

## COMMUNITY PHARMACY CONFERENCE

# Community pharmacists: are you ready to shine yet?

*“Securing the future”, the first conference for community pharmacists organised by The Pharmaceutical Journal, was held on 23 November in London. Conference chairman Annie Coppel, director of corporate governance and programme management at the National Prescribing Centre, asked the conference: “The future is bright: the question is are you ready to shine yet?”*

*Lin-Nam Wang and Clare Bellingham report*

## A lethal prescription for pharmacy?

The new economics foundation report ‘Ghost Town Britain’ published last year highlighted the loss of one fifth of our corner shops, post offices and local pubs between 1995 and 2000, and the damage that this would do to the fabric of our communities, according to Andrew Simms, policy director of the new economics foundation, an independent think-tank. It is the result of several economic trends together creating consequences that nobody wants, he says. Small newsagents were being lost at the rate of almost one per day, and 20 per cent of post offices are the only local shops left in a local shopping area.

“The day after the launch of the report, we received a phone call from a senior NHS administrator saying something confusing about a delayed report from the Office of Fair Trading that we might be interested in. It was then that our attention turned to the future for community pharmacies,” Mr Simms explains.

‘Ghost Town Britain’ did not examine the case of the 12,250 local pharmacies. “We had not included them for a reason: everything seemed calm and happily functioning in the world of community pharmacies. People were happy with the service they provide and the Government was talking about enhancing their role in line with the NHS plan,” he says.

Then in January this year, when the OFT recommended handing the sector on a plate to the major supermarkets, it looked like the depressing history highlighted in ‘Ghost Town Britain’, was about to repeat itself in the community pharmacy sector.

### IMPACT OF OFT REPORT

Eighty per cent of local pharmacy income is from prescriptions and only 20 per cent from other products, so the sector is highly reliant on NHS contracts transactions, says Mr Simms. If pharmacies follow other services in ‘Ghost Town Britain’ they will decline at the rate of 4 per cent a year — that is the loss of more than one pharmacy a day. The OFT report mentioned over 3,000 medium to large supermarkets are currently without pharmacies. Research commissioned by Lloyd’spharmacy showed that



*Is the high street under threat?*

6,624 pharmacies are located within the catchment area of two or more supermarkets, placing them most under threat.

Most disturbingly, in the zones where community pharmacies are under threat from supermarkets, between a fifth and a third of those populations, in regions such as the north west and north of England, are defined as “most deprived” by the official Index of Multiple Deprivation. Community pharmacies are most under threat in precisely the areas where people with the least mobility live, he explains.

In addition, demands on health services are much higher in deprived than in affluent areas. According to the Office of National Statistics, low-income households pay twice as many visits to the doctor as affluent households.

There is also a clear knock-on effect of the closure of services that has not been properly addressed by the OFT, he said. When the last bank and post office branches close in a given area, other local businesses see drops in trade of between 10 and 30 per

*Andrew Simms was due to speak at the conference but was unable to attend for personal reasons. This report summarises the presentation he planned to give*

cent. The loss of local pharmacies is also likely to have a knock-on effect.

Community pharmacies fulfil a social function and are the launch pad for many Department of Health initiatives, says Mr Simms. Their role is vital, each serving on average 50 patients with diabetes, 150 patients with asthma, 10 patients with mental health problems, 750 older people and 50 patients recently discharged from hospital. They provide services such as controlled methadone for drug users and emergency contraception. If the role of pharmacies is extended as outlined in the NHS plan, for example when pharmacists are able to organise repeat prescribing, the Cabinet Office estimates that 2,545,455 GP appointments a year would be freed for more essential cases. “But undermine community pharmacies and those benefits will be lost,” he warns.

The OFT report flies in the face of the Government’s own stated aim of “joined-up thinking”, says Mr Simms. This is a case of the Department for Trade and Industry and the DoH working against each other supposedly to deliver choice in health care. The OFT proposals would actually reduce accessibility and choice for most people, he adds.

