The Pharmacy Practice Research Trust

Medicines & People

Turning Knowledge Into Know-How

The effect of the new community pharmacy contract on the community pharmacy workforce

A monograph based on a subset of data from the evaluation of the community pharmacy contractual framework

Prepared for the Pharmacy Practice Research Trust

June 2008

Christine Bond, Alison Blenkinsopp, Jackie Inch, Gian Celino, Nicky Gray

UNIVERSITY of ABERDEEN

KEELE UNIVERSITY

webstar health

The research on which this report is based was funded by the Pharmacy Practice Research Trust. The research was led by Professor Alison Blenkinsopp, Keele University School of Pharmacy, in collaboration with Professor Christine Bond, University of Aberdeen and Gianpiero Celino of Webstar Health. The views expressed in this report are those of the authors and not necessarily the funding body.

Published by the Pharmacy Practice Research Trust
1 Lambeth High Street, London SE1 7JN

First Published 2008

© Pharmacy Practice Research Trust 2008

Printed in Great Britain by the Pharmacy Practice Research Trust

ISBN: 9780955696954

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, without prior written permission of the copyright holder.

The publisher makes no representation, express or limited, with regard to the accuracy of the information contained in this book and cannot accept any legal responsibility or liability for any errors or omissions that may be made.

Acknowledgements

The study was funded by the Pharmacy Practice Research Trust, an independent charity.

We would like to thank all community pharmacists who responded to our questionnaire surveys and a special thanks to Professor Amanda Lee for statistical advice and Mrs Breda Anthony for conducting our telephone interviews.

Contents

The effect of the new community pharmacy contract on the community pharmacy workforce

Summary

The new Community Pharmacy Contractual Framework (CPCF) was introduced in England and Wales in Spring 2005. The aim of the work reported here was to determine the effect of the new CPCF on the community pharmacy workforce, specifically issues related to workload and job satisfaction.

Methods

The study included a postal survey sent to all community pharmacies (n=1,080) located in a stratified random sample of 10% of the Primary Care Organisations (PCOs) (n=31) in England and Wales and qualitative findings from five case study sites.

The survey included basic demographic questions about pharmacists and pharmacy, assessment of job satisfaction, pressure and stress, workload and workforce. The survey was mailed incrementally from September 2006. There were three postal reminders and a final telephone reminder. All data was entered into an SPSS version 14 for Windows database and analysed. The case studies included transcribed tape-recorded telephone interviews with GPs, and focus groups and interviews with pharmacists and PCO staff. The data were subjected to thematic analysis using the framework approach.

Results

The overall response rate to the survey was 71% (762). Twenty two GPs were interviewed and 40 community pharmacists took part in focus groups or interviews. Most pharmacy survey responders were under 44 years of age and 59% were male. Just over half worked for large multiples (>31 stores), and slightly under half worked in “management” positions. Nearly half the respondents (47%) worked 40 hours or more per week. Most time was spent on dispensing, followed by counselling patients, with approximately a quarter of their time spent on other activities. Since the introduction of the CPCF, two thirds reported delegating more work to non-pharmacy staff, and a third were planning further staff changes.

In general, pharmacist respondents were most satisfied with aspects of their work which related to colleagues and the responsibility they were given (scores 5.36 and 5.01 respectively out of maximum of 7). They were least satisfied with the respect they received from GPs and their remuneration and role since the introduction of the new contract (scores 3.8, 4.0 and 4.0 respectively out of maximum of 7).

There was evidence that all three tiers of the CPCF (Essential, Advanced and Enhanced) had led to increased pharmacy workload. Overall 96.5% of pharmacies were providing either the Medicines Use Review service, enhanced services or both. Although many enhanced services were being provided prior to CPCF the percentage of pharmacies providing those most commonly commissioned had increased by between 13 and 40%. The new contract was perceived to have increased workload and made additional demands on

pharmacists (score 3.93 and 3.97 respectively out of a maximum of 5), with noted increases in paperwork (3.87) and insufficient time to do justice to the job (score 3.75). Fear of assault at work (score 2.04) and financial worries (score 2.7) were reported to cause least pressure.

Taking all things into consideration, pharmacists were three times more likely to be satisfied with their role since the new contract was introduced if they were providing an MUR service. Fifty seven per cent said that they had felt stressed at work. Taking everything into consideration only 10% were more satisfied than before the introduction of the new contract. Just over half (53%) said they were "highly likely" to still be working in community pharmacy in the next five years.

