literature search attempted to focus on general practice, as a comparator to community pharmacy, rather than the hospital service.
The National Association of Sessional GPs (Anon, 2009d) estimates that “approximately 50,000,000 consultations occur every year between patients and general practitioners who are unfamiliar with the working ways of the practice in which they’re working”. The 2006-07 general practitioner (GP) workforce survey identified 8% of the UK GP workforce as locums (GSS, 2007) (other categories being GP partners, salaried GPs and GP registrars and the categories were self-defined by the individuals surveyed). This is a significantly lower proportion than for the pharmacy profession, possibly reflecting the different nature of the contractual working environment. Medical general practice is in general much less managed and operated by large corporations, similar in picture to community pharmacy in previous decades when independent contractors predominated. This means that proportionately, fewer general practitioners are employees, which perhaps removes one of the drivers that creates a locum pharmacy workforce.

This work did not differentiate between part-time, occasional locums and those regularly working in practices, but identified that the mean number of hours worked by GP locums was 15 hours per week. It also noted that locum GPs spent a higher proportion of their time on consultation work with patients compared to partner and registrar GPs, noting that locums do not have the managerial responsibilities that partners have. This has parallels with the approach that locum pharmacists appear to take to their work, focusing on clinical tasks rather than management tasks (Shann and Hassell, 2004), (Symonds, 2000).

Interestingly, the paper identified the extent of locum GP participation in the General Medical Service contract Quality and Outcomes Framework (Anon, 2010b) (essential, advanced and enhanced services. This service structure mirrors the pharmacy contractual framework described in Appendix 1). Participation in essential and advanced services was at a similar level for locums, partners, salaried GPs and registrars. Locum doctors were slightly less likely to be involved in enhanced services. Again, this has some parallels with the pharmacy workforce, where it has been proposed that locum pharmacists are less likely to be engaged with pharmacy enhanced service delivery (John and Turner, 2010), though this has also been identified as an opportunity for locum pharmacists to enhance their marketability (Pike, 2005). (A description of the community pharmacy contractual framework structure is shown in Appendix 1).
2.11.1.1 Why doctors choose to work as locums

McKevitt et al (1999) surveyed locum doctors to discover the ‘motivations and experiences’ of locum general practitioners. Four main reasons for choosing to work as a locum were identified as wishing to gain experience of a range of work settings, to provide employment between permanent jobs, to maintain work/non-work balance (dealing with family and other commitments) and to continue after retirement from ‘regular’ employment.

The survey also identified that locum doctors used a variety of channels to find locum work, but ‘overwhelmingly’ used personal contacts as their preferred method. Whilst the routes used by pharmacists to find locum work are anecdotally known (Mason, 2002) (Mason, 2008), it is not known which routes are preferred by the pharmacy locum workforce – an area for further research.

2.11.1.2 Access to CPD

Difficulties accessing continuing professional development (CPD) opportunities are a theme throughout the literature on locum doctors. Guidance from the General Medical Council on CPD recognises that locum doctors have particular issues with CPD in general (Anon, 2004a). The National Association of Sessional General Practitioners has developed a code of practice for locum GPs that acknowledges that equal opportunities for CPD and appraisal opportunities are essential (Anon, 2004b). It also recognises professional isolation of locums (and provides advice on how to avoid it).

From 2009, all registered doctors were required to have a license to practise from the General Medical Council. Licensed doctors undergo revalidation, where they must demonstrate their continued competence to practise. Carvel (1999) blames the short term nature of locum contracts for difficulties engaging with the general practice revalidation processes. Carvel describes how this short-termism means he is rarely seeing the outcome of his actions, has difficulties auditing his practice, and that the nature of the consultation and its context are different to that of doctors established in the practice. This has direct relevance to the situation of a pharmacy locum. It is noted that pharmacist locums have reported difficulties engaging with CPD (Shann and Hassell, 2004), and this has tended to refer to lack of access to courses. It may be that locum pharmacists need assistance with access to resources, but also may need
support in developing the wider, more holistic aspects of CPD, which as Carvel reports, is difficult in a rapidly changing work environment.

2.11.1.3 Performance of locum doctors

McKevitt et al (1999) make the point that reference to locum doctor performance has focused on ensuring that the performance of the locum is up to scratch, whilst identifying that mechanisms for ensuring this are not clearly in place. However, it is a valid point that quality works both ways – for both the practice and the locum. Locum doctors identified that the type of practice that they preferred to work in was organised, friendly, tidy, up to date. Locum complaints included practices that failed to provide sufficient information, are disorganised and unfriendly. The National Association of Sessional GPs has produced a locum code of practice that includes what is effectively a ‘contract’ for both sides (practice and locum) that describes the responsibilities of both partners to the contract (Anon, 2004b). McKevitt et al (1999) conclude that strategies in general practices which improve the support given to locum doctors will encourage high quality performance of those doctors. In a similar vein, the Royal Pharmaceutical Society factsheet on working as, and employing, a locum (RPSGB, 2007) gives a description of what each side of the contract should provide and expect.

The National Clinical Assessment Service (NCAS), the body that works with health organisations on concerns about health professionals performance, has recognised that there are particular problems in tracking the performance of locum health professionals, where there is no ongoing record of work or management structures to support the individuals (Anon, 2008b). NCAS recommends that organisations keep records of locum performance (example documents are available on the website), and that locums can support themselves by keeping a portfolio of posts, references and responsibilities. It is not known to what extent this recommendation has been taken up by health organisations and individuals.

Some of the negative attitudinal responses to locum pharmacists described in Section 2.8 also appeared to be the case for locum doctors. The ‘[he’s] only a locum’ statement appeared to be a shared issue with pharmacy (McKevitt et al., 1999), with doctors reporting feeling like an outsider, and undervalued.
2.11.2 Nurses

Around 686,000 nurses were registered with the Nursing and Midwifery Council (NMC) in March 2007, the last statistical analysis of the register by the NMC (Anon, 2007). This report also notes that the nursing workforce is 89% female, in contrast to a 56% female pharmacy workforce (Seston et al., 2007).

Buchan and Seccombe (2008) note differences in the nursing workforce between community and hospital sectors, with most nurses currently working in a hospital environment, with community-based nurses being on average older (to some extent due to a traditional model of early years spent in the acute sector followed by a move to community care). Community-based nurses are also more likely to work part-time than hospital nurses. This is not a picture reflected in the pharmacy workforce, where most pharmacists work in the community, and may limit comparisons between the professions. Nursing literature commonly refers to the secondary care setting, which makes comparisons with community pharmacy difficult. Similarly, there are very limited opportunities for nurses to become independent contractors providing NHS services, the picture being much more of employment.

The nursing profession refers to ‘bank’ or ‘agency’ nurses, rather than ‘locums’, to describe flexible, temporary working. Nurse banks are generally run by NHS Trusts to provide staff flexibility within the employed workforce, whereas agencies are private companies. As bank nurses are employees of the NHS, and managed via NHS mechanisms (Anon, 2005c) (whereas agency nurses are not), it may be inappropriate to combine the concepts of bank and agency as a single method of temporary working (as much literature seems to do). Differences in the practical and governance processes around the two ways of working may make the types of staff working in them, and the outcomes, very different. Comparing bank nurses to the locum pharmacist may not be an appropriate comparison. A comparison with the ‘relief’ pharmacist, a pharmacist employed by a company who works peripatetically within that company, may be more appropriate. Such a pharmacist will be integrated into the working methods of that company, and whilst may be faced with unfamiliar staff, the processes within the pharmacy will be familiar. The concept of NHS-run staff banks is rare in the pharmacy profession, presumably due to the much smaller size of the secondary care pharmacy workforce compared to primary care making it not worthwhile. As mentioned, the nearest comparator is the employed relief pharmacist. John and Turner (2010) do make reference to the possible advisability of employers establishing banks of employee pharmacists to provide cover, rather than use of locums. The benefits of this are suggested as greater cost-effectiveness, in addition to
career development and flexible working for the employee. Clearly, there are other workforce models than the existing locum paradigm.

In terms of the tasks that agency nurses undertake, one report indicated that the role of the agency nurse was necessarily limited, in that they were unable to undertake all the tasks of a permanent staff member (Manias et al., 2003), because of their temporary nature and lack of knowledge about activities undertaken previously (“they weren’t there yesterday”). This reflects to some degree on the pharmacy locum situation, where it appears that locum pharmacists do not undertake all the activities of the permanent pharmacist. The paper also describes professional and social (at work) isolation of agency nurses, with them not being engaged in formal and informal networking opportunities at work.

Attitudes to agency nurses appeared to be mixed. Manias et al. (2003) reflected this when reporting that agency nurses tended to be older, more experienced nurses, which meant they brought additional valuable skills to the workplace, whilst also noting other opinions that agency nurses lacked professional commitment. A discussion of agency nurse competency in the USA (Novak, 2005) described a process for assessing and maintaining competency that included comment on the process improving morale for employed staff. It seems that most of the attitudinal comment regarding agency nurses is based upon reported annoyance, added workload and frustration from other employed nurses. It is presumed this is because nurses more commonly work alongside other nurses, unlike GPs or community pharmacists who experience more professional isolation.

Comparisons with other professional groups such as doctors and nurses have provided some parallels and some areas where direct comparison is difficult. The most appropriate comparison appears to be with the locum general practitioner – very often sessional, the work contract is often arranged by personal communication, doctors work with non-medical staff in an unfamiliar environment, and may be professionally isolated. In particular, access to continuing professional development opportunities and professional support was a common feature. Also, the contractual status of general practice more closely mirrors that of community pharmacy than nursing, with opportunities for practitioners to become independent contractors (albeit increasingly difficult in community pharmacy). The agency nurse may be another useful comparator, but a significant amount of nursing literature refers to secondary care, where nurses usually work with other nurses. The efficacy of bank nursing as a comparator is not clear as this group may have more in common with the part-time employee or relief pharmacist than the locum pharmacist.
2.12 Conclusion

There is a dearth of information about locum community pharmacy. Given the changing picture of community pharmacy (for example, growth in enhanced services, changes to continuing professional development requirements, the responsible pharmacist agenda) and the size of the locum workforce, it seems pertinent to examine some of the issues further. Locums’ access to CPD opportunities is an area that has been recognised by national bodies in other professions (GMC, 2004) and should be a cause for concern for the pharmacy profession. Future developments such as pharmacist revalidation may present particular difficulties for the locum workforce and locum’s thoughts and awareness of this topic will be explored within this research.

Similarly, the tasks undertaken by locum pharmacists also deserve further research. National developments in accountability within community pharmacy will bring into focus the roles played by locum pharmacists. Having a clear understanding of the roles that locums currently undertake will help clarify the impact of the responsible pharmacist agenda.

Given the large size of the locum pharmacist workforce, and consequently the number of pharmacies operating with locum pharmacists working in them, the responsible pharmacist agenda may have a significant impact on the way that locum pharmacists approach their work responsibilities. It may force locum pharmacists to have a greater consideration of the management processes behind the day to day systems in place where they work. Evidence suggests that locum pharmacists do make judgements about the safety and capacity of the pharmacy they are working in, but also that they may be in a poor position to make these judgements. This element of judgement, in assessing the safe pharmaceutical operation of the pharmacy, will be explored as part of the research.

There is a need therefore to clarify what locum pharmacists consider to be their role and how developments in pharmacy may change the way locum pharmacists view their role. Work by Shann and Hassell (2004) has explored the basis of areas of work undertaken by locum pharmacists and the literature reveals a split between clinical, ‘professional’ pharmacy tasks undertaken by locums, and managerial tasks that locums largely do not undertake. In contrast, there is some indication that locum pharmacists are less likely than pharmacy managers to undertake some professional tasks such as advanced and enhanced services. Some research insight into reasons and motivations for this would be useful.
There is evidence that community pharmacists are experiencing some stress from workload pressures. Increasing workload in community is evidenced by rising prescription numbers and increased activity from advanced and enhanced pharmacy services (Appendix 1). It is clear that locum pharmacists share these pressures with other community pharmacists (McCann et al., 2009), (Gilpin, 2009). As locum pharmacists differ in some respects to other community pharmacists, in terms of the tasks they undertake and the extent to which they engage with advanced and enhanced services, it may be that locums are subject to different stresses, but this is not known.

Working patterns can also affect work stress and performance. The growth in 100-hour pharmacies over recent years has provided opportunities for out of hours working, and what might be termed shift working by pharmacists. Shift working is known to have deleterious effects on work performance. Work underload, as well as overload, can also affect performance. Work underload may be more common in late night or early morning work situations. It might be expected that locum pharmacists are more likely to work out of hours than other community pharmacists, but this is not known. Locum pharmacists’ views on work stresses will be explored as part of the research.

There is anecdotal opinion that locum community pharmacists have a reputation for poor performance, often strongly counterargued by locums themselves. Locums’ perceptions of these attitudes will be explored during the research.

2.12.1 Research aim and objectives

Based on the conclusions of the literature review, the research aim of this study is to explore locum community pharmacists’ experiences and perceptions of their work.

The objectives to deliver this aim are:

- To describe the work pressures that affect locum community pharmacists
- To explore locum community pharmacists’ views of their role
  - Their views on their local working situation
  - Their views on changes in national policy on their role
- To explore locums’ perceptions of others’ attitudes towards locums
3 Methodology

This section describes the decision making and process activity that forms the basis of the research. The choice of research method is discussed initially, followed by a description of the approach to sampling. The analysis approach and process are described, along with ethical and practical considerations of the research.

3.1 Choice of research method

The research aims to explore the attitudes and perceptions of locum community pharmacists on a range of issues relevant to their working lives.

Qualitative research techniques lend themselves to this type of research, as the study is exploratory, and seeks to answer ‘what’, ‘why’ and ‘how’ questions (Carter et al., 1999). Quantitative methods would not be appropriate, as these could aim to address ‘how many’ type questions, when the ‘many’ has not yet been clearly identified. By using qualitative methods, ideas around processes, beliefs or models that exist can be explored (Carter et al., 1999).

Qualitative methods may be typically be grouped into three categories – observation, interviews and document analysis (Cassell and Symon, 2006). Observation is a method that could usefully develop aspects of this research further, but would not be suitable for the scoping nature of the project at this stage, as issues of relevance to community pharmacy locums have yet to be explored. Also, there are significant practical barriers to observing practitioners who may not have a regular place of work in terms of obtaining consents from the organisations involved. Observation may in fact prove a useful method for some types of research into locum community pharmacy, especially interactions with staff. In a busy community pharmacy setting, it is fraught with practical difficulties, especially given the inevitable transient nature of the locum working pattern. It also presents ethical difficulties, working with staff and patients at short notice. There may also be commercial and ethical barriers presented by the companies who have contracted the locum.

Document analysis similarly would offer some insights to locum work, including contracts, standard operating procedures, resources locums collect for themselves such as reference books and practice guidance. Again, this method could be used to further develop aspects of this research, but would be poor at exploring attitudes and perceptions.
Interviews provide an opportunity to explore ideas with participants in an interactive manner. Interviews can be categorised into three types: structured, semi-structured and depth (Britten, 1995). Structured interviews comprise delivering a fixed, structured framework to participants, with usually a fixed choice of responses. This requires a previous knowledge of the issues to be examined, and previous work which has identified the validity of the questions to be explored. Semi-structured interviews use an interview guide, that is, a loose framework of questions around the research area, which allows divergence to explore issues of interest to the interviewee and also allows the order of questions to change, allowing a natural flow of conversation. Depth interviews have less structure than the two options above, and usually cover one or two issues in a great deal of depth.

Focus groups form another structure for interview research, but these were not considered suitable in this case, as the research aimed to explore individuals’ perceptions of their work environment. A focus group environment may also make participants less likely to reveal contentious or sensitive issues in front of each other. It is likely that focus group methods could be use in future research to take forward the findings developed in this research.

Semi-structured interviews were used as the research method in this project. The method provides a flexible framework to explore issues of relevance to locum community pharmacists based on the research aim, whilst also allowing new issues raised by the respondent that may not have previously been considered by the researcher to be discussed (Cassell and Symon, 2006). It also allows a breadth of responses to emerge, that could otherwise be restricted by undertaking interviews in more depth on a narrower range of issues. It provides an opportunity for locum community pharmacists to express their views and perceptions in their own words, and for the interviewer to clarify and explore their responses. The process of interviewing itself may also contribute to the nature of the data collected. For example, interviewer questioning itself may cause the interviewee to think through ideas more thoroughly, and to formulate new ideas for themselves.

Qualitative research methods should be established within a theoretical framework that reflects the aims of the research, and this should be explicit within the research method (Braun and Clarke, 2006). A realist framework describes an approach which ‘reports experiences, meanings and the reality of participants’ (Braun and Clarke, 2006 p81), in contrast to a constructional approach, which puts forward that these experiences and realities do not have an absolute value, but that they are constructs of the person’s interactions with their environment (Braun and Clarke, 2006). A realist approach was
taken in this research, where descriptions of interviewees’ experiences are taken to represent those experiences. It was felt that this was appropriate to the nature of the study, exploring locum community pharmacists’ experiences and perceptions, which were essentially descriptive. The extent to which this approach was adhered to is discussed further in Section 5.2 study limitations.

The data was analysed using thematic analysis. This is described by Braun and Clarke (2006 p79) as ‘a method for identifying, analysing and reporting patterns within data’. The method is described in more detail in Section 3.5 below.

3.2 Sample

The sampling process aimed to provide a diverse range of participants, in terms of age, gender and geographical location in England. Diversity would increase the likelihood of identifying a range of experiences around the interview topics, giving a greater validity to the themes that emerged from the data. In addition, the sampling process was allowed to develop over time if necessary, to accommodate exploration of the emerging research themes. The diversity of the locum workforce has also been noted (Shann and Hassell, 2004), and while not aiming to be representative of the locum population, the sample should recognise this diversity as a factor.

3.2.1 Sampling process

The base population for the research is the locum community pharmacist workforce in England. Essential criteria for participation in the research were that the pharmacist was registered and was currently working as a community pharmacy locum.

At the time of the research, the RPSGB maintained a register of pharmacists in the UK (this role passed to the General Pharmaceutical Council on September 27 2010). Census data were collected in 2008 (Seston and Hassell, 2009), providing the RPSGB with demographic information, and information on which sector of the profession the individual currently works in. There was the opportunity to report multiple job roles, which enables locum community pharmacists to be identified from the pharmacist register. An application was made to the RPSGB for access to this database, following receipt of University of Manchester ethics approval for the study. Due procedure for authorised access to the database was followed.

The sample requested from the RPSGB was defined by the following:

- Registered pharmacists
• Working as a community pharmacy locum
• Age/gender representative of register
• Contacts – email and address
• England, with three quarters of the sample from north west England

In addition, a request was made that any potential participants who had been previously involved in other research undertaken by the University of Manchester were excluded from the sample. This filtering was undertaken by a member of University staff, and was put in place to avoid harassment of pharmacists with multiple research requests.

The requirement for a portion of the sample to be located in North West England was a pragmatic response to the need of the researcher to gain experience of both telephone and face to face interview techniques. This ensured that some potential participants were relatively close geographically.

The number of potential participants selected was based on informal discussion with other researchers doing similar work with a pharmacy population. This revealed a likely response rate of about one in ten. The research project aimed to complete interviews up to data saturation, or until a maximum of twenty interviews had been completed. Twenty was considered the maximum given the resources for the project, following discussion with supervisors and other researchers.

The sample provided by the RPSGB consisted of 166 pharmacist contacts, 103 from north west England and the remainder from the rest of England. Seven pharmacists were then removed from the sample as they were personally known to the researcher.

The invitation letter, consent form and study information sheet (provided as appendices to this report) were sent to batches of potential participants, along with a stamped addressed envelope. Initially, batches of ten were issued, but following a slow response rate, batches of thirty letters were issued at approximately three week intervals. The author issued all invitations to the pharmacists and undertook all other communications with participants.

The approach to selecting participants follows a theoretical sampling model, where the nature of the data gathered influenced future decisions about the demographics of the participants invited to take part (Mays and Pope, 1995).

The demographics of the sample were reviewed after three positive responses had been received, and interviews taken place. A decision was taken to issue invitation letters to the next thirty pharmacists in the sample list who were 35 years old or less to
retain the diversity of the sample by targeting a younger population than had been interviewed so far. In the end, invitations were issued to all participants in the sample. The response rate is discussed in the results Section 4.

3.3 Interview process

3.3.1 Interview guide development

Semi-structured interviews require the development of an interview guide, which gives a structure to the interview. The guide usually covers a range of issues which should be discussed during the interview, but allowing for a naturalistic interaction with the interviewee. It should also allow for exploration of issues in greater depth where it seems appropriate, and for new, unexpected issues to arise (Britten, 1995). It is also usual for the guide to develop over time following reflection on previous interviews, as the research progresses. The interview guide is shown in Appendix 3: Interview Guide

Cassell and Symon (2006) suggest that interview guides generally derive from three sources: the research literature, the interviewer’s own experiences, and informal sources such as discussion with others with knowledge of the research area. This approach was used for development of the interview guide for this study.

Research literature provided the basis for a significant proportion of the interview guide, principally in areas such as stress, roles locum pharmacists undertake, participation in enhanced services and continuing professional development. The researcher’s own experiences as a locum community pharmacist contributed to issues including the impact of staff on locum working, attitudes to locums and national changes to law and policy that have had an impact on the pharmacy profession. Informal discussion with others (pharmacists and academic supervisors) provided some validation of the proposed questions. No changes were made at this stage, but the discussions provided some supplementary, more in depth questions to explore the issues further (‘why’ and ‘how’ – for example from the interview schedule, ‘Why did you choose to become a locum?’ and ‘How do you feel about that?’).

During the interview process, the concluding statements included a prompt to invite the interviewees to comment on any other locum issues that they felt had not been covered by the questions, and that they wanted to express (Cassell and Symon, 2006). No interviewees made suggestions for further questions that could have been included in future interviews.
However, changes were made to the interview guide as the interviews progressed. After interview 4, a question on patient safety was added, based on themes apparent from the first four interviews. It is outside the scope of this study to examine the impact on patient safety of locum working, but the question did highlight locum issues with workload and continuity, so was felt to be useful. Similarly, a question on the historical context of locum pharmacy (‘Is being a locum different nowadays to say, 10 or 20 years ago?’) was removed after interview 5. This question was intended only for interviewees with sufficient years experience to answer it, but did not elicit any meaningful responses. It was felt that exploring the emerging issues, particularly staff interactions, in greater depth was a greater priority than historical context.

To illustrate another progressive change, reflection after interview 1 revealed that it was likely that the interviewee had not understood the question on concept of pharmacist professional revalidation, and this had not been explored further during the interview. In following interviews, the question prompting consideration of revalidation was expanded from ‘do you think revalidation will have any impact on you as a locum’ to ‘what about the impact of revalidation, where the pharmacist has to demonstrate their competency to stay registered?’.

3.3.2 Arranging the interview

On receipt of a signed consent form, participants were telephoned or emailed to confirm a convenient time to undertake the interview. These were done immediately using the telephone if the participant was willing. A total of twelve interviews were undertaken. Two interviews were conducted face to face, one in the pharmacist’s home and the other in the workplace (an office-based setting). Both participants volunteered to have a face to face interview. These two interviews were undertaken principally to provide the researcher with experience of face to face interviewing. Interviews took place between May and September 2010. The remaining ten interviews were conducted over the telephone. Of these, nine pharmacists were interviewed by telephone in their homes and one in his/her workplace (an office-based setting). No interviews were conducted whilst the pharmacists were in a community pharmacy. This decision was guided by ethics approval restrictions and requirements to obtain head office approval in some cases to undertake research on company premises.