According to the OFT’s own analysis, 86 per cent of people are currently satisfied with local pharmacy provision. “So if it’s not broken why fix it” he asks. The OFT appears to be offering a solution to a problem that does not exist.

“Instead, rather than undermining them, we believe we need to enhance the role of local pharmacies — by extending the function they perform for communities on public health issues.” Local pharmacies could be a site for increasing local participation in health services, for example by being active members of local Time Banks [a scheme for people within communities to exchange practical help, see [www.timebanks.co.uk](http://www.timebanks.co.uk)], he suggests.

“It seems to me that there is an unresolved tension between those who would like to see pharmacies operate like straightforward retailers — in which case we can expect a repeat of exactly the phenomena of ‘Ghost Town Britain’ — and those who believe that they have a wider role, and as

such need a regulatory position that allows them to keep providing a fuller public service," comments Mr Simms.

#### WHAT NEXT?

The new economics foundation is bringing its experience of local economic dynamics to bear, he says. Next it is promoting the Local Communities Sustainability Bill [introduced to Parliament in March 2003] which it thinks is the only comprehensive proposal to revitalise local economies. It is also a campaign to give communities real self-determination. The Bill makes provi-

sion for local communities to draw up sustainability strategies — say what local goods and services are important to them — and for the Secretary of State to grant such freedoms and flexibilities to local authorities as are necessary to make them happen. "Community pharmacies fall squarely into that category and are mentioned in the proposed Bill," he notes.

The OFT places great faith in the invisible hand of the market, he says. But in a market potentially dominated by a few major supermarkets you end up with Adam Smith's classic observation that: "People of the same trade seldom meet together, but

the conversation ends up in a conspiracy against the public." Mr Simms comments: "I believe that if the invisible hand is active at all, it is most likely to be picking the pockets of the poor. Even after the cool response of the DoH to the OFT proposals, over 400 large supermarket stores could be setting up their own pharmacies, with knock-on effects on community pharmacies that have not been assessed," he says.

Further information about the new economics foundation, including its reports, is available at [www.neweconomics.org](http://www.neweconomics.org).

Mr Simms plans to publish an update to 'Ghost Town Britain' later this month.

## Supplementary prescribing: a new role for pharmacists

Felicity Davies, a community pharmacist in Pulborough, West Sussex, is training to become a supplementary prescriber at King's College London.

Supplementary prescribing should be confined to a pharmacist's area of particular interest or specialty, she said. In her case, this was diabetes. "You need to find a niche for supplementary prescribing, identifying both an independent prescriber to work with and a set of patients where supplementary prescribing will be a useful addition to their management," she said.

In terms of applying for the supplemen-



*Felicity Davies: total commitment*

tary prescribing course, Mrs Davies said that the university application forms had been straightforward.

"Those for the local workforce development confederation [for funding] were more complex," she pointed out. Details required included why the supplementary prescribing model would be better than current systems of care (ie, the impact of the model) and how access to patients' medical records would be achieved. Mrs Davies also had to find a medical mentor. "The PCT was helpful and supportive," she commented.

The course finishes in December, with examinations in January, which will "cast a

small shadow over the Christmas break", she said.

Mrs Davies has needed to devote 39 days over the three months of the course to studying. "For most community pharmacists, this course means total commitment," she said. "Leaving the community pharmacy to go to the classroom and doctor's surgery was a scary experience, especially for those of us who have been qualified for some years," she commented. "But sharing learning experiences at the university each week has been useful."

Once qualified as a supplementary prescriber, Mrs Davies will work in a GP practice so will have access to patients' records in the surgery. "If you cannot do this then you do need to ask yourself if you have enough information without access to notes to make safe prescribing decisions," she added.

Initially, Mrs Davies will prescribe in a diabetes clinic. "But in the future, I hope to move into coronary heart disease and asthma," she said.