Discussion and Conclusions

The vast majority of community pharmacies are engaging well with the new contract and there has been a general increase in the range and extent of delivery of innovative new services. Participation in the MUR service was associated with increased pharmacist satisfaction. Pharmacists reported increased workload associated with the new contract, in response many had delegated work to other staff and a substantial percentage were planning other staffing changes. Many said they were often stressed by the daily demands of their work and a large minority reported the new contract had had a negative effect on their job satisfaction. However, overall the majority are neither particularly satisfied nor dissatisfied and the new contract has had little overall effect on the job satisfaction of the majority of pharmacists.

1. Introduction

Understanding the pharmacy workforce is increasingly important in order to ensure that as the aspirations of the profession are translated into new roles, the workforce is both competent, confident, and has the capacity to deliver them. Inevitably change can create uncertainty and have a destabilising effect on those affected, although this is often temporary. Such effects on the workforce need to be identified, understood at the earliest opportunity, and concerns addressed promptly so that desired beneficial effects of the change in question can be experienced.

It has been recognised for some time that pharmacists are an essential component of clinical decision making in the secondary care setting, but until recently this has not been the case in primary care. Over the past decade the clinical role of pharmacy in primary care has steadily increased, but through PCO mediated or GP practice-based appointments rather than in the traditional community pharmacy setting. A paper describing the pharmacy workforce in 2005 showed that 6% of pharmacists were now working in these posts[1], albeit many only part-time and as part of portfolio working[2].

The new Community Pharmacy Contractual Framework (CPCF) was introduced in the UK in Spring 2005[3]. It consists of nationally negotiated and delivered Essential Services[a], and Advanced Services, together with locally negotiated and delivered Enhanced Services. To be eligible to deliver Advanced Services, pharmacists are required to be formally accredited on the basis of a post registration qualification, and pharmacy premises are required to meet specified criteria mostly related to a confidential consulting facility.

The intentions of the new contract were that it should: improve patient choice; reduce demand on other primary care services and support the new GP contract; improve the care of people with long-term conditions; reduce health inequalities; improve public health and patient safety; and overall give better value for money than the previous contract in which remuneration was based primarily on dispensing prescriptions with little recognition of the other more holistic services which could be provided (often referred to as pharmaceutical care). A majority of community pharmacy contractors voted in favour of the principles set out for the new contract by negotiators[4]. The exact details of the new services were only clarified as negotiations between the community pharmacist representatives and the NHS progressed. In contrast to general practice, where the majority of GPs are individual independent contractors, most community pharmacists are employees; almost 60% of pharmacies are now part of multiple groups and a single contract vote could represent many hundreds of pharmacies and pharmacists. This raises the interesting question of the extent to which current contractors' body represents the views and interests of individual community pharmacists.

Many of the changes inherent in the CPCF were a formalisation of existing locally delivered services and good professional practice (see Box 1). The new contract also included a requirement for more record keeping and more detailed

[a] Essential services comprise: Dispensing medicines; Repeat dispensing; Waste disposal; Public health; Signposting; Self care; Clinical governance.

service specifications all linked to an increased awareness of the need for improved clinical governance in the community pharmacy setting. Although clinical governance is a specific essential service its effects cut across all services and our findings on this will be the topic of a separate paper. In totality, these changes represented a theoretical increase in workload for community pharmacy, with little, if any, new resource being identified to support the new contract. This was recognised, but anticipated to be compensated for by more efficient ways of working such as repeat dispensing and electronic transmission of prescriptions (ETP, now referred to as the Electronic Prescription Service or EPS). However, although £36 million has been invested in IT to enable ETP[5] this is still in the relatively early stages of implementation and well behind the planned schedule for national roll out[6]. Whilst for many professional leaders the new contract was seen as an opportunity for the pharmacy profession to use their knowledge and skills more fully in the interests of better patient care, it was recognised that for some members of the profession the changes proposed might be seen as challenging, requiring changes in the way community pharmacy operated at an individual and organisational level. As part of a large multi-methods programme of work to evaluate the overall impact of the new Community Pharmacy Contractual Framework the effect of the new contract on the community pharmacy workforce was assessed.

The aim of the work reported here was to assess to what extent the infrastructure and workload of community pharmacy had changed, and the specific objectives were to: determine the infrastructure and workload changes which had occurred in community pharmacies as a result of the introduction of the new contract; to describe the effects of the new contract on the pharmacy workforce (e.g. skill mix, workforce patterns and capacity, role satisfaction, pharmacists' perceived pressure at work and training needs).

2. Methods

The design of the overall evaluation included a survey of PCOs and SHAs, use of routine data held by Prescription Pricing Division, a community pharmacy self completion postal survey, and five qualitative case studies. This paper draws primarily on findings from the community pharmacy survey and the pharmacist, GP and PCO data from the case study sites.