The interview guide (Appendix 3: Interview Guide) was used as a semi-structured outline to undertaking the interview. Participants were reminded of the purpose of the interview, and confidentiality issues explained, using the consent form (Appendix 5). They were then asked if they agreed to the interview being taped. All participants
agreed to this. At this point, the taped interview was begun. At the end of the interview, participants were thanked and asked if they wished to receive a summary of the results, and told the likely timescale for this. All participants agreed to this.

3.3.3 Conducting the interview

All interviews were undertaken by the author. The interview process was structured to provide a natural flow of conversation, and began with some demographic questions about the interviewee. After reflection on the first two interviews, the initial questions were made more open and less directive, to put the interviewee at ease and establish rapport. Questions were used as a guide to subject areas only, and the interview structure was significantly guided by interviewees’ responses.

The questioning technique of the interviewer was reviewed by supervisors after each interview from the transcripts, with feedback on performance. Reflective statements were written by the interviewer immediately after each interview, and again after transcription of the interview. These reflections included information on the interviewer’s performance, on how the interview schedule was utilised, practical issues that may have impacted on interview and the interviewer’s feelings about the interview. They also described thoughts about the content of the interview and how this should amend or contribute to the future research process. The reflection statements and transcripts of the interviews were shared with supervisors to discuss and reflect on the interviewer’s performance and developing skill. In this way, the skill of the interviewer was reviewed during the process of interview, along with the growing data. An additional factor was reflection on the rapport established during the interview process. This was assessed by recording the researcher’s feelings about each interview, but also by the researcher reviewing and reflecting on her use of the interviewee’s own words to frame questions.

Participants were given the option of taking part in a face to face interview, or telephone interview. Two participants were interviewed face to face. In part this was a practical consideration, as participants were geographically spread across England. There is some evidence that telephone and face to face interview processes do differ in terms of the interactions that take place between the interviewer and interviewee (Irvine et al., 2010). For example, that interviewees talked more during face to face interviews, but there was no evidence that misinterpretations were more common with either method. In practice, differences were not noted between methods, and the
project supervisors were unable to identify which method had been used from the transcripts.

Participants were advised that the interview process would take approximately thirty minutes, and this proved to be a good approximation. Duration of interviews ranged from 21 to 46 minutes with an average of 34 minutes. It is notable that interview duration decreased during the study. This may be due to randomness, or changing demographics of the participants, or more likely, increasing skill of the interviewer in identifying and targeting key issues.

All participants were asked before interviews commenced whether they still agreed to the interview being recorded, in addition to them having completed a consent form. All participants agreed to this. Ethical considerations are discussed further in Section 3.9.

An additional issue that arose during the course of the research involved the use of third party stories. Many interviewees offered stories or descriptions about other people (usually other locum pharmacists that they had heard about through staff members) that described issues they appeared keen to express. This prompted some thought by the researcher about the nature of the data obtained in the interviews. Analysis of stories is an acknowledged approach in qualitative research, and can be used to explore emotional and symbolic aspects to situations (Cassell and Symon, 2006).

All descriptions of circumstances that interviewees had experienced may be filtered through the interviewee’s own values, sense of self-worth, and desire to give a good impression to a fellow pharmacist. Descriptions of third parties’ activities must be treated with caution, as such stories are likely to have been filtered through many sets of values as they are distributed. Certain locum pharmacists stories can be thought of as ‘folklore’, in the sense that it is likely that similar stories circulate, which may or may not have a factual basis. The factual accuracy of the story in some respects is not the point of telling it, it is the meaning that it intends to get across that is important to the teller. It may provide interviewees with a ‘shorthand’ method of expressing issues that they may otherwise be reluctant to do (Cassell and Symon, 2006). There may be professional reticence to discuss the failings of other pharmacists and use of stories passed on by others may help express these ideas (though it has to be said that this was not evident in most of the interviews, where pharmacists proved remarkably frank in their views on other pharmacists). Third party stories in this research have been reported within the results section, but with the caveat that they may or may not represent the truth of the situation (Cassell and Symon, 2006). This is discussed further in the results section and in discussion of realist and constructionalist approaches to the research. In acknowledging that stories may not necessarily reflect reality and may
be presenting meanings, a constructionalist approach is being taken to these stories, in contrast to the planned realist approach to the remainder of the research.

3.4. Data saturation

The study was designed such that interviews would be continued until data saturation had been reached, or until a maximum of twenty interviews had been completed. This upper limit was based upon practical considerations – the resources available to the researcher and the duration of the research project. But when is data saturation reached? It is clear that every new interview interaction with a pharmacist will yield some new issues, however insignificant they may seem. People express their views in different ways, and different interpretations can be made of similar issues. Cassell and Symon (2006) suggest two questions to ask of data: “Is this adding to my understanding of the topics I set out to study?” and “If not, is it raising new and related topics which are of interest?” These two questions were used as the basis for identifying data saturation. The reflective statements created after each interview and transcriptions were used to identify and record responses to these questions.

It was agreed by the researcher and supervisors that data saturation had been reached after interview 11, but as interview 12 was already arranged, this was also undertaken and analysed. This final interview confirmed the data saturation.

3.5 Analysis

This section covers the processes of data transcription and subsequent coding.

3.5.1 Transcription

Nvivo 8® was used as a software tool to store and to partially analyse the data. Audio data files were imported into the Nvivo® programme, and transcribed within the software to create a text document linked to the audio file. Transcripts were then copied into Microsoft Word® to facilitate sharing with supervisors and further analysis.

The researcher developed a series of conventions rapidly over the first two or three interviews for consistent transcription. Notes were made on each reflection statement following the transcription as to the conventions employed.
Descriptors such as [pause], [sigh] and [laugh] were used to indicate the flow and tone of the conversation. Supporting phrases such as ‘um’ and ‘er’ were included. Some accent issues (dropped consonants) were removed for ease of reading. All references to personal names, company or organisation names and towns were removed. One name that was in the public domain (as a legal case) was maintained. A ‘playwright’ format, where the speaker is identified at the beginning of the paragraph phrase, was used. ‘P’ and ‘I’ were used for ‘pharmacist’ and ‘interviewer’. In most cases, paragraph breaks indicated change of speaker. In some cases, paragraph breaks were used to break up large volumes of text, to facilitate analysis.

Recorded interviews were transcribed in full, including farewells and informal comments about the environment during the interviews (for example, problems with phone batteries). For each interview, there was a short period of unrecorded introduction at the start, until verbal consent to record was obtained. Also, in several interviews, there was a short period of comment from the interviewee after the recorder was turned off, as the participant added a further point. Where this was related to the research area, notes were made in the reflection statement about these points, immediately after the interview.

The only exception to full transcription was removal of the interviewer’s affirmative statements during the interviewee’s speech (usually ‘yeah’). These were removed to allow a coherent flow of speech from the interviewee.

Transcribed interviews were checked for accuracy against the audio recording by the researcher.

3.5.2 Sorting data into themes

Thematic analysis clearly describes sorting, or coding, data into themes. But what is a theme? A theme has been defined (Braun and Clarke, 2006) (p82) as a piece of data that ‘captures something important in relation to the overall research question’, and this definition was used as the basis for theme identification in this study. It is also noted in that paper that researcher judgement is the key factor in deciding whether a data section is a theme or not, which was the case in this research. Prevalence of themes (how often the same idea appeared in the data) was considered in the analysis. The results section gives some indication of prevalence, but this was not given undue emphasis in interpretation of the results. Prevalence was described in terms of how many interviewees described a theme. However, themes considered significant, which may have appeared only once in the data, were given equal weighting in the results to repeated themes.
The process of thematic analysis has been described as either inductive or theoretical (Braun and Clarke, 2006). An inductive approach means that the data is coded as it appears to the researcher, without any pre-existing framework in which it needs to fit. A theoretical approach in contrast would be driven by the researcher’s aims, and themes would tend to follow the interview question schedule. These might also be described as being ‘data driven’ or ‘theory driven’. It was intended that a broadly inductive approach be taken to the analysis in this study. The research objectives were kept in mind during the analysis, in that themes which matched the objectives were identified, but the analysis allowed for the development of themes outside these objectives, and the results reflect this. Thus the results section does not follow the pattern of the interview question schedule, but does contain elements that clearly relate to it.

However, this is influenced by the place of the literature review in the study, and of the researcher’s own experience. (Braun and Clarke, 2006) note that there are differing views about the place of literature review in qualitative analysis. By the above definitions, an inductive approach would mean examining literature after analysis, so there is no pre-existing mental framework for the researcher. A theoretical approach will involve using the literature prior to analysis to frame the research. This theoretical approach has been used in this study. An additional factor is the extensive community pharmacy background of the researcher, which creates its own framework that cannot be ignored in the analysis.

Thus, it is acknowledged that there is a mix of approaches in the analysis, taking in account the need to explore previously unidentified themes in the data and not be restricted by the theoretical framework, versus the requirement to complete a literature review as part of a degree award and taking into account the experience of the researcher.

An initial draft of coding was undertaken with the first four interviews using Nvivo. Following that, each interview was coded sequentially, reflecting on the codes already identified. The coding process was systematic, which each phrase being given equal consideration. Initial coding was largely descriptive, or open coding (Cassell and Symon, 2006), followed in later iterations by more analytical coding, for example, reviewing meanings and attitudes exhibited by the interviewees (Gibbs and Taylor, 2010).

Following the initial coding of all interviews using Nvivo®, a tree-structure of major themes was identified. Nvivo® was thus used as a transcription and data storage tool, and to create an initial draft of major themes. Following this, interview transcripts were again reviewed for these, or new, themes by on-screen review in MicroSoft Word®.
Relevant sections of text from all transcripts were cut and pasted into separate documents for each major theme. These were then rearranged into sub themes within each theme document. An example would be a major theme of ‘staff’, with sub themes of ‘good staff’, ‘locum interactions with staff’ and so on. The theme documents act as a repository for all data items linked to the themes, which then provided the basis for composition of the results of the research. Quotes were taken selectively from the theme documents to support and illustrate the results. Links between themes were identified during this process, and highlighted in the results section. Within the coding process, identification of themes which contradicted existing themes was actively pursued.

3.6 Quality considerations

3.6.1 Researcher bias

This research was conducted by an experienced community pharmacy locum, and as such, the potential for researcher bias is significant. It is acknowledged that in qualitative interview research, the interviewer is a part of the research process, along with the interviewee (Cassell and Symon, 2006). The rapport, empathy and interaction between interviewer and interviewee can be seen as part of the research process. The interviewer will shape the research process by her adaptive listening and communication skills. The interviewee shapes the process by the nature of their responses, which can actively alter the path of the interview. However, it is pertinent to examine the interaction between the researcher and the research participants in this project, and explore the influence of that interaction on the research data.

3.6.2 Collusion between researcher and interviewee

Whilst the interviewer is part of the research process, it is important that the interviewer does not impose her views or experiences on the interviewee, or on the interpretation of the interviewee’s responses (Britten, 1995). Collusion may be described as the interviewer and interviewee appearing to come to a joint agreement about an issue. In reality, this joint agreement may be an illusion, misinterpreted by both sides.

The researcher and supervisors discussed issues of collusion after the first interview had taken place. When two pharmacists discuss pharmacy issues, there is considerable use of jargon, acronyms and jointly understood phrases that are used as
shorthand in conversation. The supervision team explored the issue of whether the researcher should accept these shortcuts to communication, or explore each in depth with interviewees, to avoid assumptions and bias from existing researcher knowledge sabotaging the research process.

It was agreed that commonly used terms about the practicalities and structures of pharmacy, such as MUR, EHC, enhanced services, multiples, independents, should be used as part of the interview process. These are readily understood terms used in the pharmacy press, and to explore each one in depth would create an unwieldy and prolonged interview process that would inhibit the true data collection required of the interview. Some element of joint understanding of language also helps rapport.

However, it was also agreed that the researcher should not collude on understanding about thoughts, actions, attitudes and feelings discussed, and these should be explored fully. Quality assurance of this process was provided by the supervision team reviewing transcripts and researcher reflections on each interview, and commenting on any examples of collusion found in the transcript. The researcher then applied these reflections to all future interviews.

3.7 Validity

Validity means the extent to which the results represent the true situation under study. Triangulation is a common approach to demonstrating validity in qualitative studies, where evidence to support the data is sought from other sources (Mays and Pope, 1995). This involves seeking corroborative evidence from other independent sources, and by different means. This sometimes involves use of focus groups to reflect on the emerging finding, or using documents as an additional resource. Given the limited time and financial resources for this research project, use of other participants such as focus groups was not considered. Supervision meetings provided an opportunity to discuss emerging findings with colleagues experienced in workforce issues, who were familiar with the existing literature.

Methods used to demonstrate validity include deviant case analysis, and constant comparison, which are reflected in the interview and analysis processes. Deviant cases, which contradict the emerging theories, were actively sought. Examples from the study relate to the diverging views revealed on access to continuing professional development (see Section 4.3.1) and isolated views on pharmacists using staff to compensate for their lack of competency in some areas (see Section 4.4.5.2). Constant
comparison involves progressive reflection on the emerging theories, to inform their future development. This process also contributes to the assessment of theoretical data saturation, to conclude the data collection process by providing a sense of when no new major concepts have emerged.

3.8 Reliability

Reliability relates to the extent to which the research could be reproduced by others, with similar results.

External reliability, the extent to which a different researcher could replicate the study, is enhanced by clear descriptions of the methods and processes used in the research. Mays and Pope (1995) put forward a series of questions to ask of qualitative studies, and Hoddinott and Pill (1997) reviewed the methodological detail in a range of studies, finding a lack of explicit detail which reduced reliability. This research study has aimed to provide that explicit detail about methodology.

Internal reliability describes the extent to which a different researcher would reach the same conclusions with these research data. This research is of necessity the work of one researcher, as is required of a University degree award. Transcripts of the interviews were shared and discussed with supervisors, as were the developing concepts from analysis. The recordings of the interviews were also kept, as a point of reference for the accuracy of the transcripts and to ensure the probity of the study (that the interviews had actually been carried out).

3.9 Ethical considerations

The study received ethical approval from the University of Manchester in January 2010. Discussion was undertaken with the University of Manchester and NHS research ethics departments as to whether NHS ethics approval was required. This may have been required because locum community pharmacists are providing NHS services to patients, but the advice provided was that, being subcontractors, NHS approval was not required. Hence, University of Manchester approval was obtained.

Confidentiality issues were paramount in the interview process, and also in management of the data following the interview. Participants were assured of
confidentiality, and this was reinforced at the start of each interview, when they were
told that any names or recognisable information that they talked about would be
anonymised in the transcripts. Identifiable features such as named motorways and the
type of organisation worked for were also anonymised where it was felt this might
compromise confidentiality. It was hoped that this would give interviewees the
confidence to talk freely about their experiences. Data storage confidentiality was
maintained by having numbered transcripts, the researcher being the only person able
to match the number to an individual. Participants were advised in the research
information sheet (Appendix 6 in this report) that there were some circumstances
where confidentiality would not be maintained, if patient harm would result. No
instances of this nature occurred.

Interviewer safety was protected by the purchase of a mobile phone SIM card, the
number for which was used for the research. University policies on lone working were
followed.
4 Results

The results of the interviews are presented in the following way. Each section heading within chapter 4 comprises a main theme from the analysis. Within that section heading, subthemes are also explored. Data are presented for each theme, along with interpretation of the theme and reference to the literature where appropriate.

The order in which the themes are described derives broadly from the order in which they were revealed in the analysis, which in turn derives from the interview schedule and the flow of the interview conversations. The presentation order does not imply frequency or importance of the theme.

4.1 Demographics and characteristics of the sample

At the start of each interview, locums were asked some questions about themselves and about their practice as a locum community pharmacist, and the results are shown in Table 2:

Table 2 Demographics and characteristics of interviewees

<table>
<thead>
<tr>
<th>Interview number</th>
<th>Gender</th>
<th>Age</th>
<th>Duration of locum working</th>
<th>Number of days per week worked</th>
<th>Hours worked per day</th>
<th>Regular or variable pharmacies worked in</th>
<th>Other jobs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>M</td>
<td>57</td>
<td>20 years</td>
<td>3 days</td>
<td>Full days</td>
<td>Variable</td>
<td>Non-pharmacy</td>
</tr>
<tr>
<td>2</td>
<td>F</td>
<td>40</td>
<td>8 years</td>
<td>3 day</td>
<td>Full or part</td>
<td>Regular (second pharmacist)</td>
<td>None</td>
</tr>
<tr>
<td>3</td>
<td>M</td>
<td>55</td>
<td>10-15 years</td>
<td>7 days</td>
<td>Full, some evenings</td>
<td>Variable</td>
<td>None</td>
</tr>
<tr>
<td>4</td>
<td>F</td>
<td>40</td>
<td>15 years</td>
<td>16 hours</td>
<td>16 hours/week</td>
<td>Regular (second pharmacist)</td>
<td>None</td>
</tr>
<tr>
<td>5</td>
<td>M</td>
<td>32</td>
<td>3 years</td>
<td>5-6-7 days</td>
<td>8-9-12 hours a day</td>
<td>Variable</td>
<td>None</td>
</tr>
<tr>
<td>6</td>
<td>M</td>
<td>67</td>
<td>6 years</td>
<td>2 days</td>
<td>9 hours</td>
<td>Variable</td>
<td>None</td>
</tr>
<tr>
<td>7</td>
<td>F</td>
<td>54</td>
<td>17 years</td>
<td>1-2 days</td>
<td>Full day</td>
<td>Regular</td>
<td>Other pharmacy</td>
</tr>
<tr>
<td>8</td>
<td>M</td>
<td>62</td>
<td>10 years</td>
<td>2-3 days</td>
<td>Full day</td>
<td>Variable</td>
<td>None</td>
</tr>
</tbody>
</table>
A total of 18 consent forms were received from the 166 invitation letters sent, indicating willingness to be interviewed. A suitable time for interview could not be found with one interviewee during the timescale for the project, and the other consent forms were received after a satisfactory number of interviews had been completed. Pharmacists who had returned consent forms but were not interviewed were thanked for their interest in the study.

4.1.1 Discussion on characteristics of the study sample

Five of the interviewees were male. The average age of respondents was 46, with a range of 32 to 67 years. No interviewees were in their twenties, four were in their thirties, three in their forties, three in their fifties and two in their sixties. The lack of any interviewees in their twenties is a limitation of this study (see Section 5.2). Age became relevant when considering motivation for locuming (see Section 4.2), considering where people were in their lives, for example, retired or dealing with childcare and when considering locum professionalism issues (Section Error! Reference source not found.).

As discussed in Section 2.5, the total locum population is a very disparate group. Seston and Hassell (2009) report that slightly more locum community pharmacists were female than male (52.8% versus 47.2%) and locum community pharmacists were on average slightly older than the general pharmacist population (44 years versus 42 years). The pattern of the sample in this study does crudely match these averages.

Interviewees gave an approximate indication of how long they had worked as a locum. This ranged from two to twenty years. They were also asked approximately how many days per week they worked as a locum. The range given was from seven days a week to half a day or less (for example, half a day per fortnight or one evening).

The number of hours worked per day was also recorded. This was helpful to explore evening or shift working with locums (described in Section 4.6.6).
Interviewees were asked if they currently worked in the same pharmacy all the time, or if they worked at different pharmacies as a locum. This was not defined for interviewees, but they were asked to describe their working patterns in their own words. Half of locums said they worked regularly at the same pharmacy, and half described variable working. ‘Regular’ also included working across several different pharmacies, for example, interviewee 2 worked in a range of pharmacies for the same small chain of pharmacies. For the purposes of categorising in Table 2, regular means the pharmacist will be largely familiar with the working environment, and variable means the pharmacist will encounter totally unfamiliar pharmacies.

This is an important concept as lack of familiarity with the working environment and the impact on this on the locum experience is a key focus of the research. Whilst half the respondents currently worked regularly in the same pharmacy or pharmacy, all respondents were able to draw on a wide range of previous locum experiences to describe that unfamiliarity. In no case was the current locum pharmacy position their first locum job.

Two respondents said they worked regularly as a second pharmacist. Interviewee 5 also described some experiences of working as a second pharmacist locum in previous work. This proved useful experience to document, as it provided interesting information on attitudes to pharmacists (see Section 4.8) and motivations for locum working (see Section 4.2).

Interviewees were also asked about other jobs they had, in addition to locum community pharmacy. Six interviewees said they had no other jobs other than locuming. This either meant they were full time locums, or that they worked part time as a locum and had no other paid work. The 2009 pharmacy workforce census (Seston and Hassell, 2009) noted that in the total locum population, two thirds reported that they only worked as a locum community pharmacist. This compares with one half of the sample in this study. Other respondents' jobs were described as primary care, hospital, academic or non-pharmacy ('other business interests'). No respondent indicated they were an employed community pharmacist, who also worked as a locum. This again provided useful information on motivations for locum working (Section 4.2).

4.2 Motivation for undertaking locum work

Previous research into motivation for undertaking locum working was discussed in Section 2.6, and revealed a wide variety of reasons described for working as a locum.
These included the flexibility of the role, to accommodate family commitments but also other working and social opportunities; the financial contribution that locum work provides; social contact was identified particularly by older pharmacists; avoiding management pressures of an employed post; variety; and keeping up to date professionally.

All interviewees gave some descriptions of their motivations, and their responses corroborated this variety of motivations for locum working.

4.2.1 Keeping up to date

Seven interviewees discussed keeping up to date as a motivation, or reward, for the locum experience. Locum work was considered as an ‘insurance policy’ by some, maintaining competency in the community sector to keep it open as a future job option.

“Well, it’s good to keep your hand in, I suppose, because if I were to ever want to go back to community pharmacy it would be a lot easier if I’d kept up to date with the necessary skills” (Interview 11, line 4)

4.2.2 Not wanting to work for a company

Ten interviewees reported poor experiences of working for larger companies, which motivated their change to locum working.

“And I just felt, I mean, maybe I had a bad experience with [company 2], but that did really put me off going back into full time employment again” (Interview 4, line 42)

“I don’t want to work for a company” (Interview 1 line 28)

The negative experiences were also described as contributing to ill health as an employed pharmacist.

“That was a big mistake moving to [company 2]. They basically worked me to the bone for two years. I was very ill. I was running a shop by myself with no staff. One day I was on my own in the shop for five hours, I had drug addicts, I had, doing the dispensing I was doing everything. That day I changed my mind about working for a big company. I thought this is not safe, for my own safety, and I’m not getting anywhere like this, and they were not supportive at all... But I was so fed up and I even got ill, I even had to go to hospital because I got ill, I was off work and I was really really ill and I was stressed out” (Interview 4, line 14)

“Having got out of that management pressure thing, I thought I don’t want to go back into that really. It is a bit of a self-fulfilling prophecy isn’t it. Because people aren’t going to want to go back and be treated like [company] treat their managers. Why would you do that? When there’s an option?” (Interview 7, line 68)

Working for a company was also described as ‘soulless’, being reflected in the pressures and restrictions imposed on the employed pharmacist.
“Because pharmacists don't want to be tied down to the rules and regulations of a multiple. And I think that many of the young pharmacists that I speak to don't like the pressures that they're being put under by the management of the companies that they work for. They feel that they're just a number, that it's a soulless job” (Interview 8, line 72)

The two interviewees who did not describe poor experiences of working for larger companies were interviewees six and ten. Interviewee six was a retired hospital pharmacist, and interviewee ten had worked with a PCT for nine years, so it may be their lack of employed community experience that explains this result.

