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3 The evolving community centre



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6 Doing so much more in pharmacies

A neglected resource

The National Health Service is stretched. No matter what your politics and what remedy you wish to apply to the service, there can be no doubt that extra demands are being made on it at every level, and the big parties are worried. So it might be a surprise to learn that a major resource, one that could take the pressure off both GP surgeries and hospitals, is chronically underused.

Community pharmacies could work more in partnership with GPs and hospitals to help ease the strain. This has been the case for a long time. Campaign after campaign has highlighted the qualifications a pharmacist needs to acquire to take up the job. Pharmacies have for some years had campaigns offering people 'flu jabs for the winter; some also offer advice on stopping smoking, needle exchange and other services relevant to the

area they are in. And yet it is this localisation that has often been the pharmacy's undoing as a resource.

Like GP practices, community pharmacies have a contract with the NHS. However, the types of services a pharmacy can offer vary significantly. Often this is because the commissioning of services is different in one area from that in another. In addition, there are inevitable differences in demographics; a pharmacy serving, say, the north-east, where there is a history of lung difficulty among former mine workers, will necessarily offer different services from one by the seaside.

Yet some consistency is essential if community pharmacies are to play their part in an increasingly strained NHS. As our lead article (see page four), there are too many differences in life expectancy because of a health-based postcode

lottery. The practitioners and their leaders are trying to get behind change but there is a long process to go through yet.

It's an essential process, though, and it has to start happening. There is no need for people to visit their local doctor's surgery or return to hospital for every repeat prescription or minor ailment when a pharmacy can check blood pressure, monitor sugar levels and perform other specialist but routine tasks. And yet people head back to the places they are used to.

It is not sustainable. It's not working and it's not a good use of time for either the patient, who often has to wait for an appointment at inconvenient hours, or the doctor, faced with yet another routine test-and-repeat-prescription.

This supplement should help to fill in the background. ●

This supplement, and other policy reports, can be downloaded from the *NS* website at:
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The evolving community centre

There are moves towards securing the consistency that will make our pharmacies a resource of choice. *Guy Clapperton* talks to the Royal Pharmaceutical Society and a director of public health

The difficulty with the common perception of community pharmacies, says Ash Soni, president of the Royal Pharmaceutical Society, dates back to 1947 and the establishment of the National Health Service. The doctor was the person you went to see when you wanted an illness dealt with and the pharmacist simply fulfilled the order for whatever medicine was prescribed.

Fast-forward almost 70 years and the reality has moved but the perception remains largely static. “Things have changed to a certain extent but probably not as much as they should,” Soni says. “I think to a great extent that’s because from a patient’s perspective there is no consistency throughout the country, so people default to knowing what they can get from their GP or A&E.”

Historically a GP’s contract would have been built on the shape of the local population and the pharmacist would simply have had a “supplier” remit, so any services have evolved somewhat unevenly.

Paul Edmondson-Jones is the director of public health for Redcar and Cleveland in the north-east of England and sits on a number of national bodies. His responsibilities in terms of community pharmacies are around health improvement – in obesity, physical activity, smoking, substance misuse and alcohol – and a lot of time is spent supporting clinical commissioning groups and the various health services they commission.

He agrees that pharmacies can be doing more, and that they want to. “I’ve just been to a meeting around urgent care and how people use their GP, and particularly



Time to standardise services?

younger people – young parents and so on – will use their GP and A&E services as their first port of call,” he says. His experience chimes with Soni’s comments. “We struggle to get across what services you can get from a community pharmacy. “Part of the difficulty is that it varies from pharmacy to pharmacy – you go to some and you can access not just the general dispensing services but also lifestyle services like smoking cessation, alcohol intervention and possibly minor ailments services – whereas some are simply dispensing services.”

The trick will be for service providers and their representatives to move the public to a view of what’s going to be on offer while that offer is inconsistent. Making it less so is a tall challenge, Edmondson-Jones says. “There are over 11,500 community pharmacies on our high streets. It’s a large number to standardise.”

Moves are afoot, however. The Healthy Living Pharmacy project is poised to make

pharmacies more proactive and offer some of the services discussed. “We have about 1,000 of those across the country now, and each has a member of staff who’s being trained as a ‘lifestyle champion’, able and equipped to talk through lifestyle, health and the sorts of things that might be able to help, and we’re hoping to double that by the end of next year.” More people will come on board; the hope and belief is that as that becomes the norm, those who don’t offer the services will find their customers will ask: “Why not?”

There needs to be some form of localisation, however. Go to an area where the population is substantially BME and under 50 and the health needs will be very different from those of a predominantly elderly group of other ethnicities. Yet there is enough commonality to ensure some sort of baseline. “We’re talking coughs and colds and minor ailments,” Soni says. “You can be black, white or anything, and a headache is a headache. Dealing with the general hay fever, thrush, head lice and all of those common things that you can go to the pharmacy for is what we’re aiming for.” Things have started to change; this year for the first time the standard pharmacy contract includes ‘flu vaccination as a national service.

