REVIEW OF DISPENSING VOLUMES IN COMMUNITY PHARMACIES

Report

for Welsh Government

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1. INTRODUCTION

The Welsh Institute for Health and Social Care (WIHSC), University of South Wales, was commissioned by the Welsh Government to undertake a review of dispensing volumes in community pharmacies across Wales.

TERMS OF REVIEW

The following is taken from the Welsh Government setting out the Terms of the Review:

The overall purpose of the study is to consider/answer:

- Whether it is feasible to reduce prescription volume in primary care in Wales through practical changes to prescribing and dispensing arrangements; and
- Whether such changes would release significant amounts of pharmacist time to provide direct care.

In the light of these two objectives, there is a need to consider five key questions:

1. What measures are already in place across Wales, or outside Wales, which result in a reduction in the volume of primary care prescriptions, and in particular:
   - Consideration of prescribing intervals;
   - Alternative supply models for non-medicine items such as appliances and dressings; and
   - Reducing prescribing of low clinical value items.
2. To what extent do we anticipate such measures would reduce prescription volumes in Wales?
3. What do relevant stakeholders see as the benefits of implementing the changes with the highest impact? What dis-benefits may be identified by stakeholders?
4. Is the time released by such changes likely to be material in increasing community pharmacists' time to provide clinical care?
5. What, if any, are the barriers to making the change? What are the enablers to making the change?

APPROACH

Based on the two purposes and five key areas above, the review had three elements:

1. Review of the literature

Welsh Government provided the details a literature review performed by the Government Library Service to inform the literature review for the Project. The search topic was 'prescribing intervals'. The references provided were accessed and followed up for citations and further references. A further three papers reporting research trials and evaluations were found and followed up in the same way. A number of case reports and discussion papers were identified

but since these were not research or evaluations with data to inform the Project they were not formally included.

The same processes were followed (following citations and checking referenced papers) using Google Scholar together with The Cochrane and TRIP Databases to search for relevant papers using the terms:

- Robotics
- Batch prescriptions
- Batch prescribing
- Batch dispensing
- Community pharmacy service
- Community pharmacist role
- Independent prescribing 'and' community pharmacy

The AWMSG, AWTTC, WEMEREC and StatsWales websites were searched for information and materials. In addition, references and resources for study were recommended by a number of interviewees. These included PRESQIPP, Openprescribing.net and http://www.communitypharmacyfuture.org.uk/. These were followed up and it is important to note that no research trials or relevant materials were identified. Topics mentioned in the papers accessed included:

- the need for research in each field;
- the training and education needs that will follow on from change and development; and
- the need for different business models and contractual arrangements.

It was striking to find that there were few case reports or examples of good practice that might be followed. This was confirmed by the interviewees.

A number of current services provided in community pharmacies such as health promotion and smoking cessation, lifestyle change support and a minor ailments service were not identified as examples in the literature search. The clinical fields relevant to the project that were identified in the literature were:

- INR and anticoagulation monitoring and management
- Sexual health services
- COPD clinical services
- Extended medicines use reviews to support older people or people living with long term conditions.

Wherever relevant, excerpts from the literature are integrated within the findings below.

2. Analysis of published data

Primary Care data from the NHS Wales Shared Services Partnership was analysed by Health Board and Cluster to look for variations, correlations and trends in dispensing volumes and practice. Other materials were accessed and reviewed which included searching for comparator data in

England. Data was also supplied by a number of the key stakeholders who were interviewed as part of the project.

3. Interviews with key stakeholders

Individual interviews with 18 stakeholders, and two group interviews (with 10 participants) were undertaken. A breakdown of these interviewees is provided below:

Respondent category[1]	No. of interviews	No. of group respondents	**Total no. of respondents**
Community pharmacists	5	-	**5**
Community pharmacy representative bodies	-	10	**10**
GPs	2	-	**2**
NHS	6	-	**6**
Other stakeholders	5	-	**3**
TOTAL	**18**	**10**	**28**

The schedule of questions that was used in the interviews and discussions detailed above drew on the five key questions identified under the terms of review. The interviews typically lasted between 30 minutes and an hour. We were also provided with supplementary written information by some interviewees, which has also been reviewed and integrated with the findings below.

REPORT STRUCTURE

This project engaged with a range of participants who in different ways have a stake in the ongoing debates around community pharmacy. The review team[2] feel that this sample of people represents a robust cross-section of opinion on the work of the organisation.

In Chapter 2 – Findings, for each item of the Terms of Review we gathered and arranged evidence under three headings. *"What people told us"* identifies in respondents' words the main issues they felt needed consideration. As responses came from a range of stakeholders with different interests, we analysed these and provide for the reader the range and weight of opinion under the heading *"Spectrum of Opinion".* Finally, under *"Conclusions"* we have summarised where, on balance of the views expressed, we believe the key organisations should focus their

[1] It is important to say that people were interviewed on the basis of anonymity as this provided them with an opportunity to share their views in confidence. The categories in the table are broad descriptors – it should be noted that the 'Other' category included academics and other professional perspectives from organisations both inside and outside of Wales, and other commensurate services within Wales.

[2] More on the background and experience of the team can be found at: https://wihsc.southwales.ac.uk/team-members/

attention. The conclusions are the considered opinions of the authors, based on what we think is a balanced sample of the opinions and data we gathered.

In Chapter 3 – Areas for Further Consideration, we have reflected on a range of issues that came from the discussions, but were technically 'out of scope' given the terms of the review. These focused on the things in the broader 'landscape' of community pharmacy that will need to be considered as part of a plan for action. They are designed to help work through the key decisions required to establish clarity on a future direction.