## All pharmacies should have consultation areas

Peter Marshall, a community pharmacist in Skipton and deputy chairman of Numark, said that consumer research carried out by Numark and also by the Consumers Association showed that people want a consultation area that allows confidential, discreet dialogue.

Recent research showed that approximately 25 per cent of pharmacies in England now have consultation areas, he said.

Mr Marshall described installing a consultation area as "the best things he had done" in 24 years at his pharmacy. In that time, the pharmacy has been completely refitted twice and partially refitted once. He noted that multiple chains tend to refit their pharmacies every seven years.

"The consultation area has resulted in a better working environment, happier staff, a more professional clinical environment and happier consumers," he explained.

"On the negative side is the cost, and the cost from lost sales space. But it is the best selling space pharmacists can convert: advice is the best selling point we

have." He pointed out that there are four pharmacies in Skipton, where his pharmacy is located. One of these is in a doctors' surgery and another is next door to a surgery. "It is a competitive marketplace," he said.

Mr Marshall commented that pharmacists complain about the cost of refits. A significant refit costs £20,000, he explained. Over four years, this equates to £5,000 per annum and, once offset against tax, this sum becomes £4,000. Broken down, this becomes £80 per week or £15 per day profit needed to fund the refit, he said.

"Consumers know they can get advice at our pharmacy. We have never been as suc-



*Peter Marshall: created a better working environment*

cessful as we have been since we put the consultation area in. Business has just gone up and up and we paid for the refit in less than a year. We have never been so profitable," he said.

"How can any pharmacist supply the morning-after pill without a private consultation area? I don't believe pharmacists who say they can be being honest about it," he commented.

"The question is why are so many pharmacists not investing in the future? Pharmacists should ask themselves if they can give advice and supply medicines in a confidential area: I know I can," Mr Marshall concluded.

## New contract to be agreed by next April

Negotiations on a new pharmacy contract began between the Department of Health, the NHS Confederation and the Pharmaceutical Services Negotiating Committee in spring this year, Sue Sharpe, chief executive of the PSNC, explained.

The target implementation date of the new contract is April 2004, although Mrs Sharpe said that earth-shattering change would not happen then and that a period of transition towards implementation of the new contract would follow.

The new contract will be made of essential services, enhanced services and additional services. "This terminology will change because the general medical services contract used these terms the other way around," Mrs Sharpe pointed out.

"A range of services will develop over time, in response to the changing needs of patients," she explained. She stressed that the new contract should not ossify service development.

Additional services will be locally contracted. She explained that these will be "services on a shelf for PCTs to commission, providing PCTs with a greater certainty about what a service is". Creating such a bespoke service was more sensible than the current situation when, for example, there are 130 to 150 different smoking cessation services around Britain.

But other local services could also be negotiated separately. "We are still building room for local services and local innovation," she said. Over time, local services could become additional services. Similarly, as additional services become well-established they might become enhanced services and likewise enhanced services might become essential services.

Essential services will include dispensing, repeat dispensing, signposting patients to other health professionals, clinical governance, a public health role and waste disposal, said Mrs Sharpe. Examples of clinical governance requirements are standard operating procedures, incident reporting and continuing professional development.

Consultation areas are fundamental in terms of where pharmacy was going under the new pharmacy contract, she said.

"For enhanced services, a consultation area will be needed; there will be both a facilities requirement and a training requirement," she explained. Enhanced services included medicines use review in which pharmacists would take opportunities to sit down and talk to patients about their medicines and a prescription intervention service which would be similar except that it would be triggered in a different way.

An example of an additional service is minor ailments management "It is absolute madness that this isn't an essential service," said Mrs Sharpe. "It is not there because the Department of Health is worried that it will increase the prescribing budget." However, she pointed out that 80 per cent of PCTs are interested in commissioning minor ailments services. She added that not including it



Sue Sharpe: no earth-shattering change

within the essential services was discriminatory since people who pay for prescriptions can purchase over-the-counter medicines immediately yet people who cannot afford to buy medicines have to wait for an appointment with a doctor in order to get a prescription for a free supply.