Other pharmacists described life situations (age, family) which did not suit working for a company, and that working as a locum helped them cope with.

“I think really, with my sort of situation, bringing up a family, I don't really see any incentive in working full time as a manager” (Interview 4, line 40)

“Rather than being employed? I would say so. I think, well, I look at my age and I think well, the disincentive of joining a company or what have you at my age is that there's no real prospects.” (Interview 8, lines 44-46)

4.2.3 Not wanting to be a manager

Four locum pharmacists expressed views that their reason for locuming was dissatisfaction with the manager role, which appeared to be different from being dissatisfied with working for a company. The day to day irritations and problems of management were cited as reasons for not choosing a pharmacy manager role.

“But at the end of the day, if we've had a really busy day dispensing, and I just haven't had time to do some of the extra jobs, then I can go home at the end of the day with a clear conscience. Because I know that I've worked as hard as I possibly could have done. And if I haven't got round to doing the extra jobs, then that's ok.” (Interview 9, line 31)

Dealing with staff management appeared to be a significant issue for two locums in particular. The interpersonal issues involved in staff management seemed to be the focus for this. It was felt that locuming absolved locums from these responsibilities.

“The fact that there's some bickering going on, I'm not managing it, I don't have to sort it out. It interferes with my day, but it's not my problem” (Interview 7, line 36)

“A lot of it is staff management. I'm a, I'm a confident personality in a social environment, but in a managerial environment, when you're trying to tell somebody, you know, can they change the style of what they've done, could they do something in a different way, trying to tell people they can't have holidays at the time they've requested because you've got three other members of staff that are off, that sort of governance over other people I wasn't comfortable with.” (Interview 9, line 14)

Three interviewees expressed opinions that being a manager was not what they went into the pharmacy profession to do, and they wished to focus on clinical, not
management issues. The dissatisfaction with management issues in general was summarised by interviewee 9:

“There’s just a whole host of management things that are... not what we’ve been trained for. They’re not what we wanted to do when we set out on a pharmacy degree. If we’d wanted to be business managers, we’d have gone into business management. We did a pharmacy degree and we wanted to be clinically orientated.” (Interview 9, line 56)

4.2.4 Having a clinical focus

The more positive side of not wanting to undertake a management role is the desire to focus on the clinical role of the pharmacist. Five interviewees expressed views of this nature.

Three interviewees specifically noted their enjoyment of the pharmacist role.

“At the end of the day I work because I enjoy being a pharmacist” (Interview 2 line 56)

Other interviewees noted specifically their desire to focus on the clinical side of pharmacy:

“You know, I can concentrate on being a pharmacist” (Interview 9 line 14)

Interviewee 6 was a retired hospital pharmacist, and he reflected that locuming enabled him to maintain his professional identity as a pharmacist:

“I mean I can still say with a very clear conscience that I am a pharmacist. And that I have a position and a responsibility and a standing. Yes. Yes” (Interview 6 line 38)

There was a strong sense within this theme that being a locum enabled the pharmacist to focus on the clinical elements, because some the confounders of being a manager, such as the need to meet business goals, were not present.

“And I feel as well when I locum that I am there as the community pharmacist. And I have no axe to grind with my employer, or no specific targets to meet, or no specific loyalty to that employer. So I feel that I can do the job that I trained to do. Without the constraints perhaps of being an employed pharmacist” (Interview 12 line 16)

4.2.5 Contact with others

In addition to clinical focus, patient contact was considered a valuable outcome from the locum role by three pharmacists. There was a sense that satisfaction was obtained from helping people.

“The patient contact, like I say, on a Saturday there are lots of queries. People who think they’re in real trouble because the doctors surgery is shut and then you can help out...but doing four hours of a locum you feel like you’ve helped people” (Interview 10, line 30)
Only one interviewee (interview 6) reported social contact as a reason for locuming. He was a retired hospital pharmacist, and the isolation was discussed in the context of the other health professionals that he worked with:

“I mean the nurses, the doctors, a lot of them I've known for many years... I think I'd feel very isolated if I just walked away from that” (Interview 6 lines 24 and 26)

4.2.6 Flexibility

All locum pharmacists expressed the view that the flexibility of the role was a key attraction.

“So I like the flexibility but I do realise I'm in a very privileged position that I can walk in, do the hours that I do and walk out again” (Interview 2 line 26)

One pharmacist did complain that this flexibility for other locums put pressure on him, and he considered this part time working reflected a lack of commitment and professionalism:

“And how many times have I been told by a woman pharmacist, 'oh well, I'm only here for the day, and it suits me to do this today, and I'm going at four o'clock this afternoon', and I'm there working til six thirty. Oh yeah! 'I'm only here because it's a bit of pin money, my husband works somewhere else'. Well that's the wrong attitude” (Interview 1 line 91)

Seven locum pharmacists gave explicit reasons for requiring flexibility, describing aspects of their lives that benefited from this flexibility. These aspects included being able to take extended holidays, accommodating childcare, enabling the pharmacist to undertake other work, and to pursue hobbies and interests.

“I'm planning now to leave, to maybe have a gap for a couple of years. So what I do every year is I have a gap, maybe five, six, sometimes, er, last year I had three months holiday. So when I come back, I do seven days” (Interview 5 line 19)

“I decide to work or I don't decide to work. And that suits me. My husband goes away a lot, so I'm a single parent, sort of every five weeks I'm by myself for a few weeks, with three children ranging from ten to six, I have, er, you know it's a huge commitment to the children” (Interview 2 line 22)

“My passion, my hobby is going to concerts, to pop concerts. If I'm going to see Dire Straits, or the Rolling Stones, if I give you three months notice that I'm going to do that, and I'm going to take it off my annual leave, it should be possible. Now as a locum I just don't book it” (Interview 3 line 60)

4.2.7 Financial benefits

Two interviewees stated that the financial benefits were their main motivation for locuming. Other locums did also express that the money was a welcome addition to their finances.
“Initially when I was a newly qualified hospital pharmacist, to be honest initially it was the money” (Interview 10, line 6)

“Er, purely financial. Yeah” (Interview 11, line 14)

4.2.8 Variety

All pharmacists interviewed acknowledged that they enjoyed the variety provided by locuming. This variety related to the different types of medicines and conditions that they met, the different systems and ways of working that they encountered, different staff, geographical areas and different computer systems.

“Variety yeah. I want to expand… I delve into areas like… adult leukaemias and things like that. My stuff is much broader than any normal place you know. That’s one of the pluses. I like to look on the shelves and I’ve never seen a pack of that before, what the hell is it? Oh yeah, it’s that new bloody aldosterone antagonist you know. I’ve read about it but I’ve never seen the box, that’s what I get my kicks out of” (Interview 3, line 92)

“I like going in different places every day, I don’t find it difficult you know” (Interview 5, line 70)

“Being in different places. If you’re in the same pharmacy all the time you become familiar with the GP’s prescribing habits in that locality, the patients, and it’s very much a comfort zone. Going out and locuming it takes you out of that comfort zone” (Interview 12, line 18)

Interviewee 4 noted that the variety of the locum job gave the pharmacist a good background experience with which to adapt to different pharmacy environments.

“And also a good thing is that if you have locumed in a variety of places for five years, which I did, I think you have a tremendous amount of experience at your back…and I don’t think I would have had that from just being a manager in one shop” (Interview 4, line 68)

4.2.9 Being able to say no to work

All interviewees expressed in some sense that the ability to say no to work, and to have the freedom to not return to an unsatisfactory workplace, was a key motivator for continuing to locum. This element of choice appears very important to locums.

“The best thing is being able to walk away sometimes, from a place if it’s been horrendous” (Interview 6 line 48)

“It gets me out of it. I tell them no, I’m not doing it. And er, they can take it or leave it. Because, er, the thing is, I’m in a position whereby I can say stuff you” (Interview 1 line 36)
4.2.10 Contribution of locuming to other jobs

Three interviewees provided comment that they felt their community locum work contributed positively to their other role, in terms of the wider experience it provided, and to ‘see what’s happening on the ground’.

“I like to have some patient contact which I don’t get based in an office. And because I work with other healthcare professionals it helps me to see the problems they have on the ground” (Interview 7 line 10)

“And certainly for the last eight, nine years I've been at the PCT it's been really good to do something a bit more real, you know? Rather than sit in an office. Get that patient contact and see what's happening on the ground, it's really interesting” (Interview 10 line 6)

“And the more I did and reflected on my current role as a teacher practitioner I actually think it enhances my other role, because it gives me different experiences of different pharmacies, and different companies and different ways of working, that you can tell your students about. So I think it makes me a better pharmacist” (Interview 12, line 14)

In summary, motivations for working as a locum encompass appreciation of the flexibility of the role, being able to maintain a clinical focus, financial benefits, social benefits and freedom from management pressures. In particular, a strong theme is dissatisfaction with previous employed status, which either contributed to working pressures or did not allow accommodation for the pharmacist’s lifestyle.

4.3 The locum in the professional context of pharmacy

This section describes locum community pharmacists’ responses to factors within the pharmacy profession that may have an impact on locum working. Interviewees were asked their views on access to continuing professional development opportunities, how they felt revalidation might impact on locuming and whether they felt the responsible pharmacist agenda had had any impact on their working as a locum. These issues are explored within this section.

4.3.1 Continuing professional development (CPD)

All pharmacists are required to undertake continuing professional development activities, according to the standards set by the General Pharmaceutical Council (General Pharmaceutical Council, 2011). Locum pharmacists were asked whether they thought they had enough access to CPD opportunities as a locum. Responses were very mixed, with a split between having more than sufficient access to feeling isolated and unsupported. Five interviewees felt they had good access to CPD opportunities,
three felt relatively unsupported as a locum and the remaining four reported mixed views, which are described below.

Pharmacists were asked about their access to CPD, and sufficient access was reported by five interviewees.

“Yeah, if anything there’s too many, I could do loads if I wanted to. I already do my CPD, thirty hours plus, I record it all and I’ve been, er, what’s the word, when the Society drags all your records down and I’ve passed it all, so I’m happy with that. There’s no problem with that” (interview 3 line 50)

Three locum pharmacists reported some problematic issues with access to CPD. Some degree of isolation was reported.

“I think you are cut off in that respect. I think when I was employed you are sort of force fed all the latest drugs, all the latest information. I think because you’re a locum you’re expected to learn the things, to research the things yourself. Which is fair enough but I think sometimes you don’t always have access to all the latest things that are coming up” (Interview 4 line 48)

The financial costs of funding CPD time and opportunities was raised as an issue by two locums.

“It would be lovely if you could say there was an hour or two hours a week that I could do the CPD in and it’s not coming straight out of my own pocket. Because that’s the problem, if I take the time off locum work, it costs me, if I go to the evening it costs me, if I try to do it outside of that time it’s going to cost me because I’m not doing something else. And basically nobody is ever turning round and saying well, we’ll support you to keep up to date” (Interview 6 line 66)

Other locums discussed how they managed CPD overall, in the context of their other jobs. It was clear that locums recognised the need to undertake CPD relevant to community pharmacy, when they had other pharmacy jobs as well. Interviewee 7 stated how she looked out for CPD opportunities related to community pharmacy:

“I wouldn’t need to know in my, well, it actually does, it does come into my other life, but those are the sorts of things I deliberately keep an eye open for, for when I do locums” (Interview 7 line 40)

Similarly, interviewee 10 recognised that her locum work needed specific CPD activity:

“And my CPD tends to be related more to my four hours a fortnight as a locum than it does to my full time job really” (Interview 10 line 26)

This aspect of CPD in the context of multiple job roles was considered by interviewee 12:

“Er. [long pause]. I don’t think there’s... I guess I’m pausing because I’m not sure of the difference between accessing CPD opportunities as a pharmacist and accessing CPD opportunities as a locum. Because to me, I don’t think there’s any difference” (Interview 12 line 32).
It does appear that locum community pharmacists need to be more proactive than employed colleagues to access CPD opportunities.

“I think as a locum it’s sometimes hard to know what you don’t know. So you perhaps aren’t always up to, certainly for myself that doesn’t do a lot of locuming, you’re perhaps not aware of what the local initiatives are, so you do have to be proactive about that” (Interview 12 line 34)

One problem reported several times was requiring multiple accreditations for enhanced services in different NHS areas. Whilst they are different things, pharmacists did seem to talk about CPD and enhanced service accreditation interchangeably to some extent. The Harmonisation of Accreditation Group (Pharmacy Workforce Northwest, 2010) in the north west of England has created a system whereby accreditation for an enhanced service in one PCT could be carried across to enable delivery of the service in another PCT. This reduced the requirement for multiple accreditations when working in different PCT areas. A number of PCTs in the north west have signed up to the Group standards for accreditation. This concept, which is clearly of importance to the mobile locum workforce, was picked up by several interviewees.

“It [accreditation] should be more like with minor ailments, where it’s all GSLs and what ave you, so it becomes more interchangeable for different PCTs. If you think of my area, it’s huge and I’ve actually done EHC about four times, for different PCTs, and it’s not the way to go, and if the PCTs are not bothered, I’ve thrown the towel in, I say fair enough, I’ve done it four times and I’ll limit my EHCs to [town], [town], [town] and all of them kind of places. I’m not going to start doing you know fifty of the damn courses on the same thing” (Interview 3 line 50)

Interviewee 5 was the only locum to discuss the difficulties of undertaking CPD in a locum environment because of lack of continuity, but this is an important concept.

“And there’s no continuity. When you come to see other people who are locuming, when it comes to CPD, they ask you about how to evaluate your knowledge, and that’s a difficult one. Because I see a situation, I see you today, and I never go back to that place. You never see them again. So with CPD I want to know more about insulin, type of insulin, er, injections, when I was doing MUR, I did CPD on it but I may never come across it again. I knew how to use it, so when it come to CPD, it’s more oriented to employed or permanent pharmacists in one place, to use your knowledge again, to see same patients or different patients. For me, as a locum, it’s difficult when it comes to CPD. I do not find CPD match the life, the lifestyle of locuming, being in different places” (Interview 5 line 70)

In the above quote, interviewee 5 describes how lack of feedback on learning opportunities at work impedes his ability to evaluate his learning. This is reflected in learning situations described by locum doctors (Carvel, 1999), where lack of continuity of the working environment meant that opportunities for evaluation of learning were limited.
4.3.2 Revalidation

Interviewees were asked how they felt revalidation would impact on their ability to work as a locum community pharmacist in the future. The inevitability of revalidation seemed to be accepted and it generally appeared to be regarded as a good thing for the profession, but views were mixed on whether it would affect their ability to locum. The range of responses that were received on this issue are described below.

Three interviewees expressed opinion that revalidation would affect their ability to work as a locum. Concerns centred on maintaining competency, often within a very limited number of hours of community pharmacy practice per week.

“Yes, definitely. And I think it will be, obviously they’ll have to focus on my permanent job, so they would revalidate all the hospital stuff and that wouldn’t be an issue. But I would be slightly concerned as to whether I’d pass actually. I mean, some of the enhanced services that I didn’t do all the time, and I wasn’t really exposed to in those four hours. I think it would concern me, yes” (Interview 11 line 40)

Two respondents considered that revalidation would not affect their ability to work as a locum. They expressed views that raising standards is a good thing, and that existing reflection of competency should enable pharmacists to get through a revalidation process.

“Well, it’s an added worry, but it’s not something that I have great trepidation about, I have to admit. I think anyone who feels confident enough to go out and work as a responsible pharmacist these days should be competent enough to revalidate” (Interview 9 line 60)

The uncertainty about the format of revalidation for the pharmacy profession was clear in four responses, where the implications of revalidation were either not clear, or had not been considered.

 “[Long pause]. I don’t think it’s something that I’ve really considered actually. I perhaps should do. It’s perhaps one of those things that perhaps you don’t really think about it until it’s more real... So revalidation, I’ll be honest, I’ve not really given it a huge amount of thought” (Interview 12 line 48)

Three pharmacists felt that revalidation might be the trigger to stop them undertaking locum work, particularly those in older age groups.

“I think it [revalidation] will have an impact on it, because I think a lot of people will say I’ve had enough, particularly my age group, let’s face it, how long am I going to keep going. Revalidation probably won’t affect me....but if I had to go and study for some more exams, I wouldn’t even bother” (Interview 1 line 141)
4.3.3 Responsible pharmacist

The responsible pharmacist regulations came into effect in October 2009 and are described in Appendix 2 and in Section Error! Reference source not found.. The interviews took place several months after this date. Interviewees were asked about any impact this had had on their locum working. Themes expressed were that the practicalities of responsible pharmacist proved unworkable as a locum pharmacist, that the responsible pharmacist agenda could potentially be used to the locum’s advantage, and that the introduction of responsible pharmacist had had no impact on the locum’s working environment, other than basic administration.

The practical realities of being the responsible pharmacist, in terms of reviewing the pharmacy procedures before starting work to ensure a safe pharmaceutical service could be provided, were highlighted by three pharmacists.

“For instance, yesterday I was called out as an emergency locum and the store had been open for an hour and half by the time I got there. And I was asked to sign a statement as responsible pharmacist and the words on the screen on the computer was when you sign this as responsible pharmacist it is understood that you have read all the company SOPs. Well, how can you possibly do that? I mean, it would take nearly an hour and a half to read them. It's absolutely impossible to do that” (Interview 8 line 30)

Three interviewees did report that they felt they could use the responsible pharmacist agenda to their advantage in the work situation. This took the form of being able to demand amendments to the working environment to ensure safe systems of working, such as taking a break.

“But that's something I insist upon now, I'm taking a break and I walk away. It's something, it's the one plus of the responsible pharmacist situation is that you can actually say, I'm taking a break. And walk away” (Interview 8 line 33)

Whilst acknowledging that reviewing SOPs at the start of the working day was impractical, one locum thought that if SOPs were found to be unsatisfactory, in reality, there was little the locum could do about it at that point:

“I'm glad I don't have to sign in as responsible pharmacist because what you'd have to say to somebody, I'm sorry, but your SOPs aren't up to scratch, I can't sign in. it's just not going to happen” (Interview 2 line 52)

Five pharmacists reported that they felt the introduction of the responsible pharmacist had not had any significant impact on their current locum working. It was noted that there were simple administrative changes associated with responsible pharmacist, such as signing in and displaying a certificate.
“With the responsible pharmacist, I can’t say that’s really changed the way that I approach my locuming. Again, perhaps it’s because I don’t do many, and I know where I’m going to that I am comfortable being the responsible pharmacist because I know the level that the staff are trained to, I know how the SOPs operate, I feel comfortable working in that environment” (Interview 12 line 48)

In summary, the locum pharmacists interviewed had mixed views about access to CPD, with a general acceptance that CPD was now a routine part of practice. One important point raised was the impact of lack of continuity and feedback on practice on learning. There was some lack of consideration of the impact of revalidation processes on locuming, but again a general acceptance of the need for confirmation of standards. With respect to responsible pharmacist, locum pharmacists acknowledged some of the practical difficulties of working in an unfamiliar environment and having to quickly assure safe standards. Some felt they could use responsible pharmacist requirements as a lever to improve standards, others felt that in practice this was very difficult to achieve.

4.4 Staff

All interviewees at some point discussed the community pharmacy staff that they worked with. This was usually in response to a question about what makes a locum return to a pharmacy, what contributes to a good locum experience. (Mason, 2002) noted that interaction with pharmacy staff is ‘inevitable’, and these interactions seemed to play a significant role in the quality of the locum pharmacist’s working experience.

4.4.1 Why are staff members important to locums?

A repeated theme throughout all the interviews was that staff are a key factor in the whole locum experience, both positively and negatively. Locums recognise that staff are key to a successful working day:

“Definitely the number one is the staff that you work with. Because they can really make or break your experience” (Interview 12 line 38)

Interviewees described several aspects of the interaction with staff which made it so important, which are described below.

4.4.1.1 Induction

As a locum arriving in an unfamiliar pharmacy, staff played a key role in orienting the pharmacist to the layout and working pattern of the dispensary. This could be described as an induction process, and eight of the twelve interviewees raised this issue.
“And I also like it, if you’ve not been somewhere before they say, right well, this is where the CD cupboard is, we file alphabetically generically and not by brand, and this is where your antibiotics are” (Interview 12 line 42)

Interviewees reported how difficult the role of a locum could be if staff either did not behave in this way, or no staff were present who could undertake this induction role for the locum.

“And the worst thing about being a locum is going somewhere where no one has any idea what’s supposed to be done, you’ve no staff who know the dispensary, don’t know where any of the stock is, nobody knows the password to get into the computer” (Interview 8 line 70).

One pharmacist described a negative induction process by a member of staff, and how he reacted to this:

“To a place where I’d been about four years ago, and one of the members of staff is called the poison dwarf. And her induction talk to you as a locum would be, you stand there, you do not label, you do not assemble, you do not pack orders, you do not get anything out of the cupboard, you do not go into the cupboards. And it went down this list like that. And I listened to this girl and I said fine, I have just one condition. I’ll do everything that you just asked of me, provided you get rid of the queues, because I don’t do queues. There’s like twenty patients all milling around, just get rid of the queue. And if you don’t, I will label, I will assemble, I will unpack orders, I will order. Whether you like it or not, you can’t do anything about it unless you’ve got a certificate next to mine” (Interview 3 line 94)

This induction process is noted in several opinion articles of the ‘how to be a locum’ style, ((Mason, 2002), (Evans, 2000)), and the evidence here more clearly describes how this induction process works, and how important it is to effective locum working.

4.4.1.2 Continuity

Four interviewees reported that staff provided an important contribution to the effective running of the pharmacy by providing an essential element of continuity. This consisted of being able to tell the locum pharmacist about situations and events from previous days, helping to resolve issues for patients.

“Continuity, because they’re there all week, so they know when problems have arisen. And they can often come up with solutions for the patients that come in on a Saturday” (Interview 11 line 32)

This continuity was also relevant for ensuring a smooth transition to the following day, where locum and staff member communication could ensure that problems were easily resolved next day.

“If there’s something that needs sorting out, I’ll forward to a staff member who can then bring it forward on your behalf the next day” (Interview 2 line 54)
One interviewee also reported the difficulties that arose when this continuity was not present.

“If it was a different locum every day and the staff weren’t as committed, then I think you’d get disjointed care” (Interview 11 line 32)

4.4.1.3 Local knowledge

The local knowledge of staff members was revealed as an important issue by two interviewees, which assisted locums in undertaking their jobs, and also benefited patient care. This local knowledge consisted of detailed knowledge of patients’ requirements, and of other local healthcare services.

“[the staff] know what’s gone on, and they’ll, they’ll stop me even. They’ll say, oh, Mrs Buggins doesn’t like that, or if I were you when I’m phoning Dr Jones, I’d approach him in this way. So they are willing to share their expertise and their local knowledge. It’s really important to have local knowledge. And I have been in some places where they have local knowledge, but it’s as though they’re happy to see you struggle” (Interview 7 line 20)

The statement from interviewee 7 above describes how this local knowledge of staff contributes to better patient care (“they’ll stop me even”) and facilitates the locum’s working practices (“approach him in this way”). It also describes where staff do not use their local knowledge effectively to assist the locum.