2. FINDINGS

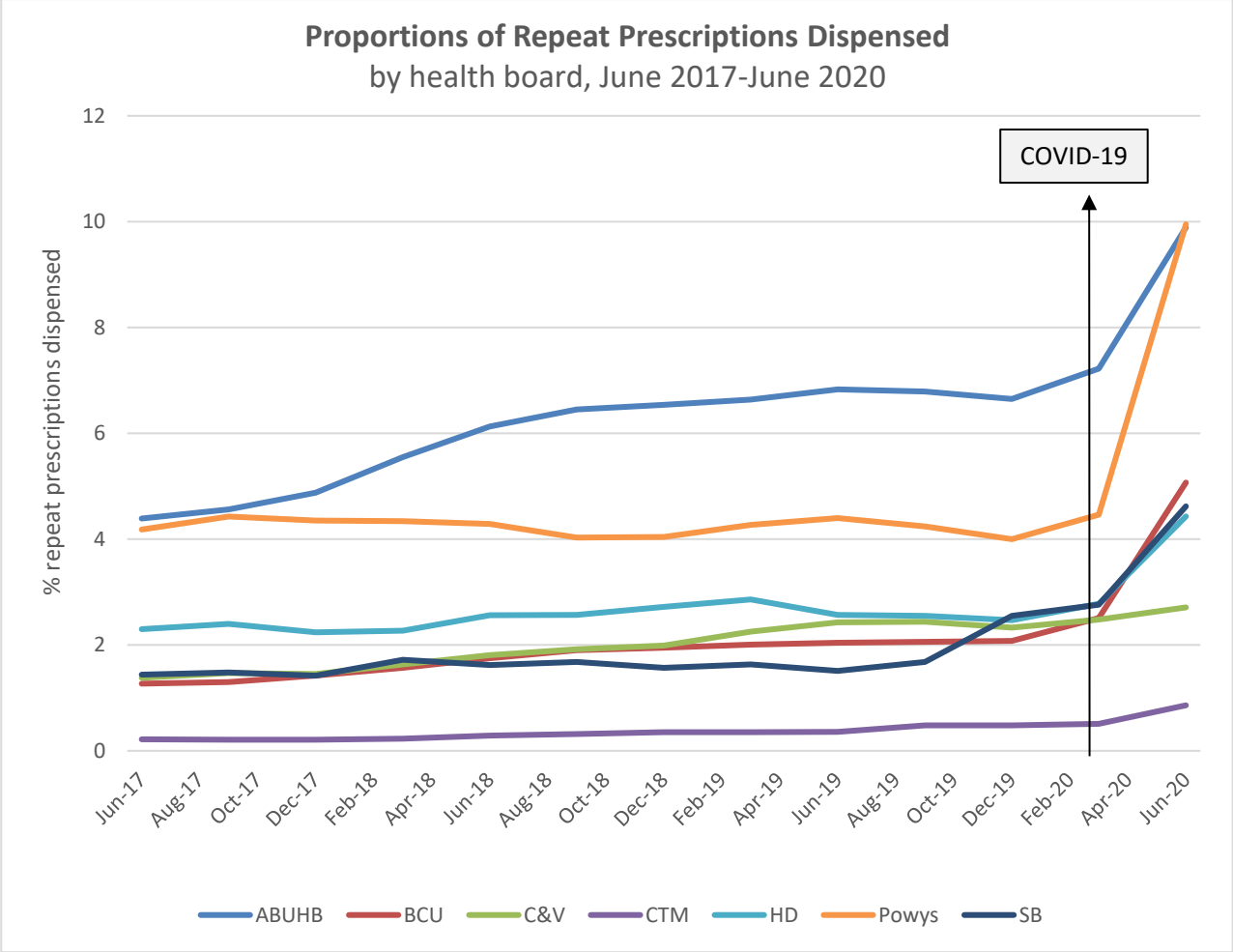
This chapter presents the findings of our work based on the data we have collected. What follows is a discussion of each of the five key questions within the Terms of Review, providing the main issues that were raised in the interviews/discussions, the spectrum of opinion offered by respondents, and a conclusion about each.

2.1 MEASURES TO REDUCE PRESCRIBING VOLUMES

What people told us/what we found

1. Prescribing intervals

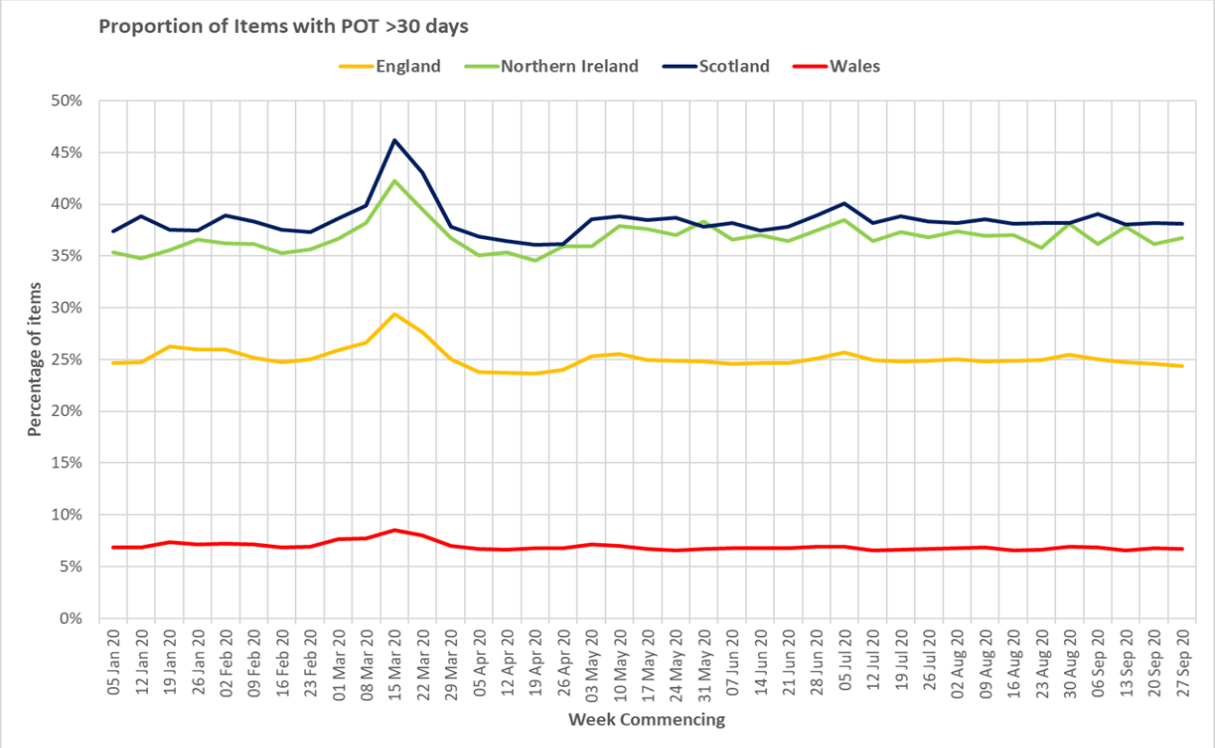
- Many GPs are already issuing 12-month authorisations for simple chronic conditions such as asthma. COVID-19 has amplified and exacerbated these behaviours. The chart below presents data from Wales on the impact of COVID-19 on repeat prescribing behaviours, and the variation between health boards is interesting to note:



