Health and Social Care Committee
Inquiry into the contribution of community pharmacy to health services in Wales

CP 38 – Dr Christopher John Harris

Re: Inquiry into the contribution of community pharmacy to health services in Wales

I write as an ex member of Betsi Cadwaladr Community Health Council and the views below are derived from my time with that body, but are my own and do not reflect any opinions held by that body. Whilst much of the information which prompted this response centres upon observations made during a Pharmacy Profiling exercise undertaken in Flintshire, no confidential information is revealed and no reference made to identifiable persons, premises or CHC members.

Introduction

To the public, the title “community pharmacy” suggests that either this is a building and service provided in a specific locality or that it is an integrated part of the local NHS system, however, it is neither and the expressed desires of the person in the street are likely to be misleading.

Part 1 The effectiveness of the Community Pharmacy contract in enhancing the contribution of community pharmacy to health and wellbeing services.

From a user's point of view it is difficult to assess the effectiveness of the contract, however, it is clear that, in the minds of those pharmacists who have been contacted, that the contract relates to the provision of medicines and not to services.

In order to enhance, using the word in its common or garden sense, the contribution of community pharmacies to health

services there is a need for the pharmacist / company to both see both a demand and a cost effective way of meeting that need. A small pharmacy may have limited space or finance and thus feel that whatever they would like to do they will not be able to meet the requirements of the service which will be assessed in an as yet unknown manner in order to measured outcomes.

Part 2: The extent to which Local Health Boards have taken up the opportunities presented by the contract to extend pharmacy services through the provision of 'enhanced' services.

I am not in a position to make comment on this question. The scope for community pharmacy to deliver a wider range of services is dependent on funding arrangements

Because the financing of the contract is focused on dispensing, the role of the dispenser is relatively simple and because Wales has a 'no charge policy' for medicines, there is no need for the pharmacist to explain the advantages of purchasing over the counter medicines where these would be cheap. In England a prescription for, say, aspirin may lead the pharmacist to explain to the customer that they could purchase the aspirin at a lower cost than the payment required for a prescription. This simplicity would disappear with the expansion of the roles of community pharmacies. Any need to change to purchasing health outcomes by the health board would be difficult to measure and be subject to the pressures of the marketplace.

Part 3: The scale and adequacy of 'advanced' services provided by community pharmacies.

Within the area which was the subject of a more detailed pharmacy profiling exercise, it was found that the provision of advanced services was not widespread, but the concept was welcomed by the majority of pharmacists whether independent or

part of the group. The pharmacy needs to be assured of a proper income and return on its investment if it is to be willing to enter into this opt-in provision of service (principally Medicines Use Reviews (MURs) and Appliance Use reviews (AURs)). A potential problem lies in the expectancies of patients as they may be searching for a clinical review (a GP task) whilst the pharmacy is offering a review of how the patient is using the medicine. How people react may be unpredictable as some people prefer the opportunity to remain anonymous and unknown to the person giving healthcare whilst others prefer to know that the GP is a member of their own community and that there is mutual respect and understanding.

There are also areas where a pharmacy may be able to offer a service, but will not have the opportunity for example in offering mental health support. GPs are familiar with the patient who attends for a stated reason. The GP will realise that this is not the real reasons for cry for help and will ask further. Whilst many local pharmacists would have the empathy and skills required, the construction of physical spaces and the psychological safety net of the GP surgery are unlikely to be available and it is unlikely that such patients will be recognised as needing help.

Part 4: The scope for further provision of services by community pharmacies in addition to the dispensing of NHS medicines and appliances, including the potential for minor ailments schemes;

A considerable amount of work which is not recorded or paid for by the health service is already being absorbed by the community pharmacies. There is a long established intervention by pharmacies where patients approach the pharmacist for advice, usually receiving over-the-counter medicines or being advised to see their GP or ophthalmologist.

If the concept of community pharmacies is to be developed into a meaningful addition to the NHS then there needs to be a

complete strategy. ‘Big bang’ changes don’t work so a clear step by step change is required and this needs handling in a manner which understands the way in which users actually behave.

If, in Wales, a free service for minor ailments were to be introduced how would the system cope with the large numbers of “grandchildren staying with me/ holidaymaker” problems without creating a bureaucratic monster?

A number of pharmacists have stated that they know that prescriptions are requested with the intention of these being used by family members in a different country 1 km up the road. Free minor ailments would be a minefield here – is one treating John or his cousin Jack?

Part 5: The current and potential impact on demand for NHS services in primary and secondary care of an expansion of community pharmacy services, and any cost savings they may offer.