Interviewee 6 described an incident of a patient collapsing in a health centre waiting room, and as a locum, the pharmacist not knowing the local resources to help out. Staff with knowledge of the local health systems were able to resolve this issue.

“But in terms of patient safety, that sort of thing, not really because you’ve got staff with you who are, they know the place in and out. So if there is a problem the senior technician can go off and sort it out” (Interview 6 line 82)

4.4.2 Staff resource and availability

Five interviewees noted that the numbers and types of staff available in the pharmacy had a major impact on the locum day, and often in the choice of pharmacy that a locum pharmacist would work in.

“I won’t do a locum for [a pharmacy], because of their lack of staffing” (Interview 5 line 23)

Two locums reported that the expected staff were not available, when the locum turned up at the pharmacy.
“you’ve been told by the agency that there will be a dispensing technician there, or dispensing technicians, and when you get there, it’s their day off. So you’re in the deep end without any help at all” (Interview 8 line 31)

Accredited checking technicians (ACTs) are pharmacy technicians who have undergone specialist training to perform a final technical check on a prescription, once it has been clinically checked by a pharmacist (NHS Pharmacy Education and Development Committee, 2010). Previous research (Waterfield and Patel, 2009) has raised the issue that locum pharmacists are sometimes reluctant to work with ACTs, as there is no standardised training process for ACT accreditation. This means that the locum pharmacist retains responsibility for the actions of the ACT, whilst not being assured of their competency.

Interviewees were not specifically asked a question about ACTs, but the issue was explored where it was raised by the interviewee. Four locums brought up the issue of working with ACTs, and all of them expressed concerns about working with ACTs, because of these liability issues.

“Accuracy checking, ACTs, yeah. For me, it’s not a concept I’m happy with as a locum. If I’m responsible for a place and I’m working with someone whose ability and training I’m not fully aware of, I’m not happy with that. I’d rather check the work myself and then the responsibility’s on my head” (Interview 4 line 54)

4.4.3 Good staff

Good staff were described as having a number of characteristics by interviewees. All interviewees were able to give some description of what, in their view, constituted good staff. Staff communication skills and teamwork were identified as being important:

“good communication skills really, with customers and with the pharmacist themselves, so that they will actually work together” (Interview 1 line 74)

Training of staff was considered an important factor to successful working. Locum pharmacists recognised the importance of staff training to assisting the effective working of the dispensary.

“First of all that they’re trained in what they’re supposed to do. So they know what they’re supposed to do” (Interview 8 line 28)

Interviewees recognised that trained staff helped the locum to do their job more effectively:

“Where a pharmacy is well organised and the staff are well trained, as a locum you have no problem to fit in” (Interview 4 line 32)

One interviewee did have some complaints about staff being unable to do simple tasks until they had been officially trained.
“And you know, it amazes me, whereby you know, you can say to someone who works in the pharmacy, whereby, there’s the CD key, I want you to go and get some, er, Fentanyl patches out for me, two packs, take the prescription with you. ‘I can’t do that because I haven’t done the training’” (Interview 1 line 76)

4.4.4 Poor quality staff

Locum pharmacists described in some detail what defined poor quality staff from the locum’s point of view, and also how the experience of working with such staff felt to the locum. There was also some description of how this impacted on patient care.

Two interviewees described situations where staff took advantage of the fact that a locum was present in the pharmacy.

“I’ve found that sometimes in the multiples staff are more inclined to take advantage of you if you are a new face” (Interview 4 line 32)

The social interaction with staff was an important concept for locum pharmacists. Where staff were unfriendly or unco-operative, this had a negative impact on the working experience for the locum, described by three interviewees.

“Sometimes they can be quite hostile to you” (Interview 5 line 31)

“I can cope with any amount of stress, as long as I’ve got nice staff. But if I’ve got staff that either can’t be bothered, or they wander off, or they’re aggressive or umpteen different reasons for having problem staff” (Interview 9 line 24)

Four locum pharmacists (including some of those above) presented a contrary view, of good social interactions with staff.

“I would hope that there is properly a mutual respect. I respect what they’re doing and I hope they respect what I am and capable of. So yeah. Once you’ve got that, it’s not a problem. I’ve made a lot of good friends” (Interview 6 line 84)

“I do have stores where I like the staff, we get on well” (Interview 3 line 28)

The concept of friendliness and approachability was summed up effectively by one pharmacist:

“If you’re a good locum and you’re approachable, then they will meet you half way” (Interview 12 line 44)

Generally, there appeared to be a balance of responses about the good and bad characteristics of staff from all respondents, except interviewee 5 who only described poor experiences with staff.

Interviewees reported that staff had several issues with locum pharmacists that might account for an initial unfriendly approach. All locums made some reference to this issue, usually in response to the question about attitudes towards locums. The
differential in pay between a locum pharmacist and the staff was reported by two interviewees as an issue that caused grievance amongst staff.

“They don’t like you because you’re getting more. They always complain and say, you’re getting more than us and you don’t do anything” (Interview 5 line 68)

The fear of the unknown was raised as another reason for staff being wary of a locum presence.

“One thing about being a locum is that you’re a complete unknown when you arrive. And you’re looked upon as an outsider. You’re not generally welcomed into the place, honestly, it’s not like being in a hotel when you’re a guest and they welcome you. When you go into a pharmacy you’re unknown and treated very warily” (Interview 8 line 26)

Previous poor experience of locums was also put forward as a reason for staff reticence with an unfamiliar locum.

“How many times do I walk in the door and they say, ‘thank God it’s you’” (Interview 1 line 103)

Low morale of staff, caused by their working conditions, was also suggested as a reason for staff being less than friendly to a locum pharmacist.

“Because when I go in, and like I say, they’re fed up with the way they’re treated by the senior shop and pharmacy staff” (Interview 7 line 26)

One locum pharmacist provided a comment about finding it difficult to relate to pharmacy staff.

“I think the problem is that you’re a qualified, an educated qualified person. You don’t have any peers to correspond with. And it can be the case that you’re very much on your own professionally, all day long. With nobody to talk to, nobody to discuss things with. I think it’s different in larger stores where you have two or three pharmacists working there, and some highly qualified technicians. But in the main, I think it’s difficult to get on to the same wavelength as many of the staff. And so you are isolated” (Interview 8 line 40).

Two locums did report experiencing situations where staff were dissatisfied or distracted because of working relationships in the pharmacy. This was described as ‘backbiting’ or ‘chitchat’.

“If people are backbiting, if they don’t like their manager, pharmacy manager, if they don’t like their shop supervisor and there’s a load of infighting and backbiting, you’re on a hiding to nothing. It doesn’t matter how good the systems are, if the people don’t work together as a team. Er, and once you’ve done enough locums you can walk in the door and think, oh no, this is going to be a hell of a day” (Interview 7 line 24)

4.4.5 Working and interacting with staff

Locum pharmacists provided some thorough accounts of how they interacted with staff to get their work done. This provided some insights into how workload is organised by
locums, and how skill mix influences the nature of tasks undertaken by the locum. It was also clear that this is a flexible process, with locums adapting to each different situation to undertake different types of tasks.

4.4.5.1 Who does what

Interviewees described how when a locum pharmacist enters a pharmacy, there is a process of assessing and deciding how the workload of the pharmacy is divided up amongst the staff and the locum. This is sometimes very explicit, and dictated by the locum, described by two interviewees.

“I have certain ground rules, when I start work, I introduce myself and say, I do not dispense unsigned prescriptions, faxed prescriptions have to have current copy before I leave this evening, otherwise they don’t go out to the patient” (Interview 8 line 30)

Some locums reported difficulty with this assessment of the tasks to be undertaken.

“Knowing the systems, and what they expect of me... the hardest part is not the medicines, it’s knowing what they expect you to do” (Interview 6 line 30)

Others reported an adaption to the different tasks the locum was required to undertake in different pharmacies.

“Well in one place you’ll be expected to handle the computer and handle all the interactions with everything else, yeah, and other places you won’t be expected to do that. But other people will do that, will pass it on for you to consider. Which is quite different, because you’re not looking at it directly, you’ve got to go back and say tell me what you’re talking about. So that’s a difference. You know, do you handle the till, do you not handle the till. Do you hand out medicines or does somebody else do it” (Interview 6 line 42)

Two locums noted how this process of deciding on tasks to be done was undertaken, either by asking staff directly what they wanted the locum to do, or by observing staff’s behaviour towards the locum.

“[laugh] Just usually ask them. What do you want me to do. I think it’s something you gather, when you do something and they’re looking at you and thinking, oh my God” (Interview 6 line 44)

“It’s almost like they’re trying to tell you subtly, don’t do this, or we like it when you do this” (Interview 12 line 50)

One interviewee described how staff appeared to feel about the process of allocating workload.

“And that causes a feeling of hostility, you know, our regular pharmacist always does that. And I’m not your regular pharmacist and these are my rules and these are the way I work round here” (Interview 8 line 30)

The process of adjusting expectations of workload was described by one locum as:
“I always do my best and fit in with... whatever, how the pharmacy works, and how the staff want me to work” (Interview 4 line 36)

4.4.5.2 Accommodating locum deficiencies

On two occasions during the research interviews, locums described how they used staff members to accommodate their own deficiencies as locum pharmacists. One pharmacist described how staff supported her lack of knowledge of over the counter preparations.

“And the counter staff are all NPA trained, and that’s the bit that used to worry me slightly, is that I didn’t feel I had all the necessary skills for the responding to symptoms thing. But if you’ve got very good counter staff... when you’ve been asked about the herbal remedies, how blunt do you want to be? I don’t think any of this works. I can do the prescription side quite happily, but it’s the counter side where I feel I need that extra support with really” (Interview 10 line 14)

Similarly, one locum pharmacist acknowledged that he found using computers difficult and utilised staff to enter data on the computer for him.

“I will ask is there a dispenser there who can work the computer and if there isn’t, I just say I will not go” (Interview 1 line 54)

4.4.5.3 Assessing staff competency

Locum pharmacists talked about how they made judgements about the competency of staff during the course of the working day. Some of this judgement appeared intuitive, based on social interactions and observation of staff behaviours. Six interviewees talked about ‘getting a feel’ for the situation with staff.

“You generally get a feel, it’s the way in you’re welcomed in. As I say, I always walk in and I say hello, my name is [name], I’m your locum for the day, can you tell me what your names are and what your positions are. Yeah, and generally speaking from the response you get you know whether you’re going to have a good day with the staff or a bad day” (Interview 8 line 37)

Sometimes assessing staff competency appeared to be conscious and explicit. Two interviewees described specific situations where they took action based on their observations of staff behaviours.

“And you always have to work on the basis that you double check everything, don’t assume that just because somebody looks like they know what they’re doing and has passed an NVQ 1, 2, 3 that they’ve got the level of accuracy that you’re assuming they have” (Interview 9 line 50)

“If you get wind that somebody isn’t necessarily up to the mark, then I would explore that person in a bit more depth. If my observations, my elephant’s ears, I think yes, that was really beautiful questioning, and you said exactly the right thing and what a nice manner, I’m not going to delve. Whereas if I think, that’s a bit strange, what an odd
thing to have said to a patient, I might, I will explore that person more” (Interview 7 line 54)

Locum community pharmacists appear to make both intuitive and explicit judgements about staff competency, as they interact and work with staff. This is an important concept as it relates to the responsible pharmacist agenda and how locum pharmacists ensure that the environment of the pharmacy is adequate to provide a safe pharmaceutical service. This is a suitable area for further research, particularly, as interviewee 9 noted above, that possession of a particular qualification does not necessarily indicate competency.

4.4.5.4 Conflict over tasks undertaken

Three locum pharmacists described situations where, having made a definitive statement about a task that would not be undertaken by themselves, this caused hostility between the locum and the staff.

“I say OK, I won’t do it. And that causes a feeling of hostility, you know, our regular pharmacist always does that. And I’m not your regular pharmacist and these are my rules and these are the way I work round here” (Interview 8 line 30)

This theme relates to assertiveness (see Section Error! Reference source not found.) and taking responsibility for the safety of the pharmaceutical service provided (see Section 4.3.3). It is clear that the ‘suite of skills’ for being a locum pharmacist includes knowledge of safe working practices, and the assertiveness to put these systems in place when necessary, in the face of hostility and established practice.

In summary, staff are clearly vital to the locum working experience. There appear to be explicit and implicit induction processes taking place, and significant negotiation over working practices. Locums have clear ideas on what makes staff good or poor in their view, and there is an appreciation of the contribution of staff continuity and local knowledge to patient care.

4.5 Delivery of advanced and enhanced pharmacy services

The structure of the community pharmacy contractual framework, including definitions of advanced and enhanced services, is described in Appendix 1. In brief, within the community pharmacy contractual framework there are additional (advanced and enhanced) services beyond the core pharmacy role. The one national advanced service is the medicines use review (MUR). Enhanced services are locally commissioned by the local Primary Care Organisation according to local need.
Examples of enhanced services include emergency hormonal contraception, minor ailments services, smoking cessation services and supervised methadone consumption.

Locum community pharmacists’ participation in advanced and enhanced pharmacy services has been discussed in Section 2.7, with some anecdote and suggestion that locums do not participate in these services to the extent that employed managers do (Schofield, 2009).

This section explores these issues further. Nine of the twelve interviewees participated to some extent in advanced and enhanced service provision. One of three who did not was however accredited to do so.

It was clear during the interviews that interviewees did not differentiate in their conversation between the MUR advanced service and the other enhanced services – the tendency was to refer to them all as enhanced services. The researcher felt that drawing attention to this technicality was unnecessary and would disrupt the flow of the interviews. The interview process accommodated ‘enhanced service’ as a generic term where this was introduced by interviewees. Advanced and enhanced services are discussed as one topic in this document.

It is not the intention of this research to survey the services undertaken by locum pharmacists, but to explore issues around participation or non-participation. Hence interviewees were not asked to list their accredited services, but were allowed to talk about their involvement as they wished. Continuing professional development and accreditation related to enhanced services was frequently raised, and is discussed in Section 4.5.1. In addition, stress related to pressure to undertake MURs was often discussed, and this is described in Section Error! Reference source not found.

The following sections describe the issues raised by interviewees about advanced and enhanced services.

### 4.5.1 Accreditation to deliver services

Access to continuing professional development activities related to advanced and enhanced services, and requiring multiple accreditations to deliver the same enhanced service in different areas, are discussed in Section 4.3.1. These issues have been extensively discussed in the pharmacy press ((Connelly, 2010), (John and Turner, 2010)) and are reinforced by the following comments from interviewees:
“But before the PCT started to get their act together for if you were trained for EHC in one PCT you could cross the boundary to another, that used to be a problem. Because I used to work across boundaries, so a girl would come in for EHC and I couldn’t give it to her” (Interview 7 line 38)

The above comment recognises that service continuity is still affected by the mobile locum pharmacist population being unable to transfer their service accreditations across NHS areas, and consequently being unable to deliver enhanced services to patients in those areas.

The NHS in the North West of England has established the ‘Harmonisation of Accreditation Group’ (HAG), which attempts to standardise training and accreditation for enhanced services across North West England primary care organisations (Pharmacy Workforce Northwest, 2010). This was referred to by four pharmacists as something they would welcome.

“So there’s certain things that we should be doing nationally I think, like accrediting locums for this [EHC]. But isn’t there some scheme in the north for accreditation of enhanced services, and that’s something we’d like to see everywhere” (Interview 10 line 36)

In addition to the issues described in Section 4.3.1, interviewee 10 raised an issue of locum pharmacists not wishing to take undertake accreditations, rather than not having the opportunity to do so:

“I know with our enhanced services people still think that they’re not allowed to sign up to PGDs and things, when really if they feel competent and they’ve done their training, CPPE training or whatever, we don’t make them do the local course, it’s entirely down to whether they feel competent in themselves. I do get annoyed with this, well, I’ll sell you EHC but I won’t give it to you free of charge on the PGD. And all they’ve got to do is read the PGD and sign it, I don’t think that’s acceptable really” (Interview 10 line 34)

When asked why she felt this was the case, interviewee 10 responded:

“It’s putting it down on paper, whereas a sale is obviously more anonymous isn’t it. And a sale isn’t traced to either pharmacist or patient. Whereas with a PGD supply its linked to the patient and the pharmacist. So perhaps there’s a bit of that” (Interview 10 line 36)

Whilst this was only raised by one interviewee, this is a potentially very important concept. It indicates that some locum pharmacists may choose not to become accredited for enhanced service delivery so that they remain anonymous, and do not leave a paper trail where they can be called to account for their actions. This indicates a wish by some locums to not take full responsibility for their actions. It may be speculated that this could be driven by a lack of professional confidence, or awareness of a genuine lack of competence. Speculating again, being a locum may give such pharmacists an opportunity to practice relatively anonymously, with little opportunity for feedback on their professional decisions. Such locums may welcome this lack of
feedback, as it could enable them to hide their lack of confidence or competence, perhaps even from themselves.

This issue of accepting professional responsibility for actions is worthy of further research. If it is true that some locum pharmacists choose locum work to avoid that responsibility, this would have major implications for the quality of patient services.

Other reasons why locum pharmacists did not undertake enhanced services are revealed through discussion throughout the following sections on enhanced services.

4.5.2 Working with other pharmacists on advanced and enhanced services

Two pharmacists mentioned that they either supported other pharmacists to deliver advanced and enhanced services, or delivered the services themselves whilst another pharmacist was in charge of the dispensary.

Interviewee 2 worked as a second pharmacist employed to deliver advanced and enhanced services. The following quote describes her role, supporting the work of the other pharmacists.

“I can do everything the PCT requires of me. And while they were introducing a new manager at the shop who hadn’t got her certificate up, I stepped in whenever I was there to offer those services. So if we started someone on nicotine replacement they would make sure they came back on the day I was there, there was also another pharmacist and until she was up to speed, because she came from a different PCT so needed to do different bits and pieces” (Interview 2 line 28)

Interviewee 6 presented a related view that his role was to provide a dispensing service, which enabled other pharmacists to undertake advanced and enhanced services.

“But I think the work that people are asking me to do doesn’t lend itself to that sort of thing [undertaking MURs]. It’s much the other way round, in that me being there frees someone else up to do that sort of thing” (Interview 6 line 52)

These examples demonstrate that the locum workforce can provide opportunities for increased provision of advanced and enhanced services to patients, by supporting other pharmacists in various ways.

4.5.3 Concerns about MUR quality

Three interviewees did raise concerns about the quality of MURs undertaken by other pharmacists.

“But that’s, with MURs I don’t think they’ll last much longer because I think they’re being abused. Again, yesterday, I had a directive from the head office of the particular company, it said you’re expected to do three to five MURs a day, each MUR should
take no more than ten minutes. Well in my experience, an MUR takes thirty minutes, probably closer to forty minutes, if you’re to do it properly” (Interview 8 line 54)

Interviewee 3 described a scenario where the actions of the regular pharmacist meant that the locum was effectively prevented from undertaking MURs:

“I did an MUR, it was an intervention one, like I say if I pick something up I’ll do it, and we had a good discussion about it and I got it typed up and off it comes, and I said to the staff where does he… has he got a file or something for his MURs? ‘Oh no no, he’ll destroy that’. And I said what do you mean, he’ll destroy it? And apparently the pharmacist has got some sort of beef with the company, he’s saying he hasn’t the time to do any MURs whatsoever. His evidence of this is that all the pharmacists who attend are unable to do them also. So if he’d submitted mine, it knocks his argument on the head. So I didn’t do a second. What I did was swap anything that might be MUR into straightforward counselling” (Interview 3 line 58)

This scenario highlights the perverse incentives that can exist within performance-targeted services, where managers will manipulate their behaviour in the presence of these targets (Moyo, 2010). It also highlights further how management targets can impact on locum activity.

4.5.4 Concerns about delivery of MURs

One interviewee gave a description of working conditions that she felt meant she could not safely undertake MURs.

“I don’t do MURs. I have looked into doing it. It's not particularly the course or anything like that that puts me off. What does put me off is there's only myself and one other member of staff. So if I were to do an MUR that would take me out of earshot of that member of staff, not that I don’t trust them at all, I do implicitly, but I have a responsibility for care and I'm supposed to be supervising sales, and I just physically don't see how I'm supposed to be doing that when I'm not in the room” (Interview 11 line 34)

4.5.5 Professional satisfaction from advanced and enhanced services

Three interviewees gave descriptions of the positive aspects of MURs for themselves, citing enjoyment, satisfaction, clinical improvements and the chance to take a break from dispensing as positive reasons for undertaking MURs.

“Yeah, absolutely [enjoy MURs]... And I did think when I started doing it, it was possible that it was going to be a tick box exercise on behalf of the company, but clinically I’m getting loads out of it. Patients love them” (Interview 2 line 30)

Interviewee 8 described two scenarios where MURs turned into opportunities to support patients who had been bereaved. She reflected that even though the MUR had not been completed, she felt a satisfaction that she had helped patients:
“They’ve come back to see me though and thanked me though, and they’ve actually then sought counselling from their doctor and followed your advice and taken it on. You might not have completed your MUR but you know you’ve helped someone at the end of the day, which is what, which makes it worthwhile really” (Interview 8 line 58)

4.5.6 Does being able to deliver services enhance locum value?

One interviewee raised the issue of whether being able to deliver advanced and enhanced services added to the locum’s value to employers. She was clear that it did not:

“No. I don’t think it makes the slightest bit of difference whatsoever. Although the agencies say you’ve got to be MUR accredited these days, I think that’s only because the multiples insist upon it because they have their targets of three to five a day” (Interview 8 line 54)

Interviewee 2 was equally clear that that she felt undertaking MURs was part of the locum role, and that employers did make booking choices on the ability and willingness of locums to do those MURs:

“And I think as a locum you can’t say I’m not going to do the MURs, I think the employer will say, well, I’ll take you for the booking, but if you get a chance to do three MURs, you need to take them, and I don’t think you’re going to be able to say no I’m not going to do that because I’m just a locum. I know [company owner] is starting to do that with some of his regulars [locums] at some of his busier shops” (Interview 2 line 58)

This issue relates to locum professional reputation and the impact of this on employability, which is expanded further in Section 4.9.3.

4.5.7 The superlocum

Two interviewees raised the ‘superlocum’ concept, where they postulated that the locum workforce would eventually be divided into a ‘basic’ locum who checked prescriptions and gave usual over the counter advice, and a more advanced, consultant-style locum who took on extra services.

“So hopefully I’m harnessing all my other experience to almost create a consultant-locum type person, I’m trained in everything and more than the PCT requires of me, and I think that’s what’s going to happen. With locums who can basically just check, then the next grade of locum who’s got all the PCT qualifications, then the next level is a locum who can do MURs and pre-reg, and I think there’s going to be a scale of how qualified a locum you are. It’s going to go down that road. For every service you’re not going to get the booking, I think that’s going to be the way” (Interview 2 line 58)

This idea of the superlocum, who undertakes specific locum bookings where there is a requirement to undertake advanced and enhanced services, links to the concept of
locum quality, and whether perceived quality has any impact on the locum’s employability. This is explored further in Section 4.9.3.

In summary, locum pharmacists interviewed were clearly engaged with the idea of advanced and enhanced services, but recognised some difficulties in service delivery in terms of training and the practicalities of an unfamiliar environment. The locum workforce can also offer a flexibility that may aid service delivery. One interesting point raised was a third party story of locums who did not engage with enhanced services because of an apparent desire to remain professionally ‘anonymous’ and not leave an auditable record of their activities.