Source: Date Request to Primary Care Services, NHS Wales Shared Services Partnership – 'Repeats Dispensed'

- In comparison to the rest of the UK, Wales is perceived as being behind other countries in extending prescribing intervals beyond 28 days. The Company Chemists Association shared

the graph below which provides an interesting insight into the differences in Period of Treatment (POT) intervals of >30 days across the UK (for medicines where POT is calculable):



Source: Community Chemists Association

- The original source of the 28-day interval guidance appears to be a 2010 report from York followed up by Welsh Government guidance in 2012.[3] The original focus is on saving wastage in the medicines budget, usually driven by HB pharmacists.
- The belief that script lengths of >28 days increases waste of medicines to a significant degree is now not widely held or accepted by community pharmacy. It is also felt that operating to minimise waste in the medicines budget is not cost effective or efficient given average script costs, and any financial saving is insignificant compared to the opportunity cost of the time of community pharmacists and healthcare professionals spent in chasing waste.
- There is evidence that longer dispensing periods improve patient adherence and such longer periods of time are preferred by them. However, it is important to note that this study did not engage with patients, nor with patient groups.
- There are strong calls for greater trust and responsibility to be placed with community pharmacists to make determinations about intervals when they are dispensing for patients that they know well. The current system offers no discretion to community pharmacists and many felt that as they have good and long-standing relationships with many patients, there is scope for thinking about offering some latitude on intervals and quantities of products dispensed.

[3] The Welsh Government guidance referred to can be found at: https://awmsg.nhs.wales/files/guidelines-and-pils/all-wales-review-and-guidance-for-prescribing-intervals-pdf/. The original 2010 report from the York Health Economics Consortium, School of Pharmacy (Evaluation of the Scale, Causes and Costs of Waste Medicines) is available from: http://php.york.ac.uk/inst/yhec/web/news/documents/Evaluation_of_NHS_Medicines_Waste_Nov_2010.pdf

2. Non-medicine items

Gluten free

- There was little support for providing these items through community pharmacy, particularly now there is a good range in many supermarkets.
- Some areas have already instigated changes such as points systems, centralised supply, direct to patient delivery.
- Participants reported that some areas that had moved all gluten free products to be classified as items of low clinical value and stopped NHS provision.
- The pilot projects in Hywel Dda UHB seemingly offers an interesting alternative whereby people who receive a prescription for gluten free products receive a monetary amount instead of the product. The sum of money has been assessed to cover the cost difference between the gluten free version and its equivalent which contains gluten. Uptake has been good, and this has proved a popular alternative for the vast majority of people in the pilot scheme to receiving these items on prescription via community pharmacy.

Stoma products/appliances

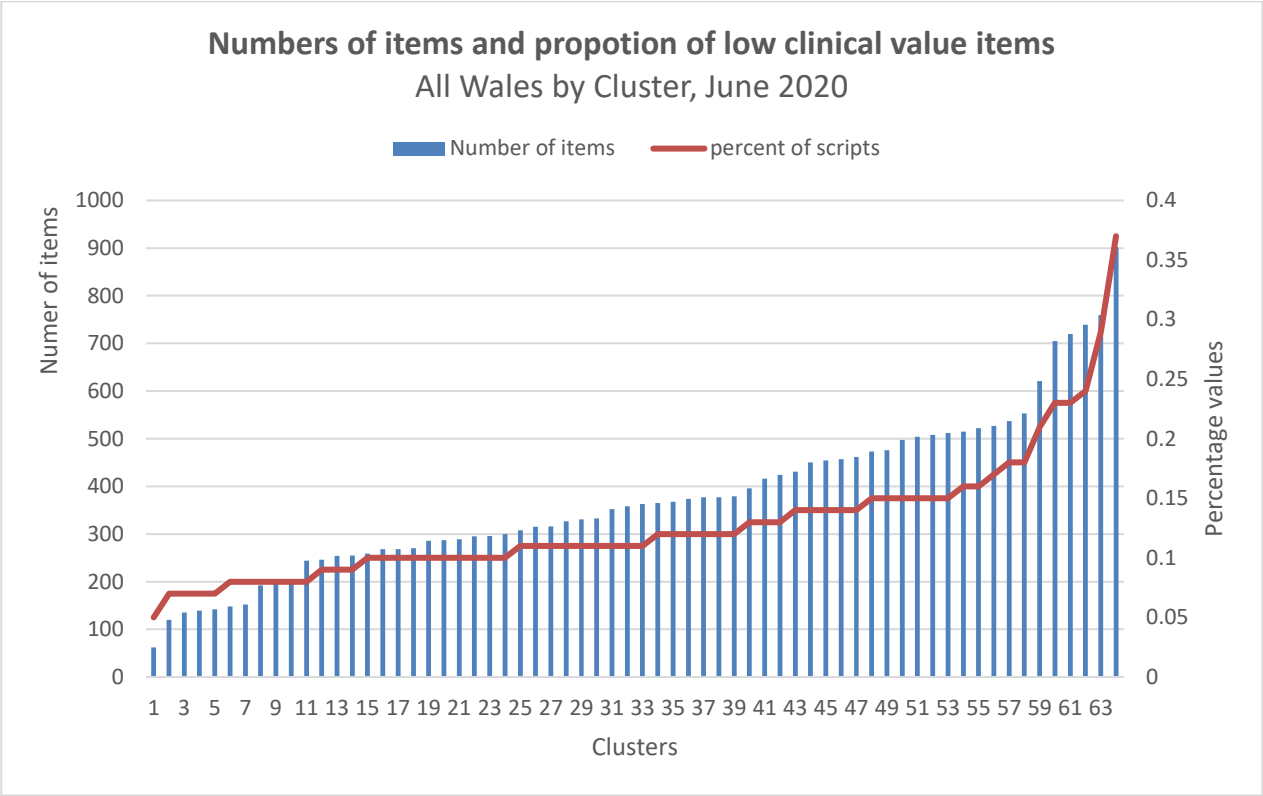
- Several respondents described that this work had largely been taken away from community pharmacy by both hospital discharge and community centralised contractor systems which provide direct delivery to patients.