An expansion of community pharmacy services could (not necessarily would) enhance the availability of health care to the population and this would be welcomed. There is no proof that such an expansion would offer any cost savings especially in the initial stages of setting up the necessary schemes for improvement of the services, support systems and the monitoring systems. From a patients’ point of view the impact upon primary care would depend upon the cost of treatment. Whilst patients may obtain prescribed medicines from a GP at no cost, unless a similar scheme exists within pharmacies then it is likely that the people who currently obtain advice and remedies from the pharmacy will continue to do so whilst those currently using a GP with the expectation of obtaining medication or referral will continue to do so. Figures often quoted for cost savings assume that time is saved at the GP salary rate, whereas GP support staff are much cheaper and the real savings much lower.

In secondary care the situation is more complicated and any benefits must take into account existing contractual obligations such as dialysis fluids and patient reviews.

The choice of using a pharmacy or GP will probably not exist in reality for persons relying upon others for transport. Such people will have no choice but to use the GP service because they have multiple needs. The effect of those will be to skew the work of the GP and may increase the burden upon the out of hours services.

The provision of a minor ailments (including in the user's terms, very minor injuries) service adjacent to the centres of population seems logical and would be welcomed by the public. This may not remove a large number of people from the waiting areas of A & E units. Whether this would have an effect on cost is a matter of speculation as once again assistance with cuts, grazes, cleaning wounds, allergic reactions etc. is already being dealt with by pharmacies and the need for X-ray facilities means that people would be referred to A&E by pharmacists. If such a service were to be set up, the public would decide whether or not to go to the community pharmacy, the GP or A&E according to their expectations rather than knowledge of the opportunities offered by any one of those providers.

Part 6: Progress on work currently underway to develop community pharmacy services.

There is a difference between the formal, contracted development of the services and the way in which these services are evolving due to the pressures of the marketplace. This means that the concept of a community pharmacy service varies according to the provider and to the user and in turn these are dictated by the situation geographically, financially and socially. This also means that the paradigm of a pharmacy is difficult to change both within the population and the healthcare professions and, at the same time, is not uniform across Wales.

There is no uniformity in the physical size of premises, their cost effectiveness as business ventures, their financing arrangements or in the long-term ambitions for the service provided. A number of independent operators are of an age and financial situation which is unlikely to facilitate the investment of time and money which they may not recover in their working lifetimes. Conversely many retail operators, especially supermarkets, have seen the investment in a pharmaceutical area of the store as being not only cost-effective in its self, but a way of providing the one stop shop and so attracting customers into other parts of the premises. This is combined in 'superstores' with the provision of other areas of healthcare especially opticians. Some have developed the concept to the point of offering drop in GP provision.

The concept of a one stop shop may be very attractive in the short-term, but development of this type of service will lead to a defacto fragmentation of the existing health service structure. This will come about as smaller pharmacies, opticians or dentists find that they cannot compete with the major retailers. Within a short time there will be a power structure wherein a small number of very large organisations will be able to dictate the salaries of pharmacists, the prices that they are willing to pay for drugs and the level of legal responsibility accepted by staff members. Furthermore one will see the concentration of such services within stores leading to the decline in business for retailers within the catchment area of the superstore, including existing pharmacies which serve a much smaller but very local population. This evolution is driven by the market place and may not be compatible with the way in which the NHS wishes to develop community health services.

At first glance, the larger multiple pharmaceutical retailers appear have premises which are readily used for enhanced and advanced services. In fact many of these sometimes very large premises are badly designed. There are a number of specialist pharmacy designers in the UK, but not one of the pharmacies visited in Flintshire had used their expertise. The effect of this can be seen when entering these larger stores. The layout, lighting, sound

system, signing and aisle layout is designed to attract average sized people who are walking about to different parts of the store. Wheelchairs or other aids to mobility are catered for by having automatic doors and other devices, however, if one that sits in a wheelchair and tries to negotiate the premises it is quite clear that the design is flawed, for example a wheelchair user straining to see a sign which is hung at high-level finds often that they are looking directly into the luminaires.

The majority of pharmacies, even quite small ones, did have a consulting room. In many cases this was quite simply a tiny room to allow customers to speak to the pharmacist in confidence. In order to provide even simple services such as inoculations, there is a need for space and hand washing facilities which do not exist in many of pharmacies visited. In many cases provision of the plumbing or other building services would be quite difficult and cost prohibitive.

There are also many changes needed to the design of buildings and concepts of service if community pharmacy provision is to be properly developed. This is linked to a requirement to understand the needs of users when the ideas are taken beyond the dispensing chemist scenario. For example, a common question raised by pharmacists during the Flintshire exercise was why the questionnaire asked about the provision of space and water for assistance dogs. Any dog which has been leading the person about it town centre in and out of overheated premises will be in need of hydration and a rest whilst the pharmacist is dealing with the owner, but this had not been recognised.

Conclusions

(i) The fundamental concept of developing community pharmacy services is good if it increases access to healthcare.

(ii) There would be considerable expense in setting up a viable system and failure to complete would mean the loss of the investment.

(iii) The concept is unlikely to make a large reduction in either primary or secondary care demands or costs.

(iv) It may have the effect of transferring NHS power to unaccountable business empires.