4.6 The physical environment of the pharmacy

Interviewees described various aspects of the physical environment of the pharmacy that affected either their decisions to work in a particular pharmacy, or their working experience during the day. These descriptions were unprompted, but did sometimes arise when interviewees were explaining how they decided where they would work, or what contributed to stress during the day.

4.6.1 Tidiness and chaos

Two interviewees provided some description of the physical conditions they found in pharmacies, and how this affected their view of the pharmacy. Messy dispensaries seemed to indicate to locums a chaotic approach to managing the pharmacy, with locums describing how this indicated that systems were not clear under the mess.

“If the store itself is clean and tidy, the dispensary is clean and tidy, the staff are well presented. And you see a row of certificates up on the wall. The management of the company, whichever it may be, are keen on educating their staff and getting them qualified. And you go into other places and there's boxes of stock everywhere, there's dust on the shelves, and you know it's not going to be a pleasant day” (Interview 8 line 38)

4.6.2 Amount of space available

When asked what made a pharmacy an acceptable working environment, three pharmacists described the amount of space available in the pharmacy. Sufficient space was considered one indicator of a safe working environment.

“I don't particularly like confined spaces. So a pharmacy that's very boxy, no elbow room, trying to check MDS trays on top of paperwork, because there's not enough bench space. I'm not particularly comfy because I tend to think that the more cluttered you are, and the more chaotic the arrangement, the more likely you are to make dispensing errors. So if something's nicely laid out, you've got enough workspace,
you've got enough elbow room between you and other members of staff and the computer, then yeah, you're likely to make less dispensing errors, so a spacious one's very nice” (Interview 9 line 26)

4.6.3 Distractions

One interviewee described distractions of radio noise and frequent phone calls that he felt contributed to a distracting and potentially unsafe working environment.

“There’s one major company that has the house radio on, all day long. At a volume that you can’t adjust. And it’s not conducive to good dispensing. I mean quite a few places do have radios on, but in my experience, the more distraction there is, the more chance there is of making, of people committing errors...you continually have the phone ringing all day long... it’s very disruptive” (Interview 8 line 32)

4.6.4 Local population

Five pharmacists expressed opinions about the nature of the local patient population, that had some impact on their wish to work in a particular area or not.

“If the patients are lousy then that doesn’t help [laugh]. I mean I’ve worked in places where the patients, if they have to wait one minute they’ve been grumpy and that’s not very nice” (Interview 4 line 38)

Two interviewees considered that substance misuse clients who were prescribed methadone sometimes presented a challenge:

“And the area. I mean I’ve worked in [town] when we lived in [town], and I’ve had to do thirty methadone dispensings in one day and that’s a challenge sometimes because you’re dealing with all sorts of unsavoury characters” (Interview 4 line 36)

Three other interviewees gave some description of the demographics of the areas they worked in.

“But [town] is not the wealthiest area in the world, but neither is it the roughest. It’s reasonable suburbia” (Interview 6 line 34)

Of these, only one expressed the view that he would not choose to visit some deprived areas because of the behaviour of the local people.

“If the patients are nice, you can go to grotty areas, places like [town], where the patients generally do swear as part of their normal vocabulary. They’re not being excessively rude to you, erm, by swearing at you, it’s just their vocabulary. So those kind of areas I’m a little bit more cagey with, I’m a little bit more… I just find it slightly embarrassing when they’re effing and jeffing in front of the girls. I mean, it’s their language, that’s how they speak, so in those kind of places I tend… I won’t go to certain areas” (interview 3 line 28)

In contrast to this expressed preference, interviewee 5 stated that he undertook his pharmacist role regardless of the area:
“So in that, in answering your question, do I have any preference to work in an area, no, not really. I do my job, regardless” (Interview 5 line 43)

4.6.5 Travel to the pharmacy

It has been noted that travelling distance is an influential factor over where people choose to work (Shann and Hassell, 2004). Travelling to work was described as a stressor by some interviewees (see Section Error! Reference source not found.), but was also discussed in the context of choosing where to work by four interviewees.

“I’ve a geographical area that I stick to as well, which is determined by commute time, erm, and the ease of the commute” (Interview 3 line 28)

Interview 12 noted her unwillingness to travel long distances late at night:

“So I don’t, perhaps because I’m doing it late at night or I’m doing it on a Saturday morning, I’m unwilling to travel great distances” (Interview 12 line 46)

4.6.6 Evening working

Interviewees were asked if they ever worked evenings as a locum, and if they did, what it was like. Over the last several years there has been significant growth in the number of pharmacies who are open 100 hours per week or more, due to relaxation of contract restrictions for certain types of pharmacies (including those open over 100 hours).

There is anecdotal evidence that 100-hour pharmacies use locums to a greater extent than other pharmacies, principally because of the number of shifts that are required to cover the opening hours. There is very little information available on the differences in working conditions between daytime and evening hours in pharmacies. There is evidence from other employment situations that shift work can contribute to stress, and also that work underload (insufficient stimulation) can be stressful and contribute to error.

The following insights therefore are useful in determining the nature of the pharmacy working environment out of hours.

Four of the twelve pharmacists interviewed had experience of working out of hours. Interviewee 9 in particular showed a distinct preference for this type of work. For others, evening work provided a flexible method of working that did not involve extra childcare costs, extended the working day to enable more money to be earned, or hours that just suited the rhythm of how they wanted to live their life.

“Yeah, I love evenings! I’m not a morning person at all! So the shop where I do most of my hours I do three in the afternoon until half ten at night” (Interview 9 line 16)

“But I can’t get out of bed in a morning! I quite like a bit of a sleep in, and I do some housework before I go to work, and it suits me quite well” (Interview 9 line 20)
It seems clear that evening work can be quiet in terms of dispensing workload.

“It’s not like an intense dispensing load, a few an hour. Usually you’re busy in the daytime, but in the night-time, it’s very quiet you know, you hardly get a prescription. In fact, you want to have the contact with people, because you get bored you know, sit there and do nothing” (Interview 5 line 17)

It was noted that prescribing practices tended to be different at night, with different types of prescriptions being presented. Interviewee 3 also described some of the challenges of night-time work, including increased chance of violence and other criminal behaviour.

“Yes, what I find, it’s very unusual, doctors, prescribers tend to experiment a little out of hours. Say, azithromycin suspension, let’s see how it goes. And it never occurs to them that we don’t keep them, because they’re not used. Challenging, out of hours work. It’s more dangerous, more potential for violence against staff, and also more likelihood of attempts to pass forged scripts. Because you can’t get in touch with prescribers, so on all those counts it is” (Interview 3 line 18)

In addition to this change in prescribing patterns, it was noted that the number of queries at night was greater, with some limitations on how those queries could be resolved out of hours.

“Not perhaps a huge volume [of prescriptions], but there’s a lot of queries in an evening as opposed to a normal working day” (Interview 12 line 26)

Evening hours were also viewed as a period of calm in the pharmacy, when work could be caught up on because of the lighter dispensing workload.

“And then after six o’clock when the surgery closes it’ll calm down a bit and you can carry on with the main body of checking for the following day. And then we also do the nursing homes trays and MDS trays at night. It’s a lot calmer” (Interview 9 line 18)

Interviewee 1 expressed criticism of other pharmacists who he felt put themselves and presumably patient care at risk through working excessively long hours:

“But I do know, a lot of these ... pharmacists do, they do travel, do till six o’clock in [town1] and then shoot over to [town2] which is probably an hour and a half away to do the late shift for [company1]. And, er, that’s not on. That’s not professional” (Interview 1 line 80)

In summary, evening work seems to present its own challenges to pharmacists, with low dispensing workload, risks of criminal activity and difficult queries with few other resources to help resolve them. It also presents an opportunity for locums to practice flexibly in a way that fits in with their families and their own needs. For busy pharmacies, it also provides a period of calm for undertaking routine or developmental tasks that cannot be accommodated during a busy day. No definite instances of any impact on patient safety of evening working were found during this research.
Of the eight pharmacists who did not undertake evening work, most provided a very definite response that this was not a style of working that they wanted to undertake. It seems that evening working is a specific lifestyle choice. The impact of the circumstances of evening working on personal stress and patient safety is a topic that warrants further research.

In summary, the physical environment of the pharmacy appears to have an impact on locum working, in terms of the desirability of the booking, risk of error and the nature of the activities undertaken. Evening work appears to be a clear positive or negative choice for the locums interviewed.

4.7 Stress

Interviewees were asked about the stressors involved in locum working. A follow up question related to possible stressors that were removed by locum working. Opinions were mixed, but with an overall view that locuming was less stressful than being employed. Many pharmacists gave descriptions of other employed pharmacists who they felt were stressed. Locums were however able to supply full descriptions of how the locum situation did provide its own stressors. This report will highlight stressors which relate primarily to the locum situation, rather than stressors that impact on all community pharmacists. It will however initially also describe other more general pharmacy stressors when they were raised.

One interviewee introduced a nice note of balance when she said, "pharmacy isn’t a stress-free profession" (Interview 4 line 66).

The following sections indicate the main themes revealed when locum pharmacists talked about stress.

4.7.1 Stressors that could apply to all pharmacists

When questioned about stress, one locum pharmacist described it initially in relation to other people rather than herself.

"The managers that I work with, they’re under a great deal of stress" (Interview 2 line 32)

One pharmacist did describe how he felt his job was to reduce the stress imposed upon staff by having a locum present.
“One of the things that I find gets through to them [staff] straight away is that I’m there to work with them, that I’m there to help them get through the day with as little stress as possible” (Interview 8 line 66)

Four interviewees clearly expressed views that they undertook locum work because of the stress from companies and area managers. The stress related to management tasks that the pharmacists were asked to do and being a locum meant that they avoided this stress. However, the impact of company pressures is also implicit in most of the interviews, as revealed in pharmacists’ motivations for locum working, described in Section 4.2.2.

“I was stressed, because of my previous experience, most of the time I was stressed because of the line manager you know. Asking me to do this and that. And now, I am less stressed, because you know [inaudible] people to stress you out. That's why I like being a locum” (Interview 5 line 37)

Interestingly, interviewee 9 gave a similar response linking stress to company management (“The best thing is no management stress” (Interview 9 line 54)), but then gave a rationale acknowledging why that stress exists.

“I don't see that there's anything round the management stress that exists to be honest. I mean, companies want feedback on various different issues so they can try and improve their business, so there'll always be paperwork issues there. There'll always be shop windows to do a display, there'll always be PCT surveys coming through that'll need filling in, there'll always be staff turnover having to deal with interviews, having to deal with staff sickness, staff holidays, invoices that haven't been paid” (Interview 9 line 56)

Five locum pharmacists talked about workload causing stress. Clearly, this is also relevant to employed pharmacists, but it may be that factors particular to the locum situation such as unfamiliarity (described in Section Error! Reference source not found.) and lack of continuity (Section Error! Reference source not found.) may add to the difficulties of a heavy workload.

“Lack of staffing, pressure to do MUR, turnover of prescriptions and .... I think that's quite stressed” (Interview 5 line 39)

Interviewee 10 provided a story where unfamiliarity with the computer system contributed to an already difficult situation:

“I remember once doing a bank holiday, an Easter Sunday, and I didn't know the computer system and I was assured there was going to be a dispenser there who would know that, but the counter assistant had phoned in sick, so the dispenser had to be on the counter, and we just had a huge number of people coming through the door. And to be honest, everybody was really good because we were keeping them waiting much longer than I would have thought acceptable. And that's what puts pressure on me, I think, that you're not able to help everybody at the same time.” (Interview 10 line 18)
Interviewee 5 raised the issue of pressure of workload leading to the potential for mistakes.

“It is a big thing, because you don’t have the trained staff to do the job. If you have to do the job yourself, if you have to it, it will be more people to wait, and it will put me under pressure, and could lead to... stressing me out, because you have to do everything on your own, so you have to speed up, and you are more prone to make a mistake” (Interview 5 line 43)

Whilst there may be factors that contribute to additional workload stress for locums, interviewee 12 presented a contrary view that she felt workload stresses were the same for employed and locum pharmacists:

“Obviously there will be the day to day stresses, you know, if there’s a high volume of prescriptions, if you get customer queries, there’ll be those sort of stresses. But I wouldn’t say they’re any different to an employed pharmacist” (Interview 12 line 28)

One specific workload pressure mentioned by six locum pharmacists was that related to the pressure imposed by companies to undertake MURs. It was mentioned in the context of either being a pressure, or that being a locum meant that the pressure was removed.

“Demands to do, walk in and they say you have to do five MURs today” (Interview 8 line 33)

One interviewee noted that being a locum meant the pressure to do MURs may be somewhat removed.

“But there’s definitely sales pressure, definitely. I don’t know that if as a locum you actually side step it a little bit than if you work for the company” (Interview 11 line 42)

Four locum pharmacists recognised that not having a break was a stressful factor in their working day.

“Having no break, or when you have a break and you come back, all the work, you don’t have a break, you don’t have a break because you are quite busy, that would stress me out” (Interview 5 line 39)

Interviewee 11 recognised that not taking a break was sometimes what the locum wished:

“I think a lot of locums want to earn as much money as possible, so if they have to be somewhere for nine hours a day they’d rather be paid for those nine hours than have to be there for nine hours anyway but go and sit somewhere for an hour when they don’t get paid” So it works both ways (Interview 11 line 44)

One interviewee reported conditions of the pharmacy environment that he felt contributed to his stress.

“Erm, what else causes stress? There’s one major company that has the house radio on, all day long.” (Interview 8 line 32)
The discussion above largely relates to stressors that may be considered to affect all pharmacists. The following sections relate to stressors that apply more directly to locum pharmacists.

4.7.2 Stressors that relate more to locum pharmacists

Three interviewees gave descriptions of stress derived from not knowing the systems and procedures in the pharmacy they were working in.

“I think yes, in terms of locuming it is stressful because apart from repeat work, you never know what you're going to meet when you walk in the door” (Interview 8 line 30)

One pharmacist told a story of a situation where she was asked to make up an unfamiliar prescription in unfamiliar surroundings, which she felt was stressful. This story reflects clinical concerns generated by having to make important decisions in the absence of full information about the situation.

“there was this really, really weird morphine mixture that had to be made up, that was not even, I think it was like a special request of a doctor. Staff just said oh we don’t know what to do, the pharmacist does it. And it was really complicated and the patient needed it there and then. I was quite stressed actually because I’d not made it up before, they found me the formula. Now I had to assume that the formula was 100% correct, I didn’t know if the scales were accurate, so I made that up and I was praying that, you know, I won't get, that there was anything wrong with it. Now I found that very stressful because it was a very complicated mixture, nothing that I'd seen before in my life, and I was only there for a day, and it was morphine, and I didn’t know if the scales were accurate and the equipment was up to scratch and I had to do it” (Interview 4 line 66)

Related to being unfamiliar with the systems of the pharmacy, the concept of lack of continuity resulting in stress was raised by three pharmacists.

Comments often reflected the stress of dealing with patients who had an unsatisfactory outcome, whose problem could not be resolved because of lack of information about the situation. The stress seemed to issue from dealing with 'disgruntled' patients, and also the pharmacist's personal sense of dissatisfaction with not being able to do a thorough job for the patient.

“I can’t get the answer from the surgery or there is nobody there who can fill in the blank. And I have to say to a patient, I’m sorry, the information is in the manager’s head, and he’s not here. I find that very unsatisfactory” (Interview 7 line 34)

One pharmacist noted how the regular pharmacist created a situation where information was not available, contributing to the locum’s inability to resolve problems:

“The place being disorganised is stressful. I did work in a pharmacy once where the pharmacist, heaven only knows what dodgy deals he was doing, but he took all that month’s prescriptions home with him. So I had no prescriptions at all to look back on,
so when people came in with queries, he'd taken them all home. That kind of thing is very stressful” (Interview 7 line 32)

Two pharmacists described how travelling to an unknown pharmacy contributed to their stress. Travel was also referred in other contexts in Section 4.6.5.

“Er, mmm, not knowing how long it's going to take me to get to a pharmacy can be a bit stressful. I remember when I first started locuming, I was stuck in a traffic jam. And I hate being late because by the time you turn up, the rest of the staff are in a bit of a panic and then you've got customers who are grumpy that you're late. So I like to know how long it's going to take me to get to a pharmacy” (Interview 9 line 26)

Financial insecurity was mentioned on three occasions, often following on from discussion of motivation for undertaking locum work (Section 4.2). Two pharmacists mentioned it specifically in the context of stress.

“I mean, I was nervous when I first started, obviously you don't get any sick pay, you don't get any holiday pay, and you have to do your tax accounting and whatever, so I was a bit sort of anxious when I first started out” (Interview 9 line 29)

Interviewee 12 (who was employed in another sector) reflected on the issue of financial stress, but did not apply it to herself.

“I don't know how stressful it must be setting up as a locum pharmacist from scratch, and that's your full time employment, you know, having to go out and sell yourself and make sure that you've got sufficient bookings, to cover your day to day living, plus your sickness plus your holidays” (Interview 12 line 28)

Interviewee 2 revealed the uncertainty of locum work, when regular bookings could not be guaranteed:

“*In between finding positions, the uncertainty of not having regular work*” (Interview 2 line 28)

Seven interviewees gave responses that indicated locuming did remove some stresses from their working lives, compared to being employed. These responses link strongly to motivations for working as a locum (Section 4.2), in terms of reduced managerial responsibilities with locum working.

“I think in a way there's less stress, because there's less managerial stress” (Interview 4 line 66)

Two locums acknowledged that there is inherent stress in the pharmacy profession:

“Erm, I won't say there is no stress, of course there is, in that the job itself is a stressful occupation. In the sense that you've got to keep concentration and if you find, which does happen, that you've made a mistake or something wasn't as it should have been, you go, oh my god, what have I done there. It doesn't happen often but occasionally you think ah.” (Interview 6 line 48)
In contrast, locuming can generate significant stress, as one pharmacist described the strong feelings he had when he first started to work as a community locum after his retirement from hospital pharmacy:

“It was terrifying, absolutely terrifying. Because I was used to working with a staff of about eighty, to going to a staff of two, possibly three, and you’re standing on your own feet completely. I mean the first month or so was horrifying, but er, I got through it I think” (Interview 6 line 18)

Two respondents gave explicit descriptions of strategies that reduced stress on themselves and others alluded to these strategies. This involved behaviours that gave the locum more control over the working environment, before they got to the pharmacy. These included setting conditions on the booking, and finding out about the environment before they attended.

“I think you can alleviate a lot of the stresses yourself, by phoning up in advance, perhaps getting an idea, you know, what number of prescriptions do you do, what support staff have I got, what computer system do you use. I think some stresses like that you can manage” (Interview 12 line 28)

Finding out about the resources available beforehand doesn’t always work. Two pharmacists described how expected resources were not always present in the pharmacy when they arrived.

“The other stress thing you do get on a reasonably regular basis is that you’ve been told by the agency that there will be a dispensing technician there, or dispensing technicians, and when you get there, it’s their day off. So you’re in the deep end without any help at all. And the other thing is, you’re told how many items a day you expect to do, the agency will tell you, oh, 150 to 180 and when you get there it’s more like 300 to 350” (Interview 8 line 31)

Interviewee 12 described how she thought her reputation as a ‘good’ locum enabled her to choose bookings that she felt comfortable with in terms of the working environment:

“I personally am not a person who gets particularly stressed, that’s just in my nature, but I think if you’re a good locum pharmacist and you get bookings at pharmacies that you’ve worked at before and you know, then you’re perhaps not... and you can... not perhaps pick and choose, but you know that you’re comfortable with the environment that you’re going to work in” (Interview 12 line 28)

She also noted a practical mitigation for dealing with travel stress, in identifying local parking arrangements:

“I feel happier when I’m going, when I know that I can park round the back for free, or I’ve got to search for a pay and display car park” (Interview 12 line 22)

Some interviewees described their own personal strategies to deal with stressful situations:
“But I think as long as you are able to keep up to date with what’s going on, and as I say knowing what’s expected of you, generally speaking I don’t find it to be that stressful. If it gets busy, it gets busy. You’ve just to really get on top of it and say, ok, what’s... calm down lets deal with it” (Interview 6 line 50)

Interviewee 11 mentioned what might be described as the ‘get-out’ clause – the locum deferring any difficult decisions to the regular pharmacist manager on their return to work.

“I think it depends on how much responsibility you’re willing to take. But there’s the age old ‘oh, I don’t normally work here, you’ll have to talk to the manager when they get back on Monday’. There’s always that line, I suppose, that you could take” (Interview 11 line 44)

This deferral was only mentioned by interview 11, but is an important concept as it relates to the rest of her statement about taking responsibility. Other interviewees spoke about this concept from the reverse angle, describing situations which stressed them because they felt they could not take the full responsibility that they wished.

Some criticism of locums centres about this issue of not taking professional responsibility. This was mentioned by interviewee 1 in the context of locums taking responsibility, by treating the pharmacy as if it were their own for the time they were there:

“When I booked a locum, when I had my own business, I looked for a locum who would run my business as though it was theirs. Where, in the dispensary, I’m not talking about anything else, counter, erm, perfumes, not, not interested when I was away. The locum came and ran the dispensary. You want the staff to help the locum, and as long as the locum treated it as though it was their, theirs, that was fine. And that’s how I go in as a locum” (Interview 1 line 101)

The potential for locums not taking responsibility for their work is also discussed in Section 4.5, in the context of locums avoiding providing enhanced services in order to avoid the responsibility.

In summary, interviewees gave clear descriptions of the work stressors they experienced, and the sources of these. There are particular factors about locum working that contribute to stress, but the locums interviewed noted overall that they felt locuming removed them from other stressors that afflict employed pharmacists.

4.8 Attitudes and perceptions

This section covers a range of issues around others’ attitudes to locum pharmacists, as perceived by the locum themselves. Interviewees were asked about how they perceived others’ attitudes to locums, including patients, other pharmacists and other healthcare staff such as GPs.
A range of responses was received, described in the following sections. Interviewees often referred to third parties in their answers, for example, describing staff's attitudes to other locums, as well as to themselves.

4.8.1 Locum perception: Patient views on locums

Eleven interviewees gave responses on how they felt patients viewed locums. Four responses indicated that locums felt patients either didn't understand the concept of locum or weren't bothered provided they received a good service.

“I think sometimes people aren’t fully aware, for instance the public, I don’t think they necessarily… I think they might think it’s another pharmacist I don’t know whether they really understand the concept of locum, are they there for a day or are they there for half an hour or whatever” (Interview 4 line 62)

“Patients, I don’t think patients are too worried…. In general, I don’t think people are really that bothered, to be honest. As long as you give a good service, I don’t think people are worried” (Interview 9 line 52)

Two locums described how they felt patients did have some negative views about the presence of a locum pharmacist.