Dressings

- Overall, the prescription system for dressings is seen as very inefficient leaving community pharmacy with problems of storage, waste and admin.
- Positive feedback was received about the centralised Online Non Prescription Ordering Service (ONPOS) system which was thought to work well in Wales. There was one mention of this being replaced by FORMEO, an even more efficient IT system for the management of wound care supplies.
- Some informants did have concerns about the potential impacts of any changes for community pharmacies that provided large quantities of dressings to care and nursing homes.

3. Items of low clinical value

- The All Wales Prescribing Advisory Group (AWPAG) and health boards pharmacists have been working hard to drive down the use of items of low clinical value for some time in order to save money on the GP prescribing budget.
- Analysis of the data provided to us indicates that this is no longer a significant issue for most primary care clusters in Wales – these items represent a very small percentage of the overall dispensing volume, but there is wide variation across Wales.
- General practice data shows a similar range of variations. Informed discussions can identify:
  - what is safe: thresholds above or below which there may be concerns
  - what is best practice and where actions may need to be focused.
  - whether an “all-Wales approach” or initiative is required or will be effective.



Source: Data Request to Primary Care Services, NHS Wales Shared Services Partnership – 'BNF Category Report'

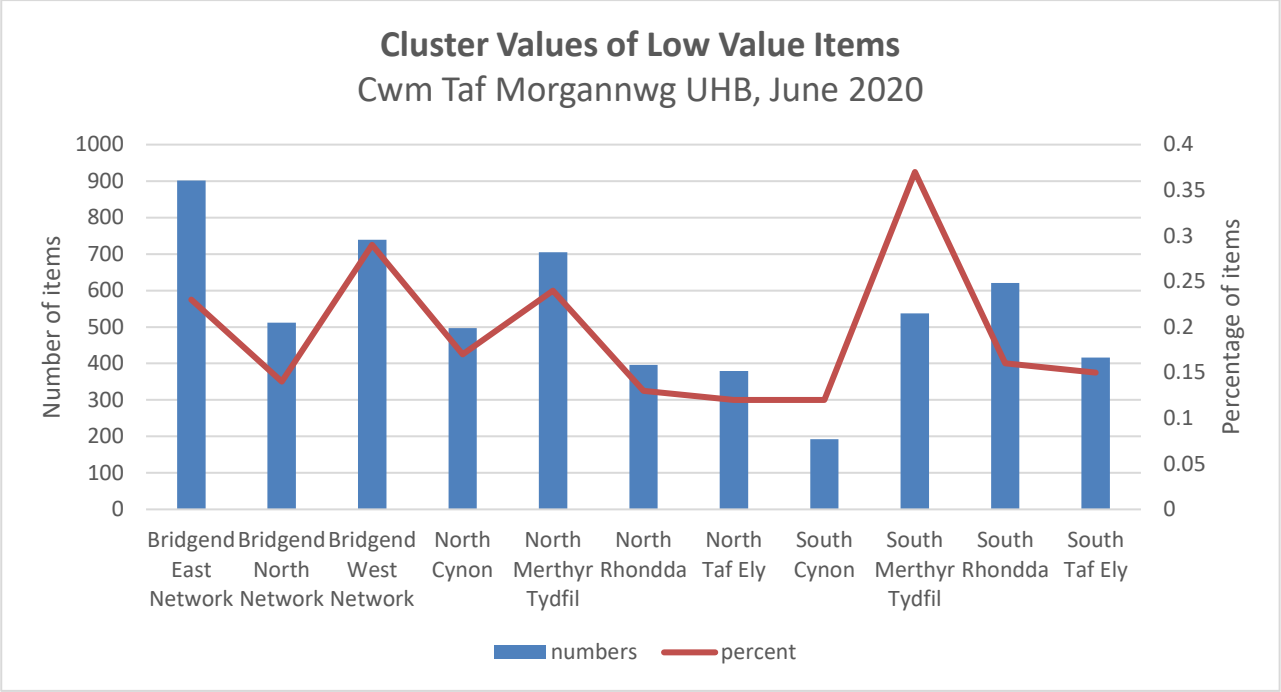
- An All-Wales approach is unlikely to be required to address the issues that underlie the variation in the continuing prescribing and dispensing of 'Low Value Items' as presented in the data table below.

Health board area	Number of clusters by category		
	Less than 0.10%	0.11-0.15%	More than 0.16%
Aneurin Bevan UHB	5	7	0
Betsi Cadwaladr UHB	11	3	1
Cardiff and Vale UHB	2	7	0
Cwm Taf Morgannwg UHB	0	7	4
Hywel Dda UHB	3	4	3
Powys THB	2	1	0
Swansea Bay UHB	4	4	0

Source: Data Request to Primary Care Services, NHS Wales Shared Services Partnership

- The variation of the data in Cwm Taf Morgannwg provides an example to inform discussion. As presented in the chart overleaf, the South Merthyr cluster has the highest value for the percentage of items prescribed categorised as 'low value' in Wales. There may be local reasons for this, such as having small general practices, single handed surgeries who often do

not participate in cluster or health board activities, or GPs who have strong views about national guidance and their relationship to it.[4]



Source: Data Request to Primary Care Services, NHS Wales Shared Services Partnership – 'BNF Category Report'

- It is clear therefore that there will be cluster-specific factors relevant to those clusters with higher proportions of items of low clinical value.
- Evidence from the English experience is that efforts to further reduce the dispensing of items of low clinical value have reached a point of diminishing returns.

Spectrum of opinion

There was a consensus that the 28-day prescribing period is driven by WG guidance from a number of years ago and that a review of this is overdue. There was a significant body of opinion that suggested that in areas where there are higher levels of prescriptions for low clinical value it is likely to be due to cultural factors such as patient expectations and GP behaviour in 'managing' patient demands and their own time. Most agreed that a review of non-medicine items was also overdue and that efficiencies could be made, building on the lessons learned in parts of Wales where new practice has been tried. There was less consensus on what alternative supply channels were best with a minority favouring supply staying with pharmacy, but with improved administrative systems in place. Patient preferences for sourcing their gluten-free products, appliances and dressings were mentioned, and the evidence from the Hywel Dda pilot appears to suggest that on the whole patients want to have greater control over some of these aspects of their care.

