Fifth Floor, 2 Caspian Point, Caspian Way, Cardiff Bay, Cardiff, CF10 4DQ

# Health and Social Care Committee
## HSC(4)-09-11 paper 1
## Inquiry into the contribution of community pharmacy to health services in Wales – Evidence from BMA Cymru Wales

September 2011

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the Health and Social Care Committees inquiry into the contribution of community pharmacy to health services in Wales

The British Medical Association represents doctors from all branches of medicine all over the UK. It has a total membership of almost 150,000 including more than 3,000 members overseas and over 19,000 medical student members.

The BMA is the largest voluntary professional association of doctors in the UK, who speak for doctors at home and abroad. It is also an independent trade union. BMA Cymru Wales represents some 7,000 members in Wales from every branch of the medical profession.

TERMS OF REFERENCE

The terms of reference for the inquiry are:

To examine the effectiveness of the Community Pharmacy contract in enhancing the contribution of community pharmacy to health and wellbeing services, including:

- 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, and examples of successful schemes;
- The scale and adequacy of 'advanced' services provided by community pharmacies
- 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;
- 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;
- Progress on work currently underway to develop community pharmacy services.

BMA CYMRU WALES RESPONSE

We recognise that there have been wholesale changes in retail pharmacy over the past decade, notably we have seen a move away from individual pharmacist contractors to the larger national companies which keep their network of pharmacies open using several employed pharmacists.

This has resulted in NHS Boards receiving an increased number of applications for community pharmacies in areas that were not previously viable for small businesses, and where patients have traditionally been served by a dispensing practice.

The growth in community pharmacies has evidently led to the increased availability of routine pharmacy services which is a welcome development but, perhaps on occasion this has been at the cost of the more 'personal service' - for example, the availability of the "local" pharmacist to attend out of hours in the event of an emergency to dispense essential medicines.

Dispensing can provide a sizeable proportion of practice resources, the abrupt loss of this presents considerable business continuity problems. It is vitally important to recognise that in many – mostly rural - areas, dispensing by general practitioners exists in order to support the provision of local services to patients. In these rural areas, owing to complex contractual calculations, dispensing income has become a vital stream of funding for the provision of primary care services in general.

Any moves that destabilise such dispensing practice may lead to a drastic reduction in the provision of general medical services in these areas. This service would be impossible to replace. We would therefore be totally opposed to any changes in the current control of entry regulations even if there were a perceived benefit to the provision of pharmacy services in isolation as the net effect on local health provision would still be overwhelmingly negative and must be a central consideration.

It is of note that the pharmacy application process does not recognise partners of the dispensing practice or the views of the local community. Therefore, practice partners are not given the opportunity to explain to the NHS Board the impact that the loss of dispensing status will have on the practice or their patients and the subsequent access to services. We are also concerned at the way in which the pharmacy contract uses category M pricing to free resources for other contractual changes with consequent effects on dispensing practices that they have no chance to ameliorate via the dispensing contract. This seems grossly inequitable.

With the advent of pre-packaging and the demise of preparing onsite, the role of the pharmacist has altered dramatically – moving away from the traditional role of the "chemist" (with unintended consequences in the rocketing price of "specials") but increasing the requirement for detailed advice made more complex by an ever widening range of drugs available.

We cautiously welcome the medication reviews and new medicine checks being undertaken at present but trust they will be targeted appropriately to ensure good value for money. Likewise, we also welcome the home delivery service now provided by many pharmacists.

We support the greater emphasis on compliance aids including the weekly dosing systems used to dispense medication for the frail and elderly, making it easier for carers to supervise medication. We recognise however that there are certain separate risks in terms of drug storage, recognition and wastage - and hope it will continue to be used appropriately for reasons of patient care rather than administrative convenience. We feel that this vital service should be adequately funded through the pharmaceutical contract.

We are concerned that in order to provide "additional services" there may be a fragmentation of existing services, with various provisions being delivered piecemeal. There is a risk that some

patients might take advantage of services provided outside their registered practice as there is no cohesive way of recording activity per patient done elsewhere. For example, the 'worried well' might have monthly cholesterol testing by going around all the pharmacies in their area, and as we assume such tests might attract a fee, this would lead to unnecessary expense. They might also travel from pharmacy to pharmacy to obtain medication. Another example may be patients who obtain emergency contraception - which we recognise is a vital service, but for which there is nothing to stop patients from repeatedly using this method instead of a more reliable and clinically appropriate means of contraception.