“I’ve felt… you do get it sometimes from patients, especially in a pharmacy where they’re used to seeing one pharmacist. They come in and they look at you and they go, oh. And you can definitely see the, oh, where’s the pharmacist. It’s that sort of, oh she knows me, and you don't, how can you possibly help me” (Interview 10 line 34)

Three interviewees did describe some strategies for dealing with such responses from patients:

“It’s easy enough to sort out, you just say I’ll treat you exactly the same way if you explain things to me” (Interview 8 line 64)

In summary, locums had mixed views over whether patients had neutral or negative views about the presence of a locum pharmacist. Locums also had several strategies that they appeared to use to reassure patients about their presence. This section may be summed up by a comment from interviewee 12:

“I think patients may have different views about different pharmacists, but I don’t think it’s necessarily whether they are a locum or not” (Interview 12 line 50)

4.8.2 Locum perception: GP views on locums

Interviewees were asked about how they thought GPs viewed locum pharmacists. Universally, interviewees did not think GPs were either aware or interested in the locum status of the pharmacist.
“I think GPs don’t notice. I don’t think GPs particularly grasp the concept. We’re just all pharmacists. I think they would just presume it was a bad pharmacist if something negative happened, or a good pharmacist if something good happened” (Interview 11 line 50)

Interviewee 8 expanded on this statement, describing how she felt that GPs may have more contact with locums that the regular pharmacist, as the prescribing is unfamiliar to the locum:

“In my experience, the time they [GPs] get a little contact with pharmacists is when there’s locums there, because the locums query what’s been going on. You will find that locums will query scripts more than regular pharmacists, because the regular pharmacists know that this is a regular occurrence” (Interview 8 line 62)

It is clear that locum pharmacists consider that their locum status plays no part in their relationships with GPs. There is some comment that locums may have more interaction with GPs, as they are less familiar with local prescribing patterns.

Interviewee 8 also had some comment about other healthcare staff and the relationship with locum pharmacists, describing how locums could not always respond to the informal arrangements for dealing with supply that may be present in the pharmacy when the regular pharmacist is there:

“In terms of, people like district nurses, health visitors and what have you who regularly come into pharmacies, tend to ignore the fact that you’re a locum. They just come in and want their usual thing. They don’t like it if you say look, give me a prescription now or you can’t have it. You know, whatever arrangement they may have with that pharmacy, they don’t realise that it’s only between them and the regular pharmacist, not between them and the locum. And I always say to people like that well it’s not my stock, I can’t give it away, I have to have something to show that, you know, I’m going to get paid for it” (Interview 8 line 62)

4.8.3 Locum perception: Other pharmacists views on locums

Locum pharmacists’ perceptions of other pharmacists’ views on them were usually not clearly explored, only three interviewees gave a clear response to this question. Where no clear response was given, this seemed to be either because it was not considered a significant issue, or the locum reflected on their own attitudes to locum pharmacists and gave stories of poor or good quality locums as described in Section 4.9.

Only one locum (interviewee 5) had a strongly expressed view on this subject, and the strength of his feelings about this issue makes it worth reporting fully.

Interviewee 5 felt that he was treated as a ‘promoted dispenser’ by an employed pharmacist colleague:

“Er, other pharmacists, yes. There is that prejudice. Er, especially employed pharmacists. They look as you as less competent at your job. Most of them have
double standard, they're happy for you to do MUR for the sake of more money, but for other things, they think you are less competent. You can't tell. Some of them, I was once, I was working in a pharmacy, a pharmacist manager, they treat you like a sort of, not as a pharmacist, not as a pharmacist colleague, but as a promoted dispenser, you know, you can't be responsible for the way you do it, they don't appreciate you as a pharmacist” (Interview 5 line 65)

He also described that he felt ‘treated like a slave’ by another pharmacist, and the experience was such that he didn’t go back to the pharmacy.

“I went to one of the branches in one area, I'm not going back there, and that pharmacist, I'm not exaggerating, he was treating me like a slave. All right, he didn't give me any chance to have any break, and when I was, even, going to use the facilities, he was asking me, how long am I going to be away. Am I going to be long away. And when I come back, straightaway he was doing something else, leaving all the dispensing for me. So you are working for me. He thought I was working for him. It's different, you are working with a colleague, same, same rank. Or you are working for someone he's your boss, or she's your boss, then you are working with someone, you know. To me, you are the same rank, doing the same job, same responsibility” (Interview 5 line 67)

Interviewee 5 goes on to describe how he was treated if he made a mistake, and how he felt like an ‘outsider’ in the pharmacy.

“But er, you know, sometimes it's really hard to work with the pharmacist managers. Because you have to be squeaky clean. I tell them I don't work with them [pharmacist managers] at all. A couple of branches, I don't go. If I go there, I will find out, before I go, if they are available, I won't work with them. Because you can't, the way they treat you is so demeaning. They treated me like a second class citizen. Not even, as their staff, like an outsider. And if you make a mistake they put it in your face so badly. I come across a situation like that. If they mistake they're there the next day. It's all right for them. But if you make a mistake, they could be rude to you, just put it that way. So working with some of the employed pharmacists, it's completely difficult, yes” (Interview 5 line 67)

Interviewee 5 clearly found these experiences distressing, to such an extent that he chose not to work in those pharmacies again if those pharmacists were present. This situation describes a lack of professional recognition of this locum by other pharmacists, a lack of integration into the pharmacy team and what appears to be a bullying attitude by other pharmacists.

In contrast, two other interviewees described more positive interactions with other pharmacists. One noted that other pharmacists tended to be interested in his locum status, with a view to adding to their pool of locum contacts for making bookings:

“When you go to local meetings or PCT meetings, you meet a lot of proprietors and of course they’re very interested in you straight away if you’re a locum. Because they want to catch you without the agency and not pay the agency fee” (Interview 8 line 62)

Interviewee 11 described how other pharmacists make judgements on locums' performance based upon feedback from staff, and hinted that there is perhaps an
element of jealousy from employed pharmacists at the rates of pay for locums compared to their own.

“And other pharmacists, other permanent community pharmacists, again, depending upon the experience they have with locums. If their staff, when they come back, say that someone is bone idle and lazy and doesn’t pull their weight, they’re more likely to phone up the agency and say we don’t want them again. But it’s not personal, because they haven’t worked with them…I don’t think it’s particularly like, tar locum pharmacists with one brush, that they’re all inferior or anything. I think they’re a bit miffed that they get paid so much” (Interview 11 line 50)

Overall, with the exception of interviewee 5, most interviewees appeared not to report any significant feedback on attitudes from other pharmacists. Most feedback appeared to come via staff.

In summary, the locums interviewed felt that GPs and patients had very little interest or concern in locum status, but with some description of patients resenting the lack of continuity the locum represented. Similarly, there was little negative description of locums reported from other employed pharmacists. The negative description that did arise appeared to be largely fed from the staff who worked with the locums.

4.9 Locum quality

Interviewees discussed what they felt constituted a good or poor quality locum in several contexts, although the issue was not raised directly as a question in the interview schedule. The topic often came up indirectly in relation to discussion on staff attitudes and staff working with locums, with interviewees describing how good or poor locums would appear to staff. Other locums described how they obtained repeat bookings by being a ‘good’ locum, and described the factors that made them ‘good’. Similarly, situations where poor quality locums would not be rebooked were described, along with the characteristics of the poor quality locum.

4.9.1 What makes a good quality locum

Locums described a number of factors that they felt contributed to being a good quality locum. Sometimes this was describing their own behaviour and sometimes feedback from staff on other locums’ behaviour. These descriptions are intended to refer to factors that are specific to the locum situation, rather than describing what makes a good pharmacist in general terms.

Two locums described a conscientious approach to working as a locum, a sense of responsibility and the satisfaction achieved from feeling that a good job had been done.
“And we do everything that an employed pharmacist does, probably as good, or perhaps slightly more conscientious because you don’t want to leave any mess, any problems, for the person who has to walk in behind you” (Interview 2 line 54)

Five locums described the difficulties created when problems carried over from one day to the next. The converse of this, that not solving or handing over problems effectively, was also highlighted as a factor for poor quality locum work. A good locum would not leave problems.

“You know, I’ve completed the task and it’s been done safely and properly tied up. I hate leaving things hanging” (Interview 7 line 32)

A more subtle factor for good quality was that of being engaged with the pharmacy. This appeared to relate to trying to understand the systems of the pharmacy, and the staff involved (see also Section 4.4.5), and consequently adapt and respond to those systems to ensure a smooth system of working. It also reflected locums who were felt to be doing a fair share of the work. This appeared to be in contrast to those locums who ‘just stand there and do nothing’.

“But to me, I like to learn what’s going on. And I presume other people do. But equally you can just stand there and do nothing I suppose” (Interview 6 line 46)

“So if they’ve [staff] moaned about a pharmacist who doesn’t help put the goods away, then you make a mental note, I’ll see if they need a hand with you know, unpacking the delivery or whatever” (Interview 12 line 38)

It appears that staff have a significant impact on the success of a locum’s working day (see Section 4.4.1), and it also appears important that the relationship works both ways – good locum pharmacists are seen as trying to build and maintain good working relationships with staff.

“I think you need a whole suite of skills to be a good locum pharmacist. It’s not just about turning up because I’ve got a certificate and I will allow that shop to open. That I can make that a good shift when I’m there. That the staff, that I have a good relationship with the staff that work there, that I might only work with on that particular occasion” (Interview 12 line 20)

4.9.2 What makes a poor quality locum

Poor quality locums were often described in the opposite terms to the good quality factors above.

Locums who left difficulties and problems for the next day, without making sufficient effort to sort those problems out or communicate them well, were described as poor quality by three interviewees.
“I may follow the locum in who’s promised patients things and not followed them through. And when I’m in, I get the flack. So it might be something simple like, can you order this that and the other, and they just don’t bother” (Interview 3 line 38)

Ten interviewees were able to provide stories of other locums who effectively disengaged themselves from the running of the pharmacy. This showed itself in locums doing other personal activities, such as reading books or newspapers, using their own laptops or talking to friends on mobile phones. Most of these stories appeared to be supplied by pharmacy staff.

“People [locums] who turn up and just sit in the corner, bring it to me, I’ll sign it off and that’s it. And don’t get involved and don’t give them [staff] support” (Interview 6 line 94)

“Basically I have heard stories of locums turning up with a briefcase that contains a book, they sit themselves in a corner and say go on, you get on with it. I’m your legal ticket for the day” (Interview 8 line 26)

“Some locums still sit in a corner with a newspaper” (Interview 10 line 34)

One pharmacist interviewee felt that part time working indicated a lack of commitment to the locum role. This appeared to be a different issue to lack of engagement with the pharmacy, and was related to the shorter hours worked, rather than what happened whilst the locum was actually working.

“And how many times have I been told by a woman pharmacist, oh well, I’m only here for the day, and it suits me to do this today, and I’m going at four o’clock this afternoon, and I’m there working til six thirty. Oh yeah! I’m only here because it’s a bit of pin money, my husband works somewhere else. Well that’s the wrong attitude” (Interview 1 line 91)

Interviewee 3 raised an important point about lack of assertiveness in locum pharmacists:

“Lots of them [locums] not having the confidence to liaise with doctors and people like that” (Interview 3 line 40)

Interviewee 1 had a rather more subtle point about assertiveness, in that he seemed to put forward the idea that locums should be more assertive about demanding appropriate conditions from the companies to undertake locum work, using the responsible pharmacist agenda as the lever:

“It’s not ideal, the responsible pharmacist, and it’s not correct or right but you’ve got to use what you were given to your advantage and I don’t think the pharmacists who work for these companies, too many companies now, I don’t think the pharmacists are being very professional and saying, well, I’m not doing this and I’ll, well, maybe, they’re not going to get asked back. And they don’t bother to do the work. And they do a poor locum. When really they should, I think you’ve got to stand up for yourself” (Interview 1 line 151)

Several interviewees gave reports of types of pharmacists that they felt were ‘less professional’ than themselves. This typing commonly referred to factors that were
dissimilar to that of the interviewee. Ages and genders of interviewees are given next to
the quotes for comparison where appropriate, so this dissimilarity can be noted. All
interviewees who described demographic factors that they felt affected professionalism
are quoted here.

Three interviewees described perceived lack of professionalism amongst younger
pharmacists:

“I do find that the good professionals now are the ones probably in the fifty to sixty age
group who were brought up in a different way, and I do think the young ones are no
longer as professional” (Interview 1 line 93, aged 57)

“The lack of energy in some of the youngsters I’ve met does astound me. The
youngsters’ lack of gravity towards the CD register and the writing of CD records”
(Interview 2 line 52, aged 40)

“One of the ladies [staff] is quite old school, so she has a different work ethic than
perhaps some of these younger locum pharmacists who come in and she just thinks
they’re bone idle. Maybe they are, I don’t know, who’s to say” (Interview 11 line 48,
aged 34)

Two interviewees made comments about issues with older pharmacists (Interview 1
also discusses younger pharmacists above):

“Some of the old ones, whereby they’re in their 70s, the last resort locum you might
say. When they’re about 70 you can’t expect them to run it [pharmacy], they’re just
there as a certificate” (Interview 1 line 104, aged 57)

“Because there are some people that I’ve seen, particularly some of the elderly
pharmacists and I don’t think they’re very up to date really” (Interview 4 line 54, aged
40)

Only one interviewee made a comment about language issues with overseas
pharmacists:

“I’m working now, there’s a lot of pharmacists in this area who are European
pharmacists, who can’t even speak English. Why should I be responsible pharmacist to
them, when I’m working with them, when they can’t counsel a patient? If you can’t
counsel a patient you shouldn’t be working as a pharmacist” (Interview 1 line 109)

One pharmacist described how she felt male locums were more likely to exhibit
unprofessional behaviour:

“When you walk into shops people will tell you how lazy, particularly men have been,
just sitting there. Drinking cups of tea and reading papers. And not helping out”
(Interview 4 line 62, female)

This is in contrast to interviewee 1, who described what he felt was lack of commitment
from some women pharmacists:

“And how many times have I been told by a woman pharmacist, oh well, I’m only here
for the day, and it suits me to do this today, and I’m going at four o’clock this afternoon”
(Interview 1 line 91, male)
4.9.3 Does your professional reputation matter as a locum?

There was some comment by six interviewees on whether professional reputation mattered to locum pharmacists. This was not a direct question in the interview schedule, but was raised spontaneously by interviewees. Selection pressure – whether there is any incentive as a locum to ensure you deliver a quality service in order to maintain bookings – was highlighted by several interviewees. It appears that quality does matter.

“I know, the pharmacies that I locum in, there are pharmacists that they will not ask back. Because of the experience that they've had. And actually all my locum bookings are done on a one to one basis between me and the pharmacy, not through an agency. Because I like to think that I've got the reputation that I'm a good pharmacist, that I'm a good locum and will do my fair share of the work when I'm there. So theoretically you need a certificate but I think if you're a good pharmacist, if you've got a good reputation, then you'll get the bookings in the pharmacies that you like working in.” (Interview 12 line 60)

Interviewee 5 did raise the point that this reputational issue also worked both ways. He felt that he was reluctant to complain about working conditions, because he may not be asked back to the pharmacy:

“But if you complain a lot, they say you don't go there again, the company say because of that, causing trouble, we don't want you locuming again. And you just don’t get any more. So the best thing is, is just get out of it” (Interview 5 line 67)

In summary, interviewees were able to describe factors that contributed to being a good quality locum pharmacist, and to provide stories (usually relating to third parties) of poor quality locums. There was mixed opinion on whether the quality of the locum has an impact on obtaining bookings, with an overall impression that quality does matter.
5 Discussion

The aim of the study was to explore locum community pharmacists’ experiences and perceptions of their work environment. To support this aim, locum pharmacists’ views on their local day to day working were explored, along with consideration of some national changes to pharmacy that may impact on locum working, such as CPD, revalidation and the responsible pharmacist agenda. Locums were also asked to consider how they perceived others thought of locum pharmacists.

This study builds on previous research into locum community pharmacy, and contributes some new ideas to the discussion. Locums described clearly their motivations for locum working, and provided information about the nature of the environment and interactions they experienced when working as a locum. By describing locum experiences and motivations, the study also reflects some aspects of the nature of being an employed pharmacist, which has some important resonances for the pharmacy profession.

The following section discusses these aspects of locum working that have been revealed in this study, and indicates where previous research supports or refutes these findings. The findings are also discussed in the context of the current pharmacy professional environment.

5.1 Findings of the research

This section is subdivided to discuss each of the themes identified in the results in turn. The order in which the themes are presented follows the order of the results. The key themes revealed in the study focus on the motivations for working as a locum, the locum in the context of the pharmacy profession (considering continuing professional development, revalidation and the responsible pharmacist agenda), the role of staff in locum working, delivery of advanced and enhanced pharmaceutical services by locums, the physical environment of the pharmacy, stress issues, attitudes and perceptions of locums and discussion on the quality of locum services.
5.1.1 Discussion on motivations for working as a locum

Previous research into motivations for working as a locum describe a variety of reasons for choosing locum work, and the fact that individual pharmacists often had multiple reasons for choosing locum working (Shann and Hassell, 2006). The previous research also notes that flexibility was ‘the most common overriding theme’ amongst the motivations provided (Shann and Hassell, 2006). The motivational themes noted by Shann and Hassell are flexibility, money, social contact, maintaining professional competence, variety and less stress and administration. These themes are corroborated by this research.

Some issues are expanded upon in this study. Dissatisfaction with employed status, and previous poor experience of being employed as a motivator for locuming were very evident in the interviews. This is reflected in pharmacy press comment that pharmacy organisations need to be made more attractive workplaces to pharmacists, to reduce this motivator for locuming (John and Turner, 2010).

Interviewees noted that maintaining some contact with community pharmacy was a motivator for locuming, the idea of ‘keeping your hand in’. This concept does relate to revalidation of pharmacists in the future, described in Section 4.3.2. Pharmacists will have to demonstrate competency in all sectors of pharmacy that they work in, and the locum pharmacists interviewed appeared to recognise this. In the interviews, this recognition appeared to be in the context of pharmacists’ own professionalism and desire to do a good job. It is also clear from Section 4.3.2 that, in this sample of locums, there is a definite lack of clarity in their thinking about what revalidation will actually mean to them as locums. In contrast, locums did appear to recognise that they required CPD activities specific to community pharmacy to help demonstrate competence (see Section 4.3.1).

Locums also reported that working in community pharmacy contributed to their working competency in their other jobs, providing them with a motivator for undertaking locum work. Cross-sector working is clearly seen as a benefit for their job roles by these interviewees. If revalidation does make working in other sectors more difficult, this will have implications for the profession, and for the effectiveness of pharmacists’ employed roles.

Pharmacists also had strong views about locuming enabling them to work as a ‘proper’ pharmacist, meaning a focus on clinical rather than managerial work. This contrasts with the working situation of an employed pharmacist which combines clinical and managerial tasks to a greater extent. Locums felt that being without management
pressures enabled them to concentrate on the patient, and on clinical issues which they felt were the reasons they had chosen to become pharmacists initially.

It is worth noting that previous work on motivations for locum work dates from prior to the initiation of the new community pharmacy contractual framework in April 2005. The introduction of enhanced services and the MUR advanced service since then appears to have added considerably to management pressures within employed pharmacy. This results in locum pharmacists recognising this pressure as a reason not to be employed. It also seems to provide a reservoir of stories about poor employment experiences that have pushed pharmacists to locum. Also, in this research, locums expressed that the freedom to say no, both to locum bookings and to situations within individual bookings, was a motivator for locum working. Again, this reflects dissatisfaction with the greater inflexibility of the employed environment.

Another factor that may have changed with the introduction of the new contractual framework is a greater emphasis on clinical governance activities within community pharmacy. These activities include audit and a much greater emphasis on record keeping and documentation of activities. These types of processes were referred to by interviewees as something they felt they had avoided by being a locum.

Thus, it appears that while a core of motivators for choosing locum work remain the same (flexibility, money, social contact, maintaining professional competence, variety and less stress and administration), work pressures, and the nature of remuneration in community pharmacy which contribute to those pressures (advanced and enhanced services) have added additional factors into the choice to undertake locum work.

In summary, the study corroborates previous research into motivations for locum working, but in particular emphasises dissatisfaction with being employed. This has particular reference to the effects of the 2005 pharmacy contractual framework and the pressures that appears to have placed on employed pharmacists. This is not just in relation to advanced and enhanced services, but also to factors such as clinical governance, with an emphasis on demonstrable quality structures. This has a potentially major implication for community pharmacy, as it reflects comment and opinion that the nature of community pharmacy employment needs to change if the sector is to maintain a motivated and committed employed workforce (John and Turner, 2010), (Wood, 2002).
5.1.2 Discussion on the locum community pharmacist in the professional context of pharmacy

The subject of continuing professional development raised mixed opinions from locums in this study. Several thought that access to CPD opportunities was sufficient, others that being a locum meant some isolation from resources that were available to employed pharmacists. There appeared to be general acceptance that CPD on community pharmacy issues was required for locums who had other pharmacy jobs, even for those pharmacists who did very few hours in community practice. Shann and Hassell (2004) described how some locum community pharmacists felt unsure what was required of them with respect to CPD, felt that CPD was time-consuming and that there was ‘anger and resentment’ against the RPSGB for introducing mandatory CPD. None of these issues were found during this research. This suggests that over time, CPD has become a much more accepted part of pharmacy practice, and that locums in this study were accustomed to the requirements of CPD.

The issue of multiple accreditations for enhanced services in different NHS areas was still a problematic issue for locums within this study. Developments such as the Harmonisation of Accreditation Group in north west England, which sets regional standards for enhanced service training so that locums can ‘carry’ their accreditation to other NHS areas in the north west, and possible development of national agreements for enhanced services, would assist in solving this issue for locums.

Interviewees had a range of views about the impact of revalidation of pharmacists on their ability to work as a locum, from feeling that revalidation would have an impact on the ability to be a locum, or that it wouldn’t. There was also some uncertainty expressed about the subject. To ensure clarity about this issue in the interview schedule, the nature of the question from the interviewer had to be expanded and adapted after two interviews had been completed, as it was clear that interviewees up to then were not clear about the nature of the question on revalidation. It was also clear that some pharmacists had not considered the issue before. There seemed to be a general agreement amongst interviewees that revalidation was a good thing for the pharmacy profession, in that it would raise and maintain standards. Some pharmacists had concerns that the amount of time they contributed to community pharmacy would mean that they did not get enough practice experience to remain competent. Others felt that they currently reflected sufficiently on their practice to ensure competency.

The responsible pharmacist agenda also provided a range of views from interviewees, considering whether its introduction had made a difference to locums’ working lives or
not. Responsible pharmacist was also referred to in the context of working with other staff, particularly staff resource and availability and working with accredited checking technicians (see Section 4.4.2 for description of this). The main concern from locum pharmacists appeared to be the requirement from companies for locums having to sign that they had read SOPs for the pharmacy, and the practical difficulties of doing this at the start of the working day when there are pressures to start work immediately.

The responsible pharmacist agenda was acknowledged by interviewees as a technical process, in that administrative processes had to be undertaken and a certificate displayed, but it appears to have had very little impact on locum working in reality. It was noted by interviewees that in theory, being the responsible pharmacist could be used as a tool to influence the resources available at the pharmacy to ensure safe working, but in reality this was not a reasonable option. Where locums do feel that safe working is compromised, they still tended to ‘vote with their feet’ by not returning to that pharmacy. The few attempts to influence poor practices that were described did not meet with success. This may be because there are few or no mechanisms within companies to facilitate this process. Indeed there may not be any willingness or motivation within companies for this to happen. This is reflected in locum opinion in the pharmacy press, which urges adequate ‘whistleblowing’ procedures be in place, and that the GPhC should support pharmacists who challenge companies on patient safety issues (Anon, 2009b). It appears at present that locums do not challenge poor practice within companies, or meet with little success when they try. This is an important issue for the quality of the pharmaceutical service.