Conclusions

The policy of 28-day prescribing to save wastage in the medicines budget is widely adhered to, but there are legitimate questions to answer over the extent to which the prescribing period

[4] This was demonstrated by detailed reviews of prescribing by general practitioners in Cwm Taf in 2015-2017.

could be extended and therefore should be reviewed. In addition, the work on reducing dispensing items of low clinical value seems to have reached a point of diminishing returns – indeed it may even be distracting from other work and so should also be reviewed. There is a mixture of approaches to the supply of non-medicine items and it seems that some efficiencies could be made by sharing best practice and standardisation. This may well involve alternative supply routes to community pharmacy. Most respondents now feel that further pursuit of reductions in items of low clinical values will yield very little return on investment, perhaps with the exception of a focus on a small number of outlying clusters.

It is important to reflect that changes to practice to save time will (or may) have an impact on dispensing fees. It is difficult to ascertain the 'reality' (whether known or estimated) of the potential links between time and income within community pharmacies.

2.2 IMPACT OF MEASURES TO REDUCE PRESCRIBING VOLUMES

There is some overlap in the responses we received to this question with section 2.4 below on the 'materiality' of changes. As such these sections should be read in parallel.

What people told us/what we found

1. Prescribing intervals

- Extending prescribing intervals is universally seen as a real opportunity to save the workload of community pharmacists on repeat scripts and is overdue for detailed investigation.
- Of the three areas of focus (prescribing intervals, non-medicine items, and items of low clinical value), this is the only area where any 'material' gains in community pharmacist time could be made.
- However, a release of time is dependent on several factors and it has proved difficult to provide accurate estimates of the amount of time saved, as:
    - Pharmacy ways of working and GP prescribing behaviour vary so much across Wales;
    - Prescribing intervals should be individualised to the patient and their medicine based on the nature of the community pharmacist/patient relationship, patient preference and attitudes to risk;
    - It is inter-dependent on other factors such as use of technicians, independent prescribing status, and the whole set-up of the community pharmacy;
    - Technological and e-prescribing advances could have a significant impact, but to date their implementation is very limited; and
    - There has been no assessment of how many actual prescriptions would be saved, and the extent to which this 'notional time saving translates into 'actual' time that can be released to do other things. For example, doubling the prescribing intervals won't halve the dispensing activity in a linear fashion.
- In part this is a function of the difference between the 'notional' time that is saved in theory should prescribing intervals be extended, and the 'actual' time that might be banked across the working day in a community pharmacy.

2. Non-medicine items

Gluten free

- Most respondents complained about the amount of work involved in sourcing, ordering and storing these products, and could find little or no rationale for continuing to provide such items for the vast majority of people who need them.
- Reducing the amount of gluten free dispensing is seen as an opportunity to save time in some areas. As above, it is difficult to estimate time savings as models of provision seem to vary currently. The Hywel Dda pilot offers an alternative set of arrangements that are welcomed by the majority of patients who participated in the pilot programme, and could provide a template for others parts of Wales should WG decide to take this forward.

Stoma products/appliances

- There wasn't a lot of evidence presented on these sorts of products. When it was mentioned in discussion, most people saw this as a minor item which has little impact on workload.

Dressings

- Although loss of income was mentioned in respect of dressings, the majority of participants were of the opinion that taking this work away from community pharmacy would be a beneficial change for most community pharmacies. It is important to note that this is a significant income stream for the small number of community pharmacies that support large care homes.

3. Items of low clinical value

- These items are not a significant part of community pharmacy as demonstrated by the graph above. The work associated these items are likely to be substituted with OTC conversations with patients.

Spectrum of opinion

In respect of the amount of time that would be saved by extending prescribing intervals, we had estimates of savings in pharmacist dispensing time ranging from 5% and 75% but these are subjective and observational assessments. No-one has yet done an analysis of the actual impact on the time of community pharmacists, and without this, it is difficult to be definitive about the quantum of time that would be saved. In addition, the practice of community pharmacy may need to be considered before actual amounts of time and resource could be released to do other things. There was seen to be some capacity and time release in alternative supply routes for non-medicine items, but on balance it was not seen as significant, and it was thought to be more a case of removing the irritations of sourcing, queries and storage than making a substantive contribution to capacity release. No one really saw items of low clinical value as saving much time and further focus might cost time.

Conclusions

The locus of estimates on the amount of time that could be released by extending prescribing intervals was between 20 and 30%. This was seen as a fair 'starting point' for estimates of capacity release, and in the absence of a formal calculation, is a good working assumption from

which to proceed. However, it is drawn from a very wide range of estimates (from 5% to 75%) and it would need to tested in practice before and decisions were made on the basis of it.

This estimate of time that might be released is contextual and situational – it is dependent on current working practices, such that if community pharmacies wish to realise some of this potential gain to use for other activities like clinical services, they will need to think about how their work is currently structured. It may be necessary to transform their day-to-day practice before such time savings could become material. A limited amount of time and irritation could be released if non-medicine items were removed; even less from items of low clinical value.

2.3 BENEFITS/DISBENEFITS OF MAKING CHANGES

What people told us/we found

1. Prescribing intervals

- The benefits associated with extending prescribing intervals included the release of (potentially significant) amounts of community pharmacist time linked to the workload around repeat scripts. This would free them up in order to undertake clinical services within pharmac, alongside the (perceived) benefit of improved patient adherence and preference.
- The two main dis-benefits mentioned were loss of income to community pharmacies and the need to manage the risk for individual patients and their medicines. In addition, the unexpected negative consequences of reduced patient and healthcare professional contact was a constant theme.
- Concerns were expressed about the potential unintended consequences of reducing the opportunities for routine contacts between patients and their pharmacy teams if prescribing intervals were increased. Many respondents noted that it was often older people with long-term conditions who would from time to time “pop in and take the opportunity to ask a question.”
- In addition, several areas for consideration prior to making changes to practice in respect of undertaking more clinical services were given. There is a need for a managed change to mitigate any risk to practice viability, and to manage the impact on the supply chain and potential patient acceptance or confusion. None of these was seen as insurmountable by those who had made such changes, and should be seen as a part of a process of change.

