

Polyclinics and Community Pharmacy – The Case for a Combined Impact Assessment

By Jill Jesson & Neil de Reybekill

The Opponents of Polyclinics

Healthcare professionals and their representatives are now regularly quoted criticising the polyclinics proposed in Lord Darzi's recent report (*Our NHS, Our Future*). Dr Tony Stanton, representing London GPs, recently condemned these 'huge, centralised polyclinics', whilst Nick Bosanquet, professor of Health Policy at Imperial College, decried '...a complete lack of any sound evidence base for the polyclinic concept'. Healthcare is big business and businessmen will defend their patch, but how can local pharmacists defend their interests and those of their patients?

The health minister Dawn Primarolo promised that the much anticipated pharmacy white paper would be aligned with the Darzi review. Rob Darracott, speaking for the Company Chemist Association (representing the multiples), focused on the positive and on the potential of Darzi to increase the chances of pharmacy services being commissioned. By comparison Hemant Patel, President of the Royal Pharmaceutical Society, has called for impact assessments to be undertaken before any polyclinics are introduced.

The two recent Darzi reports set out the government agenda. They propose the introduction of polyclinics, serving up to 50,000 people as part of a new model of healthcare that falls somewhere between the current GP practice and district general hospitals. These would provide a greater range of services than currently offered and, it is claimed, do so more effectively and efficiently.

And yet, we have been here before. In July 2000, we were promised '500 new one-stop primary care centres by 2004' (The NHS Plan). Where is the systematic evaluation of this initiative? In an 'evidence based' era, we need to know what impact, if any, this has had on health targets and community cohesion before embarking on another massive institutional change.

What Darzi says about pharmacy

The focus of these reports is on NHS services provided by GPs and hospitals. Local doctors are seen as working in inner-city, single-handed practices of variable quality and community pharmacy is mentioned only in a very limited way.

The author clearly doesn't understand the pharmacy business model, the diversity of ownership within the sector or how patient usage of pharmacies differs from general practice.

The report covers three dimensions of community pharmacy:

- ◆ Championing Healthy Lifestyles: Helping patients and those people who are not ill to stay healthy
- ◆ Long Term Care: Working with patients who have long term needs, such as smoking cessation, obesity management and medication management
- ◆ Supplying Public Needs: Provision of over the counter medication and self care support.

Significantly, dispensing NHS prescriptions is not mentioned at all.

What it may mean for community pharmacy

The report is critical of older, single-handed GP practices, so the problem the DH set out to address lies with GP practice shortcomings, not pharmacy. However, each Polyclinic will include a pharmacy, open for 18 to 24 hours a day. The expectation in Redbridge PCT is that as much as 70% of NHS prescriptions will be dispensed through three Polyclinic pharmacies. The local health economy will not be able to support both the existing network of community pharmacists and these in-house super dispensing units. The loss of NHS income will make local independent community pharmacies economically unviable and only the wealthier multiples will have the resources to bid for the pharmacy contract, serving 50,000 patients.

Historically, local doctors and pharmacists were co-located for good reasons. Not only has there been a community of interest between the professions, but there is also a commercial imperative. Without dispensing, the only other source of NHS income is from the provision of enhanced services, which is an aspect of community pharmacy that PCTs have been lamentably slow to commission.

The carrot that is held out to us is that there may be opportunities for pharmacists within polyclinics. New work, currently provided in a community pharmacy, includes supplementary prescribing, Medicines Usage Review, repeat dispensing to patients with long term chronic illness. But will these services be commissioned outside the polyclinic? If not, community pharmacists will be left competing with supermarkets to sell over the counter medication and personal care products.

Where do patients fit in?

At present, most people are never more than ten minutes walk away from a community pharmacy. This ease of access will be lost if the Darzi reforms proceed unopposed. If we believe that the existing network of neighbourhood pharmacies is a good community health resource, then, as with post offices and local schools, we need to speak up in their defence.

Although some new polyclinics may be attractive and offer a wider range of services, for most patients they will entail added journey time and greater effort to consult a GP and obtain a prescription. The local neighbourhood will lose a valuable healthcare resource and the public will no longer have their GP and community pharmacy within easy access to home.

This all seems to fly in the face of *sustainable communities* and *public consultation*, which are supposedly central goals of this government. In particular, this severely detracts from patient choice in the NHS, as it removes the option of personalised care with a local trusted professional.

Public Consultation

The rationale for changes in NHS healthcare provision is that they must support improvements to care, increase patient choice and address health inequalities. There is clearly a mismatch between the Darzi proposal and these policy intentions. The loss of local pharmacies which will be the inevitable result of the introduction of polyclinics can only serve to limit patient choice and harm community well-being.

Under the Local Government and Public Involvement in Health Act (2007), local authorities and healthcare trusts are required to 'inform, consult and involve' local people when they propose to change the way that local healthcare is provided.³ This hasn't happened.

When Darzi wrote his report, there were no polyclinics in London. But the first polyclinic is already going ahead in Redbridge. The builders are on site and staff are being hired. It is surely time for community pharmacists to challenge this ill-considered charge for change.

Local communities, local Scrutiny Committees and Local Pharmaceutical Committees need now to be working together to force PCTs to commission full health, community and business impact assessments for each and every proposed polyclinic so that the interests of vulnerable patients and communities can be protected.

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