Experience shows that offering screening won't always attract the target audience as often those at risk are least likely to take advantage. Essentially, there is a danger of "over screening" some, thus wasting NHS resources, as currently there is no mechanism for activity outside general practice to be sensibly recorded – this issue applies to the example given above regarding emergency contraception, and is an concern which should be given detailed consideration should community pharmacists begin to provide other services (such as flu vaccines, travel medicines / immunisation etc).

The practice based primary care team provides fully integrated and recorded health care, and the standard of record keeping is exemplary. If outside agencies start to work at the edges, such activity will not be recorded and may lead to duplication at best, or a failure to make appropriate diagnosis at worst. Not to mention the potential for abuse of the system. We would then be faced with a difficult medico-legal situation, where the Defence Unions might argue that in setting up an "alternate care" pathway the LHB or pharmacist might be clinically responsible for any deficiencies. We are not sure what indemnity cover currently applies to our pharmacy colleagues, but this is an issue which is crucial.

There are great difficulties in recruiting and retaining doctors in Wales generally, unfortunately our country is not an attractive career choice for those wishing to practise medicine. However, in rural (and Valley) areas this problem is even more acute. The BMA is concerned about the sustainability of services in these areas and the resulting problems with access to healthcare for patients. The BMA has previously published a report on the nature of rural general practice in the UK[1], written by the general practitioners committee (GPC) of the BMA and the Institute of Rural Health (IRH). The joint report considered issues of dispensing and its implications on practice income on the retention of doctors in these hard-to-staff areas as a key component of healthcare delivery in rural settings. In addition - the vast majority of dispensing practices reinvest a portion of their dispensing income in other aspects of the practice such as employing additional staff and/or providing a wider range of services to their patients.

Finally, many are concerned that premises contracted to provide services to the NHS promoting healthy living, are also licensed to sell both alcohol and tobacco products (many retailers also have loyalty and reward schemes for customers who purchase these items). We find these roles incompatible. The sceptics amongst us think that were this to be an either healthcare or tobacco/alcohol choice, then we suspect which way the national companies would opt.

## OPTIONS FOR THE FUTURE

Below are the key measures we would ask Government to consider to protect dispensing doctors and the provision of other services they provide:

- Legislative changes should be made to give some protection to dispensing status and to improve the pharmacy application system;

- There must be some degree of protection for dispensing status to allow for business continuity and to ease the transition where a practice does lose its right to dispense;

[1] http://www.bma.org.uk/images/rural_tcm41-20982.pdf

- It is essential that patients and dispensing doctors are allowed to participate in the pharmacy application process. Consistent with the NHS Reform Act patients must be consulted if there are proposed changes to their service delivery.

KEY MESSAGE

It is important for community pharmacies and GP Practices to work together; and in the majority of areas that is happening very effectively. However, in other – mainly rural areas - where community pharmacies are set up in localities which already have established dispensing doctors, the long-term future of the services provided by the GP Practice is, if not threatened – then severely compromised.

As with all things, pharmacy provision should be considered holistically – alongside its role and relationship to all other components in the patient pathway - including access to medical advice, assessment and to medicine.

**BMA PUBLICATIONS**

The following publications may be of interest to the Committees inquiry, please contact us if you would like a copy (some are these guides are only available for our members, and as such are not in the public domain, therefore we are unable to provide a hyperlink):

- **The community pharmacy - a guide for general practitioners and practice staff**
  This guide aims to support GPs and community pharmacists in developing more effective working relationships and in turn, improve primary care services for patients. This is a follow-up to the earlier workbook from the BMA and National Pharmacy Association called Improving communication between community pharmacy and general practice.

  14 April 2010

- **Improving communication between community pharmacy and general practice**
  The General Practitioners Committe of the BMA and the National Pharmacy Association have produced this workbook to help facilitate local dialogue between the two professional groups, helping to improve patient care.

  11 April 2008

- **Changes to the NHS Community Pharmacy Contractual Framework (CPCF) in England**
  Details of the New Medicine Service (NMS) feedback form.

  18 August 2011

- **The GP practice - a guide for community pharmacists and pharmacy staff**
  Guide to support GPs and community pharmacists in developing more effective working relationships and in turn, improve primary care services for patients.