In summary, locum pharmacists in the study had mixed views about availability of CPD opportunities, but there appeared to be acceptance of CPD as part of pharmacy practice. Most interviewees appeared to have not fully considered the potential implications of the introduction of revalidation on their community locum practice. The responsible pharmacist agenda does not appear to have provided locum pharmacists in the study with a facility for influencing standards in the pharmacy, and locums acknowledged the practical difficulties of reviewing SOPs at new pharmacies. Overall it appears that being the responsible pharmacist represents simply an administrative change for many locums in this study.
5.1.3 Discussion on staff issues

There is some anecdote (described in Section 2.7) that the interaction with staff is very important to locum community pharmacists. This research corroborates this and provides significant evidence as to the nature of the interactions, and reasons why locum community pharmacists (and in the opinion of locums, to some extent staff) consider them important. Many of the interactions appear extremely subtle, with nuances of behaviour from both staff and locums giving indications on how each should behave and work with each other. This gives the appearance of an implicit negotiation process, conducted by behaviours (smiles, tea-making) and the emotional content of verbal interactions (“you generally get a feel...”). Also, there appears to be direct, explicit negotiation and dictation of work behaviours by both pharmacists and staff.

Staff’s local knowledge of systems and local people also seems very important to locums. This reflects observational work in community pharmacies that notes the extent of this local knowledge of staff (Cooper, 2002b). Staff also clearly have an important role in induction of locums to the pharmacy environment. Previous work has identified that only 51% of pharmacies reported having an induction process for locums (Blenkinsopp et al., 2009)

Positive social interaction with staff is important to locums. Given that social contact is one reason that locums provide as a motivation for locuming, it can be assumed that hostile social contact will have a major negative impact on the locum’s work experience for the day. Locums appeared to work hard to create that positive social interaction, and described various strategies for how they did that, such as having an initial greeting process where they found out information about staff, and sharing trivial personal information (for example, distance travelled, how often they locum). “Meeting halfway” was considered a good strategy – building good social relationships with staff to facilitate good joint working. This relates to ‘tact and tolerance’ (Symonds, 2000) (p446) required for dealing with staff, but the evidence here expands upon that concept to describe some of the behaviours used.

Locums described how they assess or judge the competency of staff they are working with. Given the responsible pharmacist agenda (Appendix 2: Responsible pharmacist), whereby locum pharmacists must ensure that the systems and processes in the pharmacy are adequate to provide a safe and effective pharmaceutical service, this assessment of competency should be considered an important part of the process. Again, this often seemed a subtle process, which happened over a period of time.
rather than being explicit. Locums did describe asking staff about their roles, and also of being aware of the qualifications of staff, but there seems little structure or robustness around this assessment process. This issue is reflected in opinion expressed in the pharmacy press (Gilpin, 2010), where the locum’s lack of knowledge in staffs’ training and competency forces the locum to be more vigilant in their practice.

This lack of robustness of confirming staff competency was particularly highlighted when locums were called upon to work with accredited checking technicians. Locums reported concerns about relying on the competency of ACTs when this could not be easily assessed, due to the liability issues for the locum. With other staff, where the locum could have the final check of the work completed, liability did not seem so significant. These concerns reflect work conducted by Waterfield and Patel (2009) where community pharmacists expressed similar issues with respect to ACTs.

In contrast, locums were very conscious of the amount and types of staff that they would have available to work with, which is perhaps a more immediately visible measure than competency.

If locum pharmacists are to have true professional control over the pharmaceutical service they are providing, then this issue of the locum’s assurance of the staffs’ competency should be acknowledged and reviewed by the pharmacy profession.

Interviewees gave descriptions of situations where they had insisted on a particular way of working in the pharmacy, which appeared to generate hostility in staff who had to change their procedures, with consequent deterioration in working relationships. This insistence was described by interviewees as deriving from what they perceived as unsafe or unlawful practices existing in the pharmacy. It could be that the very act of changing working systems could also have an impact on the safety of the pharmaceutical service, as staff have to rapidly adapt to new processes. There is presumably a balance of risks between continuing with existing unsafe or unlawful practices versus the risk of sudden change.

Pharmacy staff views on the quality of locum services is also worthy of consideration. The research provides evidence of conflict between staff and locum when systems of work were being negotiated. It could be hypothesised that reasonable adjustments to working patterns insisted upon by the locum to ensure safe systems, as is their responsibility, could result in negative feedback from staff. This does not necessarily mean the locum is of poor quality.
In summary, staff are vital to effective locum working, and have an important contribution to make to patient safety via their induction roles for locums, and by the continuity they bring to dispensary processes. Staff also provide essential local knowledge to locums, and this research corroborates this contribution of local knowledge of staff, both of systems and people (Cooper, 2002b) and provides some examples of how that may work.

5.1.4 Discussion on delivery of advanced and enhanced services

Accreditation for enhanced services (but not for the MUR advanced service) still seems to present problems for locums, in that multiple accreditations are still required in some areas to deliver services in different NHS areas. Clear examples were provided where patient care had been compromised by lack of accreditation. This does have implications for provision of enhanced services, and is an issue that has been discussed in the pharmacy press ((John and Turner, 2010), (Connelly, 2010)). This research validates these opinions that service delivery is compromised by lack of a national accreditation process for enhanced services.

The research also reveals a new issue. One interviewee provided third party stories of locums not wishing to be accredited for additional services, as it appeared they were concerned about the accountability issues of having documented evidence of their practice. The example provided was of locums being willing to sell emergency hormonal contraception, but not willing to provide the same medicine under a patient group direction, because this would have meant documenting their decision. The implication here is that these locums are not willing to be professionally accountable for their work. Whilst there is supposition in this third party story, it is potentially a very important concept in terms of the quality of service provided by locums.

Locums also provided more practical reasons for not wishing to undertake additional services. The ability to perform MURs safely, whilst potentially leaving staff unsupervised for half an hour or so, was a concern to interviewees. This is in the context of locums being unfamiliar with staff competency.

Several interviewees reported how they supported other pharmacists in delivery of advanced and enhanced services, either by providing the service themselves, or undertaking dispensing tasks to allow the other pharmacist to deliver the service. Some of this was in the context of part time working. This indicates that the locum workforce could be contributing to service delivery by increasing the capacity of pharmacies in a
flexible, part time manner, which is reflected to some degree by previous work (Blenkinsopp et al., 2009) which describes locum services providing support for MUR provision. This contrasts to opinion that the locum workforce inevitably reduces enhanced service delivery by its transient nature (John and Turner, 2010).

In terms of locums’ incentives to provide enhanced services, professional satisfaction proved the major theme, with locums describing the benefits they got from feeling that they had helped people.

The idea of the ‘superlocum’ was raised, meaning a locum who was accredited for all local services and acted almost as a consultant locally, providing services additional to basic dispensing. This has been discussed in the pharmacy press (Goundrey-Smith, 2007), but does seem to still be just an idea. This perhaps links to comments made by interviewees on the value that being able to undertake additional services adds to the locum. Adding value would mean that locums accredited for additional services obtained work preferentially to those that were not. Views were mixed on this issue, and it is still not clear that market forces are operating effectively in this area, though there is some comment in pharmacy press that it is so (Anon, 2008a). There is little incentive for the ‘superlocum’ to exist without a clear market benefit. This also clearly relates to the lack of financial benefit to the locum from service delivery. Having a clear, explicit process for assessing the marketability of a locum, by means of their competency and range of skills, would enable these market forces to operate, with consequent benefits to the quality of the service provided.

In summary, there are incentives and disincentives to locums providing advanced and enhanced services. Locums reported professional satisfaction as a reason for completing accreditations and undertaking the services. In contrast, some felt that being a locum meant they were not confident in leaving the dispensary and counter in order to undertake a service in the consultation room, as they felt they needed to supervise staff, and also that there was no financial incentive to provide the service. There appeared to be mixed views on whether the ability to provide additional services contributed to the locum’s market value. This means whether they were preferentially employed because of their willingness to undertake services. Some examples of this added value were described, but overall it appears that, for the locums in this study, the current employment market does not significantly differentiate between locums on the basis of their ability to undertake additional services. This appears to be despite some locum agencies asking for accreditations from the locums on their books.
Evening working has been a growing feature of community pharmacy, since the introduction of 100-hour pharmacy contracts in 2005. Evening working appears to be a lifestyle choice for locum pharmacists, but does present its own challenges, such as different dispensing patterns and quietness. It also seems to present some opportunities for work planning in pharmacies, providing a quiet time for routine work. The impact of evening work on personal pharmacist stress, and consequent patient safety, is worthy of further research.

Interviewees gave vivid descriptions of the physical environment in pharmacies that they found acceptable. Descriptions of adequate bench space, tidiness and lack of distracting noise reflect well with guidance issued by the National Patient Safety Agency (NPSA, 2007) on the safe design of dispensing environments. Locums appear, not surprisingly, to associate tidy, organised dispensaries with efficient, safe working environments, and to make their choice of where to work accordingly. The fact that the locum is unfamiliar with the pharmacy will only add to the difficulties of working in apparently chaotic and distracting pharmacies, which the regular pharmacist may be accustomed to.

The physical amount of space in the dispensary was raised by interviewees as a factor in choosing where to work. This is a relatively little-researched area of pharmacy practice, but one investigation into the physical pharmacy work environment does talk about the importance of pharmacists having control over the work space, and how ‘muddling through risks error, and leads to clutter and untidiness’ (Rapport et al., 2009) (p318). This study also recognises that distractions cause loss of control over the flow of dispensing activities. It may be proposed that a locum, having little control over the physical environment that they enter, recognise these factors intuitively, and where possible they select their work environments (that is, where they accept bookings) in order to retain this sense of control.

Several locum pharmacists in this study did pay some attention to the nature of the patient population that they choose to work with. This is relevant to the concept of ‘inverse care law’, which puts forward that patients in most need may receive the lowest level of care. It has been suggested that locum pharmacists are over-represented in rural areas and in deprived urban areas (John and Turner, 2010). Both areas could be said to be at risk from the inverse care law, if it is proposed that high levels of locum pharmacist use compromise patient care by lack of continuity. Whilst
this research does not provide evidence to uphold this theory, it does reveal that locums do recognise the needs and challenges of the local populations where they work.

In summary, it has been noted that the physical environment of the pharmacy is important to locum pharmacists (Anon, 2009b), and this is reinforced by this research. Locums appear to recognise that the working environment has an impact on the quality of service provided. They seek out employment where they feel secure that the facilities available will enable them to deliver a safe service.

5.1.6 Discussion on stress

Stress imposed by working for a company is clearly a major reason why many pharmacists choose to undertake locum work rather than be an employed community pharmacist. It is clear that locums in this study recognise that avoidance of managerial tasks and responsibilities eases the pressures on them, reflected strongly in the motivations for undertaking locum work described in Sections 4.2.2 and 4.2.3.

The impact of heavy workload would apply to all types of pharmacist, but there are factors such as unfamiliarity with working systems and lack of continuity that contribute to making this even more difficult for locums. This is recognised in opinion in the pharmacy press (Gilpin, 2009), where the difficulties of working in an unfamiliar environment are described. This additional burden of unfamiliarity was identified as potentially contributing to mistakes by one interviewee. Locums in this study also recognised that being a locum freed them to concentrate on patient care, not having to take on managerial tasks at the same time as their clinical workload. Pressure to undertake advanced and enhanced services, particularly the MUR advanced service, appears to affect locums similarly to employed pharmacists, but some locums also felt that being a locum meant they could sidestep this pressure. There is some suggestion that unfamiliarity with staff means locum pharmacists are unwilling to leave staff unsupervised whilst they undertake an MUR in the consultation room.

Another theme that could relate equally to employed or locum pharmacists is that of taking breaks. Locums in this study did recognise that breaks were important to their own wellbeing, and consequently to patient safety, but also recognised that some locums had a financial interest in not taking an unpaid lunch break.
Noise and interruptions were also noted as stressful contributions to the working environment that could compromise patient safety. It may be that pharmacists who work continually in environments which are noisy, such as with a background radio, become adapted to this, whereas a locum pharmacist may find it unacceptably distracting.

Not knowing the working systems of the pharmacy, and lack of continuity were noted in this study as causes of stress for locums. This was in terms of the negative impact this had on patient care, in having to deal with patients who were not happy with this negative impact, and locum’s own professional dissatisfaction at feeling they were not doing the best job they might. These findings link strongly to findings on the support provided by staff to locums, described in Sections 4.4.1.1 and 4.4.1.2. These relate to the induction role undertaken by staff, into the systems of the pharmacy, and also staff’s important role in maintaining continuity of patient care. It is clear where these systems fail, or are not present, this creates a very difficult and stressful working environment for locum pharmacists.

One practical issue that interviewees brought up was travel to the pharmacy at the start of their shift. If the pharmacist is not present when the pharmacy opens, most pharmaceutical tasks cannot be undertaken (see Appendix 2), and this results in concern and distress for staff, usually from dealing with disgruntled patients who cannot obtain their medicines. Locums recognised that creating this situation by arriving late contributed to their own stress.

Locums in this study did explore the consequences of financial insecurity as a stressor, but this was commonly related to when they started out locuming and were unsure whether they would obtain enough work. From this finding, it appears that a growing local reputation is an important factor in locums obtaining work. Locums who had other jobs appeared more accepting of this insecurity, but locums with other commitments such as caring roles did express that they sometimes found some difficulty obtaining work to fit in with those other commitments.

Locums had several strategies for mitigating the stress of their role, usually focussing on finding out about the working environment beforehand, and trying to influence the resources that were present. This is also described in several opinion articles in the pharmacy press ((Evans, 2000), (Anon, 2008a)) where descriptions of actions taken by locums to find out about the pharmacy prior to their arrival were given. This was sometimes noted as an inaccurate process, or even deliberately misleading when expected resources were not present. Responsible pharmacist regulations (see Appendix 2) place a clear responsibility on the pharmacist to ensure that the
environment is appropriate for providing safe pharmaceutical services. It is clear that locums in this study had awareness of this responsibility and attempt to regulate their environment where they can, such as by insisting on a dispenser. It is also clear that these attempts are sometimes thwarted. If acceptable minimum resources for provision of safe pharmaceutical services were to be further researched, the additional difficulties experienced by locums, such as their unfamiliarity with the work environment and potential additional effort from lack of continuity, should be considered.

In summary stress appears to be a mixed issue for locums. It is clear that a motivation for locum work is to escape the pressures of managing a pharmacy. It is also clear that locuming provides its own pressures. One must assume that for the locums in this study, the balance of stresses is currently in favour of locum working, reinforced by statements from interviewees that being a locum was a very positive move for them. This reinforces the necessity of the pharmacy profession to consider the impact of stress on the employed workforce.

### 5.1.7 Discussion on attitudes to and perceptions of locums

Locum pharmacists in this study had mixed opinions on patients’ views on the presence of a locum in the pharmacy. Largely, it appears that patients either don’t notice or don’t understand the concept of ‘locum’, and locums reported that patients seem to base their satisfaction on the outcome of the interaction, rather than who the interaction is with. Confounding this issue, discussion in Section 4.4.1.2 on lack of continuity of care does bring out the point that inherent in being a locum is some lack of continuity, which may result in poorer outcomes for the patients. Patients may therefore only become aware of locum status (or more specifically, the pharmacist not being the ‘regular’ pharmacist) when the locum cannot resolve a problem for them. Some interviewees did recognise that it may be more comforting for patients to see their ‘regular’ pharmacist than someone new. This is reflected in published comment that patients are reassured by the presence of their regular pharmacist (Hassell et al., 2010).

A very indirect indication of patients’ views on locum community pharmacists is provided by a public consultation document (Anon, 2009e) (p9) which revealed some impressions of public attitudes to locums, “I would like to know if they [pharmacist] have just been doing locum work”, implying this is a less competent role.
In summary, it appears that many patients do not notice the presence of a locum, or do
not recognise the role, except where continuity issues impinge on their quality of care.
Comparisons with patients' views on other healthcare professions are perhaps not
entirely relevant. Differences in the working environments and the relationships with
patients may make comparison difficult. The media is replete with stories about
inadequate locum doctors (BBCNews, 2010). There is no comparable media interest in
locum community pharmacists.

It appears that, in locum pharmacists’ opinions in this study, GPs pay little regard to
locum status. It was expressed that locum pharmacists may interact more with local
GPs than regular pharmacists, as they are less familiar with local prescribing patterns.
The overriding view was that GPs would be more concerned about the quality of the
interaction with the pharmacist, than that pharmacist’s employment status.

Interactions with other healthcare staff who visit pharmacies, such as nurses, were
referred to in terms of delivering a supply function. Where informal arrangements exist
that the locum pharmacist is not party to, this relationship can cause some difficulties.

Other pharmacists’ views on locums were less clear in this study. In most interviews,
the issue was not expressly considered by interviewees. One pharmacist had
experienced some personal difficulties in working relationships with other pharmacists
which had caused him some distress. It may be that increasingly non-traditional
patterns of working, such as shift working in 100-hour pharmacies, may give
opportunity for more direct pharmacist-pharmacist interactions, perhaps at shift
changeover or during second pharmacist hours. This is in contrast to the traditional
pattern of working, where only one pharmacist would be present in a pharmacy during
nine-six daytime hours. This may allow for more inter-professional conversations to
take place face to face, which inevitably may contain criticisms of performance.
Community pharmacists may have to adjust to working professionally alongside other
pharmacist colleagues. This requires some adaptation to having their work visible and
observable by other colleagues. This issue relates to the concept of taking professional
responsibility for one’s work, which is also discussed in Section 4.5.

Locums’ perceptions of others’ attitudes to them appear mixed. Anecdote in the
pharmacy press (Badwal, 2008) describes some negative views of locum working, but,
with one significant exception in this study, interviewees did not report a significant
level of negative feedback. However, stories about third-parties (other locum
pharmacists) did feature, and these were most frequently stories passed on by staff
members.
5.1.8 Discussion on locum quality

Interviewees described various factors which they felt contributed to being a good quality locum. Being conscientious, taking responsibility for resolving problems effectively, being positively engaged with the working of the pharmacy and being able to build successful working relationships were considered important. This reflects literature comment and opinion on working as a locum (Anon, 2008a).

In terms of being a poor quality locum, lack of assertiveness as a theme is worthy of comment. This was referenced in the interviews to locums not feeling comfortable approaching doctors with problems, and also not raising issues about the standards and facilities in pharmacies. This links to ideas raised in Section 4.5, where it was suggested that one reason for locums not wishing to be accredited to deliver enhanced services was that they did not want to be so visibly accountable for their actions by leaving paper records of their activities. If some pharmacists do lack confidence in their own ability, and wish to effectively ‘hide’ their practice from scrutiny, working as a locum may provide them with the opportunity to do that.

One very interesting finding in the research is that two pharmacists appeared to use staff to compensate for their own lack of competency in some areas of community pharmacy practice. This research hints that some locums may hide behind staff, in that they depend upon staff competency in certain areas to compensate for their own deficiencies. This issue does not appear to have been raised in the literature before. This is an important finding because it raises issues of locum competency, and also perhaps sheds some light on negative perceptions of some locums by staff. It also links to questions of assertiveness, with suggestions of locums not wishing to assert themselves professionally.

It is worth noting that all reports of poor locum standards were, naturally enough, referenced to third parties. There were various descriptors of stereotypes of locums who were considered to be ‘poor performers’. As discussed in Section 4.1, stories of third parties should be treated with a certain caution, and may reflect emotions and concerns that interviewees wish to project rather than factual accuracy. The descriptions provided tended to be those dissimilar to the interviewee in age and gender. One weakness of this research is the lack of any interviewee in their twenties, who may have balanced these descriptions somewhat with respect to age.

There appears to be a general consideration by interviewees that having a good professional reputation locally does matter in terms of gaining work. This is in contrast
to mixed views on the value of being accredited to perform advanced and enhanced services (Section 4.5.6). The feedback to judge reputation appeared to come mainly via staff. Whether positive staff views on locum performance correlate with actual good performance as a pharmacist is a topic worthy of further research. A robust mechanism for assessing the quality of locum performance would be a major advance. Being able to get along with staff may not be enough.

The idea of locum community pharmacy being a place to 'hide' professionally is a contentious one. In its broadest sense (and this was not in the personal descriptions provided by locums in this study, only in third party reports), it describes a professional who is not engaged with the working of the pharmacy or with the patient, who has no commitment to their own development or to the quality of the service provided. Descriptions of 'lazy' locums in this study all related to third parties, and included reading newspapers and using personal laptops in dispensaries, just checking prescriptions brought to them, not problem-solving and not contributing to the day’s work. These ideas all resonate with the idea of the hidden locum. It is clear these stories are passed around pharmacists via pharmacy staff. The implication of this is that there is considerable freedom to hide poor practice within locum community pharmacy, and poor mechanisms for obtaining feedback on performance. There is no evidence to suggest that locum pharmacists are less competent than employed pharmacists. But the nature of temporary working means that opportunities for feedback are fewer as a locum, and comeback on poor performance is unlikely to be felt by the locum. This issue is reflected in a report from the University of Manchester Centre for Pharmacy Workforce Studies on managing performance concerns with pharmacists (Hassell et al., 2010) that notes that locum pharmacists lack formal appraisal processes within organisations and data is not shared between employers or agencies about performance of locum pharmacists.

Work by Magirr et al (2004) examined the clinical autonomy of community pharmacists, and highlighted how this varied with employment status. Their study found that locum community pharmacists demonstrated the least clinical autonomy when presented with a series of scenarios, compared to employee and contractor community pharmacists. This idea is relevant to the findings of this research study, but no easy explanations are apparent. On one hand, the finding by Magirr et al seems contradictory with views that clinical freedom and flexibility is a motivation for locuming expressed in this study, in that pharmacists can concentrate on clinical rather than managerial tasks. This sounds like locums relish that autonomy. On the other hand, if issues raised in this study such as lack of assertiveness and hiding lack of competency are features of some locum pharmacists, and locuming provides these pharmacists with a comfortable (for them)
working environment, then Magirr's work does have some resonances. Alternatively, as Magirr et al put forward, there may be 'organisational and managerial constraints' to locum working that affect clinical autonomy.

5.1.9 Summary

In summary, this study supports previous work on the locum workforce and raises some interesting new angles. Given the size of the locum community pharmacist workforce, this is a population that cannot be ignored, from either a motivational or quality perspective. It raises questions about the working environment for employed community pharmacists, and reinforces views in the pharmacy profession that there is something unsatisfactory about current working conditions as an employed community pharmacist. It also highlights the lack of robust mechanisms for assuring the quality of locum community pharmacy services within the pharmacy profession.

5.2 Study strengths and limitations

This section acknowledges potential criticisms of the study and describes the strengths. When appropriate criticisms are mitigated with description of how the results were interpreted in the light of possible limitations.

One valid criticism of this study is the lack of any participants aged in their twenties. This was recognised early in the sampling process, when invitation letters were prioritised to those under 35 years old, but this still did not yield any volunteers in their twenties. This is a limitation as there was some expressed criticism of younger pharmacists in some of the interviewees responses (and also criticism of older age groups). Having some younger interviewees in the sample may have balanced this criticism somewhat, and also may have explored some other motivations for locum working from a group who are likely to have different life priorities to older workers (different family and career priorities (Willis et al., 2010) ). It is regrettable that this was not explored in the research, and it is a limitation of the study.