Other additional services included substance misuse management and also disease-specific medicines management services.

In terms of negotiating the financial side of the new contract, the first thing that had to be done was to understand how much it costs to run a community pharmacy service.

"The cost of service inquiry has been completed and the data are being processed. Then we will have an agreed base of costs," she explained. To this, the projected costs of running new services under the new contract have to be added. A model for this is currently being developed. "We are taking as the basis for this a small, efficient pharmacy," she said.

"It is essential that costs relating to volume are picked up," Mrs Sharpe said. "We have got to incentivise pharmacists to dispense medicines." Otherwise a situation would develop when some patients are given lots of advice but others do not get their medicines, she said.

## Will the pharmacist workforce be sufficient?

In 2004, many pharmacists will be asked to provide medicines management services but questions need to be asked about where these pharmacists are going to come from, Dr Karen Hassell, senior research fellow, University of Manchester, told delegates.

As Dr Hassell presented some of the findings of the Royal Pharmaceutical Society's workforce census, it became clear that this demand was just the tip of the iceberg. With prescription volumes, the over-the-counter market and consumer expectations growing, more work is being demanded of the pharmacists' traditional role. An increasing population of elderly patients in the United Kingdom, and the



Karen Hassell: shortage of pharmacists

growth in the multiples and supermarkets, which are open for longer hours, are also increasing pressure. Other sources of demand include Government aims to improve access to health care, plus a whole new range of extended role activities, repeat dispensing and prescribing.

Much of this will affect the future workforce, but there seems to be a shortage of pharmacists now. Dr Hassell spoke of one-stop dispensing being stopped in hospitals and of community pharmacies being closed because there is no pharmacist available, especially at weekends.

Other indicators of shortage include

recruitment problems (according to Dr Hassell, some pharmacists say that it is taking two or three months to recruit pharmacists) and high turnover and exit rates. Arguably, a large number of people have been happy with the growth in the Register of Pharmaceutical Chemists over the years (2 per cent in the past 10 years) and think there is no need to worry. But what the census has revealed is that 30 per cent of the register have completely withdrawn from the labour market. Of the 70 per cent who are working, there are low participation rates — 33 per cent are working fewer than 34 hours per week.

There could be other clouds on the horizon. Many male pharmacists will soon reach retirement age but "we do not know much about what their expectations are and whether they are intending to carry on working or not [about 35 per cent of pharmacists over state pension age still work]. If they do not continue we might have a big problem on our hands," Dr Hassell warned. The number of people working in commu-

nity pharmacy has dropped significantly. There has been an increase in the hospital sector and primary care has emerged as a discrete employment category.

The new continuing professional development requirements have workforce implications. Dr Hassell told delegates that, in exploratory research, people who work in more than one sector say that if they have to do CPD for two, three or four different sectors of work, then one will have to give — they will not continue working in that sector. Similarly, others working just a few hours a week, say that doing CPD might not be worth while and will simply withdraw their services.

So, bearing the workforce forecast in mind, how can a pharmacist with one small pharmacy become a supplementary prescriber, or provide extended services?

Sue Sharpe, chief executive of the Pharmaceutical Services Negotiating Committee, admitted that if the census findings are

right, it will be a challenge. The increased use of automation and accuracy verification measures within community pharmacy within the next few years will change the way in which pharmacists use their time quite considerably, Mrs Sharpe predicted. “The increasing use of other support staff and standard operating procedures and the training and development of pharmacy support staff will be the ways in which even a small pharmacy will be able to manage the various parts of the competing workload,” she said.