There will still be issues with some people either not absorbing what a pharmacy can do or avoiding the place deliberately. There will also be those who go to A&E with a broken fingernail. Soni accepts that this will happen, yet wants to see change. “Unless you start to change some of the people’s behaviours, you’ll never change all of them. You’ve got to start with what you can achieve today.” ●



Can community pharmacies reach places that others can't?

By Adam Todd and Clare Bambra

Your life expectancy might depend on your postcode – and premises on your high street might be able to help you live longer

Average life expectancy in England stands at 80 years for men and 83 years for women. This contrasts strongly to the early postwar period when the average life expectancy across England was 65 and 70, respectively. However, this hides large inequalities – between the north and south of the country, and between the poorest and richest areas of our towns and cities. For example, it is estimated that a baby born in Blackpool will live to 75 years on average, whilst a baby born in some of the wealthier parts of London will live an average of 83 years – a gap of eight years. However, even within local areas, the differences can be huge. Take the city of Manchester, where child poverty rates are as high as 34 per cent in one part of the city compared with 14 per cent in another area, only a couple of miles down the road.

Beneath these figures lie great differences in the critical chronic diseases: diabetes, obesity, cardiovascular disease and cancer. These health divides represent a significant challenge. They are a result of multiple and complex processes – the so-called social and behavioural determinants of health.

The social determinants include the conditions in which we each work, live and play. They range from our education, occupation and income to our job quality, schooling, access to services, social networks and even our local environment. Behavioural determinants include both good and bad: diet, exercise, smoking and alcohol consumption. However it's the social determinants that account for the majority of the health gap between deprived and affluent areas, behavioural factors account for roughly a fifth.

One of the factors we know influences a person's health is access to health-care services. For most people in the UK this will mean the NHS. Since the Health and Social Care Act 2012, the health inequalities challenge has largely been devolved to local authorities (via their public health divisions) and GPs (through Clinical Commissioning Groups) who now have explicit responsibility to tackle local health inequalities together under local Health and Well-being Boards. In addition, NHS England is tasked with reducing inequalities around access to and the outcomes of health-care services. However, what can these local bodies do

to reduce these inequalities – particularly in a time of austerity, local authority cuts and pressures on the NHS budget?

One area where there could be local action is around improving access to health-care and public health services for people living in our most deprived areas. However, there exists something of an “inverse care law”, whereby access to such services is better in places with the least need. There is also increasing pressure on GPs and accident and emergency services, with the average waiting time for a non-urgent GP appointment now at two weeks. This is where community pharmacies can help. After all, current changes demanded by the government aside, where would you go if you had worrying symptoms over the weekend?

Over the last few years, the role of the community pharmacist has expanded from supplying medication to delivering patient-focused health-care and public health services. Many community pharmacists now offer clinics for smoking and weight management as well as minor ailment schemes – all of which take place in

A “positive pharmacy care law” will ensure access to pharmacies is best in those areas that need it most

GP-style consultation rooms within the pharmacy. A patient can see a community pharmacist almost immediately without an appointment; they are often open during evenings and weekends, making them truly available to the public.

Our recent research at Durham University has shown that community pharmacies could play an even bigger part in how public health and health-care services are delivered. We mapped all community pharmacies in England and found that 89 per cent of the population could walk to a community pharmacy within 20 minutes of their home. This increased to almost 100 per cent of people in the most deprived areas – a “positive pharmacy care law”, whereby access to pharmacies is indeed best in those areas that need it most. Access to pharmacies was higher across all levels of deprivation than access to GPs, which suggests that community pharmacies are a path to health care for the most deprived in our society.

Given this wide accessibility, and considering the pressures on other NHS services, we believe more should be done to direct patients to community pharmacies to obtain support. This is particularly evident for A&E departments, where many people present with minor ailments such as coughs, colds and fever. Most of these could be managed successfully by a community pharmacist – reducing pressure on other NHS services.

As more people die from diseases associated with smoking, obesity and alcohol misuse in the poorest areas, community pharmacies also have the potential to reduce local health inequalities – at least in terms of these critical determinants of behaviour.

In terms of current planning, this is very significant: delivering more services in community pharmacy settings could not only take pressures off other branches of the NHS, such as GP services and A&E departments, but could also improve public health, help tackle inequalities and ultimately lead to better health outcomes. Community pharmacy interventions are usually also cheaper – an increasingly important factor for local commissioners in the face of budget cuts.

What do we need to do next? Not everyone knows about the public health and health-care services that community pharmacies can provide. More, therefore, should be done to promote these services to the general public. In the longer term, and as a priority, those involved in public health and health-care policymaking must seek to maximise how community pharmacies work with other NHS services and consider developing more national community pharmacy services.

It is crucial to exploit the unique potential of community pharmacies in delivering health-care services to patients that need it the most, in the areas that need it most – something that, as a nation, we have failed to achieve so far. ●

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Testing times: Louise Lydon is one of thousands of fully qualified pharmacists across Britain

Beyond the basics

Pharmacies are more than retailers – at their best they're healthy living centres. *Guy Clapperton* speaks to a practitioner and a patient

It takes a lot of work to become a pharmacist. You are likely to need managerial skills but the qualifications are stringent. After science A-levels, your journey continues to university, where you take a four-year degree to become a Master of Pharmacy, followed by a year's on-site training at a pharmacy, usually either in the community or a hospital.