The study may be criticised with the suggestion that the sample should be have been taken from locums who worked in unfamiliar pharmacies, in order to obtain a clear view of the experiences and perceptions of that unfamiliar environment. However, this would not give a realistic picture of the true nature of the locum pharmacist. The defining criterion for being a locum is being self-employed. It is clear that the role brings freedom and choice. It is also clear that locums value variety, but that this variety
brings stresses. Being a locum is more than turning up to a strange pharmacy. It is often a lifestyle choice, and this is equally clearly described whether the locum works in the same pharmacy regularly, or a different pharmacy every day. Including locums who work in the same pharmacy regularly is a strength of the study, as it adds a richness to the sample. Similarly, the sample contains interviewees who work as second pharmacists, have jobs in other pharmacy sectors and with a range of previous community pharmacy experience. This breadth of participant may also be considered a strength.

Undertaking interviews is inevitably flawed in that they may only be undertaken with locum community pharmacists who consent to the process. It may be that pharmacists who respond positively to such an invitation are different in some ways from those that do not. It is inevitably a biased sample.

A proportion of the sample was derived from the north west of England, and the remainder from the rest of England. This was a pragmatic decision to enable the researcher to gain some experience of face to face interviews, as well as telephone interviews. (Differences between face to face and telephone interviews are discussed in Section 3.3.3). It is uncertain whether this had any impact on the nature of the sample. There is anecdotal evidence that locum community pharmacy utilisation does vary geographically, with greater dependence on the locum workforce in rural areas and deprived urban settings (John and Turner, 2010). The north west of England is sufficiently diverse to provide a range of rural and urban settings. But given the small size of the sample in this research study, which is not required to be representative of the locum population, but designed to offer diversity and be guided by the development of the research, the geographical split of the sample is unlikely to be significant.

As described in Chapter 3, a realist approach was taken in this research, where descriptions of interviewees’ experiences are taken to represent those experiences. However, descriptions of other locums’ behaviours was often described by way of third party stories by interviewees, and these stories may or may not be true. The stories undoubtedly come through several sources, usually staff. As discussed, this storytelling behaviour may have provided interviewees with a ‘shorthand’ method of expressing issues that they may otherwise be reluctant to do. However, third hand reporting of behaviours does call into question the validity of a realist approach, which relates particularly to Section 4.9.2, describing what makes a poor quality locum. It could be that the status of the data relating to third party poor quality locums can be questioned, and possibly considered as part of a pharmacy ‘folklore’. Without validation, these data should be treated with some caution, but they do add a depth to the study. Qualitative
research is an exploratory method, used to gain insight into a particular situation. As such, it is not generalisable to the wider population under study. The themes here reflect the considerations of the twelve locum community pharmacists under study.

5.3 Future direction

This research study corroborates much previous work on locum pharmacies, and raises some new issues, some of which could be usefully explored further. The research has implications for pharmacy employers, the pharmacy professional bodies and locum pharmacists themselves, but it is difficult to segregate recommendations in this way. The absolute basis for any pharmacy research is improved outcome for patients, and what affects one stakeholder will also have a strong interest for the others.

One particular theme relates to locum quality. There is some suggestion from this research that locum work provides an opportunity for pharmacists to hide poor practice. This could relate to lack of assertiveness in addressing problems within the pharmacy or with prescribers. Other issues raised were the possibility of locum pharmacists not engaging with advanced and enhanced services as it necessitates leaving an auditable trail of their practice, and also using staff as a supportive resource for areas of practice where they do not feel competent. The quality of service provided by locum community pharmacists, and their level of professional engagement compared to employed or contractor pharmacists, is an interesting area for research. The diversity of the locum population makes that a significant challenge, however. This idea links to the requirement for mechanisms for feedback on locum performance, as it appears that staff offer the only meaningful feedback processes at present, and the validity of this is questionable. Whether positive staff views on locum performance correlate with actual good performance as a pharmacist is a topic worthy of further research. Feedback also works both ways, with reliable mechanisms required for locums to highlight poor practice in pharmacies to appropriate sources.

The physical environment in which community pharmacy operates is a relatively little-researched area. This study gives some views on how important the physical environment can be to locum pharmacists. Evening working is a particular issue that needs to be considered. Further research into safe working environments and volumes of work for community pharmacy services should also consider the workload dichotomy between locums being unfamiliar with the workplace, but also being able to be more
clinically focused. Research into effective pharmacy environments should consider the needs of locum pharmacists, with respect to their unfamiliarity with the workplace and their possible greater susceptibility to environmental distractions such as radio or telephones.

It is clear from this study that the current nature of the employed working environment is unattractive to many locum pharmacists, giving them a motivation for locuming. This links to stress issues for pharmacists. The requirement for further exploration of what makes a positive, productive, healthy community pharmacy working environment is supported by these findings.

Locums’ perceptions of others’ attitudes to them were also explored as part of this study. As key stakeholders in the pharmaceutical service, patients’ views on locum pharmacists would be an interesting research topic.

It is clear that locums make some assessments and judgements about the practices of the pharmacy they are working in, and often have to deal with resource and staff competency issues that are outside their immediate control. Locums have to balance these risks of continuing with existing potentially unsafe or unlawful practices versus the risk of sudden change to working procedures. The nature of these risks, and whether locums assess this balance, or have strategies to mitigate risks, was outside the scope this study and is an area requiring further research.
 References


Wood, J. (2002). There are advantages and disadvantages to being a locum pharmacist *Pharmaceutical Journal* 269 (7207), p.102.

Appendices

Appendix 1: Pharmacy contractual framework

The contract consists of three different levels of services;

• Essential services
• Advanced services
• Enhanced services

Essential services - offered by all contractors

Dispensing - Supply of medicines or appliances, advice given to the patient about the medicines being dispensed and advice about possible interactions with other medicines. Also recording all medicines dispensed and significant advice provided, referrals and interventions made.

Repeat dispensing – Management of repeat medication for up to one year, in partnership with the patient and prescriber. The patient will return to the pharmacy for repeat supplies, without first having to visit the GP surgery. Before each supply the pharmacy will ascertain the patient’s need for a repeat supply of a particular medicine. The pharmacist will communicate all significant issues to the prescriber with suggestions on medication changes as appropriate.

Disposal of unwanted medicines - Collection of unwanted medicines from households and individuals via pharmacies. Special arrangements will apply to Controlled Drugs (post Shipman Inquiry).

Promotion of Healthy Lifestyles (Public health) - Opportunistic one to one advice given on healthy lifestyle topics such as smoking cessation to certain patient groups who present prescriptions for dispensing. Also involvement in six local campaigns a year, organised by PCTs. Campaign examples may include promotion of flu vaccination uptake or educating the public about the appropriate use of antibiotics.

Signposting patients to other health care providers – Pharmacist and staff will refer patients to other health care professionals or care providers when appropriate. The
service also includes referral on to other sources of help such as local or national patient groups.

**Support for self-care** – The provision of advice and support by pharmacy staff to enable people to derive maximum benefit from caring for themselves or their families. The service will initially focus on self-limiting illness, but support for people with long-term conditions is also a feature of the service.

**Clinical governance** - Requirements include use of standard operating procedures, patient safety incident reporting to National Patient Safety Agency, demonstrating evidence of pharmacist CPD, conducting clinical audits and patient satisfaction surveys.

**Advanced services** – requiring accreditation of the pharmacist and pharmacy

**Medicines Use Review (MUR) & Prescription Intervention Service** – The pharmacist conducts a concordance centred medication review with the patient. The review assesses any problems with current medication and its administration. The patient’s knowledge of their medication regimen is assessed and a report is fed back to the patients GP. The patient’s knowledge of their medication and why they are taking it is increased; problems with their medication are identified and addressed. The MUR is conducted on a regular basis, e.g. every 12 months. The Prescription Intervention Service is in essence the same as the MUR service, but conducted on an ad hoc basis, when a significant problem with a patient’s medication is highlighted during the dispensing process. The pharmacist will feed back suggestions and comments to the prescriber using standardised paperwork (eventually electronically). Reviews have to be conducted in a consultation area which ensures patient confidentiality. Pharmacists must successfully pass a competency assessment before they can provide Advanced services.

**Enhanced services** – specification and value agreed nationally, commissioned locally by PCTs

Services include:
- Minor ailments management
- Diabetes screening
• Substance misuse services
• Disease specific medicines management services
• Palliative care services
• Emergency Hormonal Contraception service
• Full Clinical medication review
• Care home services
• Head Lice management service
• Smoking cessation service
• Gluten Free food supply service
• Needle exchange scheme
• Services to schools

Source: Pharmaceutical Services Negotiating Committee http://www.psnc.org.uk/
Appendix 2: Responsible pharmacist

Guidance for responsible pharmacists

Securing the safe and effective running of the registered pharmacy
In order to lawfully conduct a retail pharmacy business, a registered pharmacist must be in charge of the registered pharmacy as the responsible pharmacist. The operational activities that may take place in the registered pharmacy when you are in charge of the pharmacy depend on the level of supervision provided and whether or not you are absent from the registered pharmacy.

You must

- establish the scope of the role and responsibilities you will have as the responsible pharmacist and take all reasonable steps to clarify any ambiguities or uncertainties with the pharmacy owner, superintendent pharmacist or other delegated person.
- only take on the role of the responsible pharmacist if this is within your professional competence.
- only be the responsible pharmacist in charge of one registered pharmacy at any given time.
- secure the safe and effective running of the pharmacy business at the registered pharmacy in question before the pharmacy can undertake operational activities. Only after you are personally satisfied that you have secured the safe and effective running of the pharmacy can any operational activities begin to take place.

Displaying the notice
The notice is important as it allows patients and the public to identify the pharmacist who is responsible for the safe and effective running of the registered pharmacy.

You must

- conspicuously display a notice in the registered pharmacy.

The pharmacy record
The pharmacy record is an important legal document. It shows who the responsible pharmacist is on any given date and at any time. This audit trail is particularly important in the event of any incident or error as it shows who was accountable. The pharmacy record may be kept in writing, electronically or in both forms. An entry in the pharmacy record may be made remotely as long as the record complies with all the relevant professional and legal requirements.

You must

- ensure the pharmacy record is accurate and reflects who the responsible pharmacist is, and was, at any given date and time (including whether or not the responsible pharmacist is, or was, absent from the registered pharmacy).
- personally make the entries in the pharmacy record.
- ensure any amendments or alterations identify when, and by whom, the alteration was made, if the pharmacy record is maintained as a paper-based record.
- be satisfied that appropriate measures are in place to ensure that
  - the record is backed-up,
  - the record is available at the registered pharmacy for inspection, and
  - any alterations to the record identify when, and by whom, the alteration was made, if the pharmacy record is maintained electronically.
- not become the responsible pharmacist or make an entry in the pharmacy record until you have secured the safe and effective running of the pharmacy business at the registered pharmacy in question.
- ensure that the pharmacy record is available at the registered pharmacy.
- ensure that the pharmacy record is available for inspection by the person who owns the pharmacy business, the superintendent pharmacist (in the case of a body corporate), the responsible pharmacist, the pharmacy staff and our Inspectorate.

**Pharmacy procedures**

The pharmacy procedures form part of the quality framework for the safe and effective running of the registered pharmacy. The pharmacy procedures may be maintained in writing, electronically or in both forms.

You must

- establish, if not already established, maintain and review pharmacy procedures.
- maintain adequate back-ups of the content of pharmacy procedures.
• ensure that the pharmacy procedures are available for inspection by the person who owns the pharmacy business, the superintendent pharmacist (in the case of a body corporate), the responsible pharmacist, the pharmacy staff and our Inspectorate.
• ensure that the pharmacy staff understand the pharmacy procedures that are in use.
• ensure that the pharmacy procedures
  • are reviewed at least once every two years or following any incident or event that occurs which indicates that the pharmacy is not running safely and effectively,
  • identify the responsible pharmacist who reviewed the procedures,
  • identify which procedures are currently in place,
• make a temporary amendment to pharmacy procedures if the circumstances in the pharmacy change and in your professional opinion it is necessary to change the way in which the pharmacy normally operates.
• ensure there is an audit trail to identify
  • which procedures are currently in place,
  • which procedures were previously in place,
  • the responsible pharmacist who amended the procedure, and
  • the date on which the amendment was made,
if you make a temporary amendment to the pharmacy procedures.

Source: General Pharmaceutical Council http://www.pharmacyregulation.org/
## Appendix 3: Interview Guide

The original interview guide is shown, with changes made during the research process highlighted.

<table>
<thead>
<tr>
<th>Question</th>
<th>How is the question derived</th>
<th>Research objective</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Demographics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>Literature</td>
<td>1a</td>
</tr>
<tr>
<td>Gender</td>
<td>Literature</td>
<td>1a</td>
</tr>
<tr>
<td>How long have you worked as a locum?</td>
<td></td>
<td>1a</td>
</tr>
<tr>
<td>How many days a month would you say you work as a locum, on average?</td>
<td>Literature</td>
<td>1a</td>
</tr>
<tr>
<td>Do you have another job as well? What is that?</td>
<td>Literature</td>
<td>1a</td>
</tr>
<tr>
<td>Why did you choose to do locum work?</td>
<td>Literature</td>
<td>1a</td>
</tr>
<tr>
<td><strong>Work pressures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What hours during the day do you commonly work (ie, what times)?</td>
<td>Interviewer experience</td>
<td>1</td>
</tr>
<tr>
<td>If out of hours – what’s that like?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is it different working out of hours to normal hours?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Why do you choose to work those hours?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explore stress issues here.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you work in the same pharmacies regularly, or different ones?</td>
<td>Literature</td>
<td>1a</td>
</tr>
<tr>
<td>What type of pharmacy do you most often work in? (multiple, independent)</td>
<td>Literature</td>
<td>1a, 1, 2b</td>
</tr>
<tr>
<td>Why do you choose that?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there any other factors that make you choose a pharmacy?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explore, stressors particularly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There’s been a lot of talk recently in the pharmacy press about work stress in pharmacy. Do you ever feel stressed at work?</td>
<td>Literature</td>
<td>1</td>
</tr>
<tr>
<td>If yes….What stresses you about work? Explore.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If no… what helps you deal with things?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can you remember a particular situation where you felt really stressed at work?</td>
<td>Literature</td>
<td>1</td>
</tr>
<tr>
<td>Pharmacies can be busy with high script volume, lots of enhanced services, or quieter. Which type do you prefer?</td>
<td>Discussion with others</td>
<td>1, 2b</td>
</tr>
<tr>
<td>Why is that?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Method</td>
<td>Score</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>What kind of things make you want to go back to a particular pharmacy?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have any tales to tell about coping with a busy pharmacy? <em>This question was added to further explore stress issues.</em></td>
<td>Discussion with others</td>
<td>1</td>
</tr>
<tr>
<td>Have you ever felt that patient safety might be compromised? <em>This question was added after four interviews.</em></td>
<td>Literature, discussion with others</td>
<td>1</td>
</tr>
<tr>
<td>Local working environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What things about a pharmacy <em>help</em> you when you work as a locum?</td>
<td>Interviewer experience</td>
<td>2a</td>
</tr>
<tr>
<td><em>Introduce staff, SOPs, support resources within pharmacies</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Where else can you get support as a locum? What type of support is that?</td>
<td>Interviewer experience</td>
<td>2a</td>
</tr>
<tr>
<td><em>Ask about PCT, NPA, CPPE, LPC, agencies, other networks</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you get involved in advanced and enhanced services? How do you feel about that?</td>
<td>Interviewer experience, literature</td>
<td>2a</td>
</tr>
<tr>
<td>National Policy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have there been any national changes, say, new policy, law or structures, that have had an impact on your locum work?</td>
<td>Interviewer experience, literature</td>
<td>2b</td>
</tr>
<tr>
<td><em>If not raised…</em></td>
<td>Suggest:</td>
<td></td>
</tr>
<tr>
<td><em>CPD, revalidation, responsible pharmacist, creation of professional leadership body, creation of local practice forum, multiple pharmacy</em></td>
<td>Interviewer experience, literature</td>
<td>2b</td>
</tr>
<tr>
<td>What do you think of it? Does it matter to you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you do anything differently as a result of it?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has it had any impact on you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you think it might have an impact on you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attitudes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What do you think other pharmacists think of locums generally?</td>
<td>Literature</td>
<td>3</td>
</tr>
<tr>
<td>Staff?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GPs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Response</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>----------</td>
<td></td>
</tr>
<tr>
<td>(depending upon response): Can you tell me about a particular example?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is being a locum different nowadays to say, 10 or 20 years ago? (has it changed)? (Explore historical locum experiences if appropriate, ie, if they are old enough to have worked as a locum pre-contract). <em>This question was deleted.</em></td>
<td>Discussion with others 3</td>
<td></td>
</tr>
<tr>
<td>What’s the hardest thing about being a locum? Explore.</td>
<td>Interviewer experience</td>
<td></td>
</tr>
<tr>
<td>What’s the best thing? Explore.</td>
<td>Interviewer experience</td>
<td></td>
</tr>
<tr>
<td>Any other comments</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 4: Introductory letter

Dear Pharmacist,

I am writing to invite you to participate in a research study aimed at exploring locum community pharmacists’ experiences and perceptions of their work. This research is being conducted by an MPhil student at the University of Manchester.

There is very little published information on locum community pharmacists, and they constitute over a third of the community pharmacy workforce. Consequently there is a need to explore locum community pharmacists’ views of their work experiences, their views on the stresses of locum work, and on their access to resources such as continuing professional development opportunities.

You have been chosen to take part in this study as you are a locum community pharmacist, giving you the necessary knowledge and expertise to contribute to this research. Your views are important regardless of whether you work as an occasional or regular community locum.

If you agree to take part in the study, your participation will involve a face to face or telephone interview with myself. This will be at a convenient location and will last for approximately thirty minutes. Questions will focus on your experiences working as a locum.

The discussions will be sound-recorded and subsequently transcribed. As transcripts will be anonymised, you will not be personally identified within the study. Please find enclosed an information sheet about the study, a consent form and a stamped addressed envelope.

If you would like to take part in the study I would be grateful if you could return the consent form to me in the envelope provided. I will then contact you to arrange a suitable time for an interview.

If you require any further information please do not hesitate to contact me.

Thank you for your time.

Yours sincerely,

Alison Astles, MRPharmS

MPhil student, University of Manchester
Appendix 5: Consent form

CONSENT FORM

Locum community pharmacists’ experiences and perceptions of their work

If you agree with the statements below please initial next to the box:

☐ I have read and understood the information sheet
☐ I have had an opportunity to ask questions and discuss this study
☐ I have received satisfactory answers to all my questions
☐ I give permission for the researcher to use direct, anonymised quotes in publications
☐ I understand that I am free to withdraw from the study at any time without giving a reason for withdrawing
☐ I give my permission for this interview to be digitally recorded
☐ I agree to take part in the study

Name (PLEASE PRINT)...........................................................................................................

Signed..........................................................Date............................................

Please indicate how you would prefer to be contacted to arrange your participation in an interview. Please provide your telephone number / email address:

Telephone:.....................................Email:.............................................................

Please return this consent form using the stamped address envelope provided, thank you.
Appendix 6: Information sheet for participants

INFORMATION SHEET

Locum community pharmacists’ experiences and perceptions of their work

You are being invited to take part in a research study. Before you decide whether to take part, it is important for you to understand why the research is being carried out and what it involves for you.

Please take time to read the following information carefully. Discuss it with others if you wish. If there is anything that is not clear or if you would like to receive more information, please feel free to contact me (Alison Astles) on 07792 508692 or alison.astles@manchester.ac.uk.

Take time to decide whether or not you wish to take part.

Thank you for reading this information sheet.

Why is this research necessary?

There is very little published information on locum community pharmacists, and they constitute over a third of the community pharmacy workforce. Consequently there is a need to explore locum community pharmacists’ views of their work experiences, their views on the stresses of locum work, and on their access to resources such as continuing professional development opportunities.

What is the purpose of the study?

This postgraduate research project aims to use interviews to explore locum community pharmacists’ views of their working lives.

Exploring this issue will help the pharmacy profession understand the nature of the locum pharmacy workforce and the implications of this pattern of working. It may also help identify resources or strategies that will support the locum pharmacist.

Why have I been chosen?

You have been chosen to take part in this study as you are a practising locum community pharmacist, giving you the necessary knowledge and expertise to contribute to this research. Your views are important regardless of whether you work as an occasional or regular locum.

What will happen to me if I take part?

If you decide to take part, you will take part in an interview about your work experiences and perceptions working as a locum community pharmacist. The discussion will be flexible, but will be based around the following areas:

- Work pressures that affect locum community pharmacists
- Locum community pharmacists views on their role, and how others perceive their role
- The impact of local working conditions and national policy on locum community pharmacists
The interview will be held close to where you live or work, or by telephone. It will take no longer than 1 hour.

With your permission, the interview will be sound recorded, transcribed and analysed. On transcription, the information will be anonymised. If you do not wish to be sound recorded, please indicate this to the researcher, you can still participate and the researcher will take notes during the interview.

**Will information about me remain confidential?**

All information obtained from the interviews and any other contact with you will be kept strictly confidential, except as described below. To ensure this, data will be anonymised and securely stored. Your personal details will not be used in the analysis. We may use quotes from your interview in reports or publications, but these will not be attributed to you. Sound recordings of interviews will be erased as soon as we have finished with them.

Information about your participation will only be available to the research team and staff responsible for monitoring the conduct of the study at the University. The study will respect patient confidentiality and you will be asked not to mention patients, colleagues or organisations by name. If any details of patients, colleagues or organisations are mentioned they will be promptly removed from the transcripts of the interview data.

In the interests of patients’ safety, it may be deemed necessary to break this confidentiality if you describe some **seriously unsafe** practice of yours (e.g. dispensing a ten-fold overdose of warfarin for a patient) that you state has not been previously reported through your organisation’s usual clinical governance procedures (e.g. the completion of a critical incident report). We have a professional obligation to report this to the appropriate bodies. If this situation occurs, the interview will be stopped and the matter discussed with you, making it clear what is happening, before discharging that responsibility.

**Do I have to take part?**

No. It is up to you to decide whether or not to take part. If you decide to take part you are still free to withdraw from the study at any time, and without giving a reason. You may also leave the interview at any point, if you wish to. The information collected can be destroyed after your withdrawal if you prefer.

**What if there is a problem?**

If you have any concerns about any aspect of this study, you should speak with the researchers who will do their best to answer your questions (see contact details).

If you remain unhappy and wish to complain formally, you can contact the University Research Office on 0161 275 7583. This contact is independent of the researcher and research supervisors.

**What will happen to the results of the research study?**

The results of the study will be analysed and may be published in professional journals and at conferences. They will also contribute to the completion of a postgraduate thesis. You will not be identifiable from the data used and published.

**Who has organised the study?**
The study has been organised by the Centre for Pharmacy Workforce Studies at the University of Manchester.

Who has reviewed the study?

This study has been approved by the University Research Ethics Committee.

What do I do next?

Complete and return the enclosed consent form, in the postage paid envelope provided, indicating that you wish to take part in this study. Alternatively, telephone, text or email using the contact details below to arrange a convenient date for an interview.

Contact details for further information

If you wish to ask any questions about this study before deciding to take part, please do not hesitate to contact me at:

Alison Astles, MRPharmS
Centre for Pharmacy Workforce Studies
School of Pharmacy and Pharmaceutical Sciences
University of Manchester
1st Floor, Stopford Building
Oxford Road
Manchester
M13 9PT
Telephone: 07792 508692

Email: alison.astles@manchester.ac.uk

Thank you once again for taking the time to read through this information and considering taking part in this study.