2. Non-medicine items

- The main benefits here were around the potential saving in administrative time dealing with ordering/sourcing/queries and the challenges of storage. Again, evidence from the Hywel Dda pilot is instructive in this context, but it was noted that the ambition of WG is key to understand here as to whether the scheme should be adopted and rolled-out nationwide, or whether a more stepped change in the current arrangements is promoted.
- No disbenefits were identified in respect of non-medicine items, apart from a loss of community pharmacy income, but this was not seen as being significant and would be outweighed by the benefits.

- There was some variation in opinion on what patients would prefer. Again issues around inclusivity from the Hywel Dda pilot suggest that there are benefits to patients in having alternative supply routes. There is however a caveat that for patients living in areas where the commercial offer (from supermarkets for example) is limited, or where they have limited access to supermarkets and alternative providers (in rural parts of Wales for example), the community pharmacy offer should remain in place.

3. Items of low clinical value

- As noted above, there was little benefit to community pharmacy workload to be achieved by pursuing this further.
- Most respondents mentioned the potential for increasing inequalities in health where patients have to pay for alternatives to a prescription item that they wish to continue to use.

Spectrum of opinion

Most respondents described some benefits to extending prescribing intervals, but similarly many highlighted the potential for disbenefits: notably the loss of community pharmacy income without an adequate replacement and clarity over patient preferences. The limited evidence we have suggests that generally patients preferred longer intervals, although it is important to note the point that was made above about the reduced 'informal' patient/community pharmacy contacts. All participants agreed that the change would have to be carefully managed.

Apart from some loss of income, most respondents agreed that the benefits outweighed the disbenefits of removing non-medicine items from community pharmacy supply. We had a range of anecdotal evidence that the reduced opportunities some patients would have to meet a healthcare professional would also be a disbenefit. The disbenefits identified to reducing/eliminating non-prescription medicines were similar to those noted previously around the potential for increasing health inequalities.

Conclusions

It would seem that there is, on balance, a benefit to all parties in extending dispensing intervals if the issue of community pharmacy income and thus practice viability can be satisfactorily addressed. Similarly, on balance, there would appear to be benefits in rationalising and in some cases removing non-medicine items from community pharmacy practice, though the time saved may not immediately be 'material' in the way that it is described in section 2.2. Any further push on items of low clinical value might save some community pharmacist time, but this is likely to be marginal and indeed might actually result in some time increase as patients seek alternatives.

2.4 MATERIALITY OF TIME SAVED

As mentioned above, there is some overlap here with Section 2.2 on the 'impact' of changes.

What people told us/we found

1. Prescribing intervals

- Of the areas suggested, this is the only one felt to be worth further detailed consideration.

- This was based on the fact that this has the prospect of delivering 'material' changes in terms of capacity released and potential for time to be saved.
- However, as noted in section 2.2, it was not possible to estimate savings with any degree of confidence.

2. Non-medicine items and Items of low clinical value

- There were some benefits, but no material gains in time perceived in these domains.

Spectrum of opinion

There was a huge range of estimates in potential time saved by extending prescribing intervals. Some spoke from experience of having introduced significant changes to their working practices including, but not limited to, independent prescriber status, employment of Accredited Checking Technician (ACTs) and the introduction of different types of technologies. Some had no experience of these changes and struggled to envision the sort of changes that others had made within the context of their own circumstances.

Linked to the above point, there was some discussion about the 'useability' of time freed up in this way. Everyone would accept that as it would comprise many, tiny intervals it would not and could not be easily 'set aside' to offer clinical services. However, those who had reorganised their practice, and the way they organise their time, were confident it would help as work could be grouped, many dispensing activities could be run by technicians and the community pharmacist could therefore fit their clinical checks around the provision of clinical services.

It is therefore right to be cautiously optimistic at this stage that time can be released within the working day for community pharmacists to do other types of work, but that time 'savings' are only achievable by making changes in working practices that may not be available to all community pharmacies. As noted above, being able to release up to 20-30% of a community pharmacist's time may be a reasonable estimate and 'starting point' assumption if all other things are equal, but more work is needed to provide a firmer basis for this estimation.

Conclusions

No-one argued that making changes to prescribing intervals, non-medicine items and items of low clinical value are sufficient alone to bring about transformational change. However, some saw this creation of 'headroom' (whether 20-30% or not) as providing community pharmacies with the ability to begin to make change happen, and then to build on success. There is a potentially virtuous cycle here, but one which could take a long while to deliver.

2.5 BARRIERS AND ENABLERS OF CHANGE

What people told us/we found

In discussions, the barriers and enablers of change in community pharmacy were identified in general terms, not just the three specific areas in the Terms of Review. A number of these issues are reflected in the 'areas for further consideration' in chapter 3 below as they sat outside these Terms.

1. Barriers

- Without a clear 'roadmap' and associated business case for change, there is a lack of willingness from community pharmacists to invest their own money in training, staff and equipment.
- There is an underlying concern that the income from clinical services would not adequately replace income from dispensing activity.
- The approach of some community pharmacists to risk is compounded by a lack of legal frameworks, changes in regulations and other precedents to support new ways of working.
- The variability in the attitude of health boards to providing opportunities for clinical services (and their value) gets in the way of change being made.
- A lack of IT infrastructure is a barrier to the transformational projects that are envisaged within community pharmacy.
- There is limited knowledge amongst the majority of what has been achieved by the minority in respect of the change to clinical services.
- There is a lack of support available to produce feasible business cases for change.

2. Enablers

- A national contract for clinical services offering the opportunity for reasonable return, would provide an incentive for change.
- Changing the pharmacy contract to enable more efficient practices to be developed, particularly in smaller businesses and smaller chains. One example of this would be around pharmacists in practices having to chase marginal savings themselves on generic medicine supply whereas larger chains have people who have this as their role.
- Changes to the contract could also provide the framework for community pharmacies to plan to move to provide more clinical services, and make the necessary changes to their staff and other routine activities, in a similar manner to the way in which GPs were incentivised and supported to introduce improvements in their services.
- More pharmacists qualified as independent prescribers looking for the opportunity to use their skills could enable change to occur.
- Increased support for practices to improve their effectiveness through more efficient working practices, which could mean support for developing new ways of working and business cases. Smaller practices might not have the time/resource to step back and do this pre-work. It could also include scheduling of work and utilising pharmacy assistants and technicians more widely and more effectively.
- Improved local collaboration through whole system working with GPs and other community services as an important component of Cluster Network Development.