However, according to Dr Hassell, recruitment and retention problems also apply to technicians and dispensing staff. Moreover, there is little information about the support staff workforce. Small-scale qualitative research, conducted by Dr Hassell, shows there is a wide range of views about whether pharmacy staff want to take up extended roles. Also in question is whether pharmacists are willing to delegate

their extended role activities to support staff. Another issue is the huge number of locum community pharmacists, which has implications for continuity of care: “You cannot deliver this if your workforce is a temporary one and you do not know from one day to the next who is providing the service in any given pharmacy,” Dr Hassell said.

The question of whether pharmacists even want to provide new services has not been addressed, Dr Hassell said.

Prakash Patel, a pharmacist from Woodside Park, London, said “I think we all agree that community pharmacy is basically a commercial business, so we need to plan for the future on a budget. But we cannot say what we will do in terms of additional services and enhanced services, and refitting our premises with consultation rooms, because we cannot put our finger on it and say this is the percentage of the business that we will get from enhanced services.”

## Lessons from creating a medicines support service

In the final presentation of the conference, Andrew Hartley, proprietor of Tindales Chemist Ltd, Sheffield, shared what he had learnt from creating a medicine support service for patients with type 2 diabetes in his pharmacy. When considering whether to set up a medicines support service or not, the first step to take, Mr Hartley said, is to list your objectives, keeping them “short and simple”.

Then, you need to make sure you have the requisite ingredients, he advised. Leadership skills are essential but most pharmacists, if they run their own business, have these. Suitable premises are essential if your service involves taking blood samples. A good relationship with the local GP surgery is desirable, but not essential, because often that does not exist. Delivering a good project, however, can improve that relationship, Mr Hartley said.

Pharmacists planning to provide such a service should be prepared to accept that there will be a cost to themselves in terms of time and money. Mr Hartley said he found it useful to look at a number of sources of funding rather than a single source. Indus-

try can offer some support, but will not fund the whole project. However, bear in mind that PCTs also have all sorts of little funding pots, such as patient public involvement: “You can get a few thousand pounds for doing a patient survey at the end of your project (which is essential to your project),” he added.

A number of projects that have failed, Mr Hartley warned, did so because they were not discussed with pharmacy staff. It is too late to start communicating when the project is about to be launched, he said. Your staff need to be involved earlier because they will spot things that nobody has noticed.

Mr Hartley also recommended setting a start date. “It stops your project being a dream — like saying one day I’ll climb Ever-



*Andrew Hartley: keep your objectives short and simple*

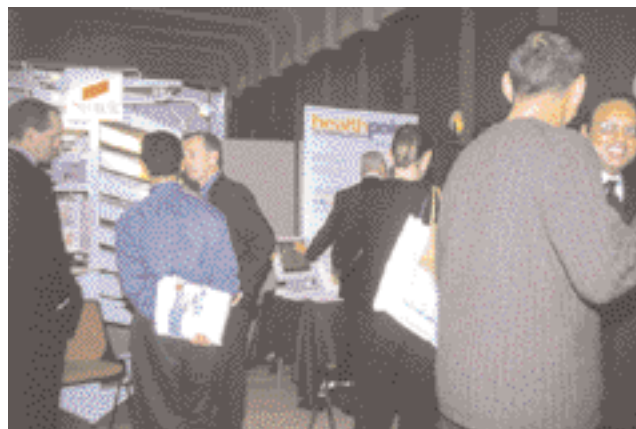
est. If you set a date, and tell people, in three months’ time, they will ask how it went. And that puts pressure on you because it is embarrassing to turn round and say that you never did it,” he explained.

If you do run a service, it is important to write it up. “The problem with pharmacy is that we know that we add enormous value and that we are an essential part of public health and NHS deliv-

ery, but we have little evidence to support this,” Mr Hartley said. Benefits from the project included the empowerment of staff and increased customer loyalty. The project also helped Mr Hartley gain confidence to write about other projects and he is now providing a PCT-funded service in another disease area.



*Conference participants browse Pharmaceutical Press titles*



*A range of exhibition stands were on display at the conference*