It's a non-trivial commitment and you end up able to do more than sell tablets. There is oversight of dispensers for accuracy, clinical checks of prescriptions against any other medication a patient might be taking, even offering GPs advice on prescribing. Pharmacists can prescribe after an extended qualification, adding Independent Prescriber (IP) to their MPharm title.

Louise Lydon owns the Lydon Pharmacy Ltd, a family-run group of four pharmacies in the north-east, as well as being secretary to her local pharmacy committee (LPC), which feeds back on a national level. She explained that the pharmacist's extended qualifications as an IP are often underutilised because there is no budget available from the NHS in the community pharmacy setting, so they end up still unable to prescribe to exempt patients. "So a lot of pharmacist prescribers will be working in a GP practice or an NHS trust like a hospital," she said.

Inevitably, there are discussions to get more IPs into community pharmacies. Until that happens, the industry is pushing the Think Pharmacy or Pharmacy First campaign for minor ailments, with the NHS behind the scheme, which saves time for doctors. "There are different names for it across the country, but it enables the patient to come into the pharmacy for minor ailments," Lydon said. "We

have negotiated a local service with the Clinical Commissioning Group so we can prescribe the medication free of charge – just for minor ailments."

There are many other areas in which pharmacies can help take the pressure off local health services. Chronic conditions diagnosed by a GP are ripe for monitoring outside a surgery, especially as no appointment is necessary. High-blood pressure, diabetes and other illnesses can all be looked after by pharmacists while offering a complete service to the patient. There are discussions about this at national level and it already happens a great deal with practice-based pharmacists.

Before this becomes mainstream, there needs to be a change to the funding structure. "At the moment we're paid primarily based on the medicines we dispense," she explained. Other services are negotiated nationally – for example, reviews of medicine use and the new medicine service – but many are commissioned locally.

"The national Pharmaceutical Services Negotiating Committee is trying to get away from the patchy, postcode prescribing approach, and then get the message out about going to your pharmacy for 'flu jabs or minor ailments.'" So, in principle, if someone is on holiday in the UK they will be able to expect the same basic levels of service wherever they are. The LPC is certainly pushing to even things out on a regional as well as immediately local level.

Increased recognition of the importance of pharmacists in the NHS over the past few years has coincided with cuts, Lydon says, and so the NHS needs all the help it can get. Things will change – and must change soon, with everybody understanding that their community pharmacy is considerably more than a retailer. ●

CASE STUDY

No car, no travel, staying local



Sam Littlejohn, a sales assistant in her late thirties, has blood clotting issues and is on warfarin – but she is also a 35-minute bus journey from her local hospital, as she doesn't drive. "I've been on warfarin for deep-vein thrombosis for 12 years, and was referred to the pharmacy by the hospital once they'd stabilised me. It was a lot closer to home," she says.

Once a month she attends the pharmacy, to which she can walk, to have a pinprick blood test. There is no wait, the result is instantaneous and staff can adjust dosages of medication immediately. Help with other health issues and flexibility with time is also on offer; it's a system that just works, without any problems.

Louise Lydon says anti-coagulation clinics were formerly a hospital-only service but the pharmacy is pleased to offer it now. "We offer home visits as well; it's a massive inconvenience for some patients having to go to the hospital every month for a blood check." As a pharmacist with many patients in rural areas, Lydon believes her business is saving patients time but also the NHS money, as some patients might otherwise need an ambulance to go back and forth. ●

The unique accessibility of **COMMUNITY PHARMACIES IN ENGLAND**



11,500+

Community pharmacies
in England. These
are more accessible
than GPs, particularly in
deprived areas¹



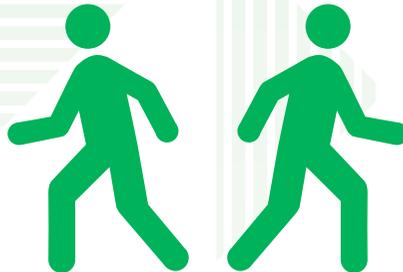
14

Number of times, on
average, each person uses
a pharmacy per year



1.8m

Number of visits per day to
community pharmacies for
health-related reasons



89%

Proportion of the
population living within
a 20-minute walking
distance of a community
pharmacy (100% in most
deprived areas)²

¹ Todd A, et al (2015). *Access All Areas? An Area-Level Analysis of Accessibility to General Practice and Community Pharmacy Services in England by Urbanity and Social Deprivation*. *BMJ Open* 5(5): e007328. ² Todd A, et al (2014). *The Positive Pharmacy Care Law: an Area-Level Analysis of the Relationship Between Community Pharmacy Distribution, Urbanity and Social Deprivation in England*. *BMJ Open* 4(8): e005764.