Spectrum of opinion

There wasn't a clear spectrum of opinion in respect of enablers and barriers. Rather, it is easier to describe the comments received in terms of different dynamics. The first was between those that had made changes towards a more clinical services form of practice and those (in a much larger group) that had maintained traditional dispensing practices. The second was in the

significant differences in the attitudes to change between larger and smaller businesses. This was not so much about the theory, ability or willingness of people to change, but more about their business models and the importance of different income streams for different CP businesses within the contractual framework. A third dynamic was in the ability and willingness of community pharmacists to take risks, particularly when financial investment was concerned. These different dynamics could also be detected in the responses received from representative organisations and respondents from other parts of the UK. It almost goes without saying that underlying all these dynamics are questions about the sustainability of financing for community pharmacy.

Conclusions

Change is often difficult and resistance or acceptance of change is a function of a range of emotional, technical and practical factors. A constant theme from the community pharmacists that had made changes to their dispensing activity was the necessity to have a positive attitude to change and to risk. Community pharmacists are not generally seen as risk takers, but they do consider themselves adaptable, and working with these approaches and attitudes is crucial in thinking about different paradigms for their work. Amongst those that have made changes, one of the most important factors is the empowerment of technicians (e.g. through regulations), reassurance for community pharmacists through guidelines and frameworks, and a willingness to invest.

Underpinning a reluctance to change is an understandable concern about income. On the whole, community pharmacists are sceptical that alternatives to dispensing will maintain their income at its current level. A consequence of this is they remain involved in dispensing and find it difficult to make change happen. For larger businesses with the resources to exploit all aspects of the contract, changes are naturally judged not on the relative merits of different service models, but on their ability to constantly improve their efficiency and effectiveness.

Finally, managing successful change is often down to practical support. Respondents reflected that smaller businesses in particular are finding it difficult to create the time and space to train, find efficiencies, build business cases and change their own and their team's working practices. Larger practices need to be reassured that changing their working practices will maintain and improve their profitability without risking their investors' capital. All businesses need to have clarity on the way forward and reassurances about the balance between risks and benefits when transforming their service model.

3. AREAS FOR FURTHER CONSIDERATION

In addition to the findings presented above, this section considers issues that were raised that are technically 'out of scope' against the Terms of Review. They are offered as points for further discussion designed to help community pharmacies/pharmacists, the Welsh Government, the NHS, and the other key stakeholders to think about how further work and development in these areas should be focused.

3.1 FUTURE-PROOFING THE FINDINGS

It is important to recognise that the areas for further consideration below need to be considered in the context of the external environment and the 'landscape' within which community pharmacy operates:

- Historically, research has focused on savings in the medicines budget, not on maximising the use of time which is an increasingly expensive resource.
- We searched for and found no research on areas associated with these proposed changes, for example on patient attitudes/preferences, impact of technology, effect on inequalities and access which means that much of the evidence in this report operates in a vacuum.
- The current contractual and legal frameworks which have driven pharmacy behaviour and attitudes seem to be barriers to transforming practice, with change resisted in different areas often depending on the size and interests of the pharmacy businesses.
- There is enormous potential for strategic change to community pharmacy provision, but this is not without significant risk to the viability of smaller and independent pharmacies viability and local equity of access. There are questions that need to be asked about how best to manage strategic change while protecting local viability and access given the forces moving to streamline dispensing outside of Wales.
- Drivers within the broader environment within which community pharmacy operates include 'big' issues that will inevitably have lasting impacts in the fullness of time. Such changes include advances in IT and robotics, electronic prescribing, independent pharmacist prescribing and more relaxed regulatory frameworks.
- It is not possible to stop the impact of technology, and the analogy of Amazon and the High Street is important to consider. However, these 'big' changes need to be contextualised within the Welsh situation where pharmacies in remote rural communities are often the only place where some patients will be able to receive their prescriptions (whether non-medicine items, or of low clinical value, or not).
- Community pharmacists are adaptive business owners. There are risks in making changes to the way they run their businesses, but there are also risks in maintaining the *status quo*.

3.2 IDENTIFIED AREAS FOR FURTHER CONSIDERATION

In addition to the findings, there were a number of identified areas for further consideration which were suggested as ways to improve efficiency and free up community pharmacist time, but which went beyond the Terms of Review. It was recognised that all community pharmacies premises are unique and so dispensing processes will vary greatly. Having said that there were a number of basic efficiency measures that could be considered in most cases.

'Out of scope' issues that need to be recognised as efficiencies that could free up time in the context of community pharmacy
The grouping of all repeat scripts, doing the clinical check in one batch before dispensing and then delegating all other dispensing activity work.
In smaller pharmacies, doing away with the sourcing of medicines to save money on the Category M price.
In larger pharmacies, the reduction in the range of branded generics to save time and space with sourcing and stocking.
The 'grouping' of an individual patient's scripts so they don't have to have multiple visits and processes.
The introduction of original pack dispensing to remove the need for 'snipping'. This could be combined with some flexibility in the regulations (as were in place in Scotland during COVID-19) whereby a pharmacist has the discretion to 'tweak' a script to avoid these small changes.
The adoption of Hub and Spoke models, dispensing robots and 24 hour dispensing vending machines as means to improve efficiency.
'E-prescribing' and repeat dispensing systems that allow scripts to be put up in good time and ready for collection.
Read/write access to patients' records and the ability to make simple changes to prescriptions even if the community pharmacist isn't a qualified independent prescriber.

3.3 CONCLUSIONS

This report has provided a summary of participant viewpoints, data and evidence from the literature to build an evidence base around dispensing volumes within community pharmacy. In conclusion, it is worth re-iterating what we see as the central underpinning logic to the findings above, given that any change that will be significant needs to focus on extending prescribing intervals.