  13 April 2010

- **Information for the public**
  This section of the 'Over the counter medication' report discusses the importance of information specifically for members of the public.

06 November 2007

- **Healthcare in a rural setting**

  In this report the key areas of medical education and training, recruitment and retention, and accessibility and sustainability of healthcare are examined in the rural context, with a focus on primary care. UK and international examples of good practice are included and recommendations for action made. The report is aimed at all healthcare professionals and organisations that can respond and improve healthcare in rural areas.

  January 2005
  CASE STUDIES

**Case Study 1:**

A dispensing GP Practice in Powys recently contacted us to highlight some serious issues of concern in the provision of pharmacy services to patients. This practice covers an area of 750 square miles; it has one main surgery and two smaller branches serving a total of 10,500 patients (a fourth branch practice was recently forced to close due to reductions in Minimum Practice Income Guarantee).

Only the patients living close to the main surgery have access to a pharmacists' expertise, other areas do not have a dense enough population base to be able to financially support a new pharmacy. Many patients therefore have a real need for access to a pharmacy / over-the-counter sales. The GP practice participates in the Dispensary Services Quality Scheme (DSQS) and employs a highly skilled pharmacy technician who is responsible for both managing dispensary services and medicines management – and who also undertakes home visits if necessary. The Practice is dependent on the income from dispensing to support the two branch surgeries:

"if we had our dispensing right removed we would have to assess the case to become a pharmacy on a least one site which would still leave our patients at the other end of the patch without a branch surgery or a pharmacist as it would be pointless running a surgery without any ability to provide medication nor would either end support a pharmacy. These patients would be 24-40 miles from a doctor or pharmacy… we have a good relationship with our local pharmacist but he has not taken up our offer to link more as we would really like medication reviews on our high-risk groups.

"It may be that for areas such as ours and our neighbouring practice an opening of the options that came with the New Pharmacy Contract would be the answer. If we could employ a pharmacist without altering our dispensing status and fund that position by gaining income from over-the-counter sales but also by performing services outlined in the New Pharmacy Contact, a pharmacist could be peripatetic on our patch available to patients on different sites on different days and working with our current technician in improving prescribing both in terms of cost and quality as well I am sure as giving valuable support to the dispensing team).

"We constantly hear rumours of dispensing being removed without any thought to how the pharmaceutical services are to replace them. It also does not seem the best way forward when there are GP sites which make ideal places to access pharmacists in areas which cannot support community pharmacies. Patients also like receiving medication from us and those living in (main practice area) who go to the pharmacist complain that it is inconvenient and on some days it closes for half of the day."

**Case Study 2**

A GP from a semi-rural dispensing practice in Denbigh contacted us recently to outline the impact of community pharmacies on their Practice:

"The introduction of the pharmacy contract has not helped us in any discernable way; there has been no reduction in our workload, we regularly receive multi-page medication reviews from the pharmacists, all advising patients to see their GP. This seems to be a duplication of work as we regularly review patients' medication.

"Recently there has been a switch from long term local pharmacists to large companies who move pharmacists around from location to location thus diminishing the possibility of any continuity of care. We are unaware of any positive benefits from the new pharmacy contract and would dispute whether any further channelling of monies in this direction is really money well spent.

"As a dispensing practice we pride ourselves in the quality of service that we provide to our patients and I know that most of our non-dispensing patients would prefer to have their medicines dispensed and, in many cases, delivered by the surgery. Both we and our pharmacy colleagues have seen a dramatic reduction in income together with supply difficulties due to manufacturers exporting medications to the continent.

"With the reduction in income, which has occurred as a result of the changes in drug tariff pricing, many smaller chemists seems to have been taken over by the larger chains. This has resulted in quite aggressive marketing to try and acquire business, particularly of the patients in nursing homes. We now have the ridiculous situation where pharmacies from more than 20 miles away are dispensing to patients in nursing homes. As a consequence, the local GP's are unable to build any sort of relationship with these organisations whereas previously it was a simple matter to liaise with a local pharmacist.

"We would urge the Welsh Government to look carefully before diverting any more funds into community pharmacies, especially in the days of financial restraint, to ensure that they are already getting value for the monies already invested in the community pharmacies. Of course, we would prefer to dispense to all my patients but am keen to ensure that those who are non-dispensing receive a service at least equal to that we are able to provide to our dispensing patients".