That:

- Extending the prescribing period will reduce the number of prescriptions dispensed by community pharmacy, although the magnitude of the reduction is unknown.
- Reducing the numbers of prescriptions dispensed will reduce community pharmacy income, although the amount of the reduction is unknown.
- Community pharmacists *may* want to compensate for that income loss by developing clinical services (based on a viable business case) depending on their attitudes towards and experiences of making such changes.
- The time released by reducing dispensing activity for community pharmacists will release time in a 'notional' sense.
- The only way that community pharmacists can utilise the time that is released is by making

changes to the organisation and operation of the pharmacy (for example through investing in technicians or technology) so that they can be released for 'actual' portions of time within which they could deliver clinical services. Releasing capacity around a reduction in dispensing activity alone (without concomitant changes being made elsewhere in their practice) will not deliver transformational change.

- Community pharmacist time could also be released by making some of the 'big' changes to the organisation and operation of the pharmacy irrespective of whether the numbers of prescriptions dispensed reduces or not as identified in the 'out of scope' list of issues above.
- There may be costs involved in making the necessary changes in that community pharmacists may have to invest in order to be able to undertake clinical services in order to compensate for the loss of prescription income.
- There is scope for radical strategic change to the whole community pharmacy model, but such change needs to be understood within a context – namely that there is a commitment within government to provide a locally accessible network of health professional access through community pharmacy.

A change of mindset is needed in order to put clinical services work first within the majority of community pharmacies currently. At the moment, the mantra tends to be that the clinical services fit around the dispensing activity. Hopefully this report provides useful evidence on how change could be made so that dispensing activity fits around the provision of clinical services, and what might be needed to move in that direction.

APPENDIX | ABOUT THE WELSH INSTITUTE FOR HEALTH AND SOCIAL CARE

The Welsh Institute for Health and Social Care (WIHSC) is part of the University of South Wales. Since 1995, WIHSC has existed to bridge gaps between academia, policy and practice.

STRATEGIC INTENT AND VISION

The strategic intent of WIHSC is to be a key player in informing and influencing the implementation of evidence-based health and care services across the statutory, voluntary and independent sectors. WIHSC has a national reputation for impact as a leading health and care policy research institute, which is built on a robust financial platform derived from the delivery of excellent academic research, evaluation and consultancy. We recognise that the following are critical factors in us delivering the strategic intent and vision:

- A **reputation** for excellence in research, evaluation and impact amongst key stakeholders – whether in government, health and care services, the media or the public
- An established **credible staff resource** including the collection of experts[5] who can be utilised to achieved the vision
- Achieving a measure of **academic impact** in order secure the role of the institute within the relevant research frameworks of the University and beyond
- A **strong, and growing, self-financing status** based on healthy revenues

PRIORITIES

WIHSC has five priority areas reflecting our current research strengths and aspirations for new areas of work and influence.

1. Prevention of escalating need

- Understanding the nature of services and how they can offset further (more costly) interventions.

  *This is best demonstrated in our recent work evaluating the impact of the Integrated Care Fund **'Stay Well@Home' programme** which runs across the Cwm Taf region and is designed to reduce escalating need through the front door of A+E.*

  *In addition our action research study for a third sector mental health charity has helped to ensure that there is now core funding for **Step by Step**, a service preventing the further escalation of issues for single homeless people presenting to the local authority with moderate mental health problems.*

2. Integration of health and care

- Analysing the ways in which the public, third and independent sectors are increasingly aligning to provide health and care services.

[5] WIHSC enjoys the support of three Visiting Professors and two Visiting Fellows. Professor Alka Ahuja (Consultant Psychiatrist in Child and Adolescent Mental Health Services in Aneurin Bevan University Health Board) has been a part of the WIHSC team for many years. In addition, we have recently developed and appointed a WIHSC Expert Reference Group. Its members are Tony Garthwaite (Visiting Professor), Malcolm Prowle (Visiting Professor), Heulwen Blackmore (Visiting Fellow), Jeremy Felvus (Visiting Fellow) and Margaret Provis. The purpose of the ERG is to help WIHSC to realise its strategic intent and vision, and act as a critical friend and to review progress towards achieving is objectives.

*Evidence of this comes from our recent study on the workforce integration of health and social care across Wales, **Working for a Shared Common Purpose**. The study was commissioned by UNISON Cymru Wales, and endorsed by the Cabinet Secretary for Health and Social Services at its launch.*

*Further, we supported organisations and public bodies through the **Strengthening the Connections programme** which provided networks, events and opportunities for collaborators to share experience and learn lessons about what works, where and why.*

3. Co-produced care and outcomes

- Reflecting on the changes in public services brought about by user- and citizen-led services and forms of support to deliver outcomes for people.

*Over many years WIHSC has run a series of citizens' juries which have provided a forum within which key issues of public policy can be discussed, debated and to some extent resolved. Most recently this focused on the crucial issue of **Antimicrobial Resistance and Stewardship** and the role of citizens.*

*Furthermore, our Health Foundation-funded research study to understand the impact of the **Prudent Healthcare** principles in practice focused in part of the way in which co-production has become (or has not become) integrated within the delivery of healthcare services.*

4. New models of care

- Providing an evidence-base upon which new modes of 'delivery' – whether new pathways, new teams, new technology, or new medicines – will improve outcomes.

*Service innovation has been at the heart of our work since WIHSC's inception. Working in partnership with the Swansea Centre for Health Economics, our UK-wide study of the impact of **Eye Clinic Liaison Officers** is one such study. We identified an evidence-base which has influenced the further implementation of this role within ophthalmology outpatient clinics.*

*Our study reviewing the approach to **Horizon Scanning for New Medicines** has impacted on the way in which the quartet of key stakeholders – policymakers in government, NHS organisations, the national therapeutics authority and the industry – will work together.*

5. Value-based care across the whole pathway

- Detailing the impact that new models of care have for pathways and the value of those pathways, expressed in financial terms.

*Understanding the ways in which the Third Sector have provided new pathways of care in many different areas across health and social care is a key part of our portfolio of projects. The **Discussion Paper** we wrote about this provides a useful insight into what is happening within the sector.*

*New pathways in the way services have moved from hospital to community settings is in line with principles of prudent healthcare and the approach of all the devolved administrations across the UK governments. Our work on **Community Cardiology** is noteworthy in this regard.*

Welsh Institute for Health and Social Care

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