The sample for the community pharmacy postal survey was all community pharmacy premises in a stratified random 10% sample (n=31) of all Primary Care Organisations[b] in England and Wales. The sample contained representation of PCOs from each of the then 28 Strategic Health Authorities in England and from the three Welsh Regions. Based on the results of the community pharmacy survey and the other components of the programme, five case study sites were selected from these 31 PCOs. In each case study area interviews or focus groups were conducted with PCO staff, community pharmacists, general practitioners and patients. Documentary analysis was also undertaken. Only those components of the community pharmacy survey and

[b] A Primary Care Organisation was the administrative unit for primary care in England and Wales at the time of the study and was formerly known as a PCT. Since the survey was undertaken there has been a re-organisation of this infrastructure resulting in a reduction in the number of PCOs in England.

case study sites relevant to this monograph are described further here. Full details of the whole study are published elsewhere[7].

2.1 The Community Pharmacy Survey

The community pharmacy survey instrument was based on a questionnaire used previously in a national Scottish survey[8]. It was adapted to include questions specific to the new English and Welsh Community Pharmacy Contractual Framework. Of relevance to this paper it included questions on: (1) pharmacy and pharmacist demography; (2) job satisfaction; (3) workload stress and pressure; (4) satisfaction with incentives and rewards; (5) changes in staffing and roles since the new contract; (6) training; (7) interprofessional relationships. A mixture of closed and open questions and Likert Scales were used. Job satisfaction was assessed using questions developed and validated in earlier surveys (the Warr-Cook-Wall scale)[9]. The questionnaire development was informed by a pre-pilot with six pharmacists, and discussion with the Project External Advisory Board. After revision it was piloted with a sample of 95 community pharmacists from three PCOs outwith the study sample. As a result of the low response rate a further pilot was undertaken with a revised questionnaire in which the order of different questions was changed, and the effect of longer and shorter versions and personalising or not personalising the covering letter was tested using a Latin square design. As a result the questionnaire was finalised using the longer version and the letter of invitation was addressed to “the pharmacist in charge”.

The main questionnaire was mailed out progressively from September 2006 as national organisations and pharmacy chains endorsed the survey and promoted it to their members. Up to three reminders, together with a further copy of the questionnaire were sent to non-responders after four, eight and sixteen weeks. In all stages of the questionnaire mail-out a reply-paid envelope and a reply-paid postcard were included with each questionnaire pack. The postcard was sent back at the same time as, but separately from, the questionnaire and indicated whether the pharmacist had completed the questionnaire. This method ensured anonymity for responders and allowed reminders to be sent to non-responders.

A final telephone reminder was undertaken in PCOs with a response rate of less than 60%. The pharmacist in charge was offered a further postal questionnaire to complete, or the option of completing a shorter version of the questionnaire, over the telephone. Pharmacies were telephoned until a minimum 60% response rate was achieved within each PCO, or until all pharmacies in that PCO had been contacted. If a locum pharmacist answered they were asked if they were the ‘pharmacist in charge’ for that pharmacy. If the answer was ‘yes’ (i.e. there was no permanent pharmacist working at the pharmacy) they were invited to take part, and if the answer was ‘no’ the interviewer called back when the pharmacist in charge was available.

Data was entered into a SPSS version 14 for Windows spreadsheet. Double data entry was conducted for a random 10% sample of survey forms to check for accuracy. Analysis included simple descriptive frequencies followed by chi square tests of association following planned hypothesis testing, and multivariate regression. This included exploring associations between

responses and independent variables e.g. type of pharmacy, engagement in new contract. Tests of associations with 'early', 'late' and 'telephone' responders were also explored. A significance level of 5% was agreed.

A prospective work study diary was designed to allow a more detailed analysis of the time community pharmacists spend on different activities during an average day. This was based on one used earlier in a national Scottish study[8]. The reply-paid postcard, by which pharmacists confirmed their return of an anonymous completed questionnaire, also indicated whether they would be willing to take part in further research which included the work-study diary. One hundred and fourteen community pharmacists indicated they would be willing to take part and the diaries were sent out at the end of February. A further reminder was sent out again in April 2007 to boost the response.

2.2 The case studies

A set of Key Progress Indicators (KPIs) was developed for the study with associated scores. The KPI scores were used to identify case study sites with varying extents of implementation of the new contract. Other factors taken into consideration in selecting the sites were the ethnicity of the population, the relative percentages of pharmacies which were independents and multiples, deprivation scores across the individual PCOs and geographical spread of the case study sites. Five sites were selected: four PCTs in England and one LHB in Wales.

Previous research experience by the team suggested that recruiting health professionals in general and GPs in particular to focus groups might prove challenging and therefore focus groups were the first line approach with telephone interviews as an alternative if recruitment to focus groups proved not to be feasible.

The fieldwork was undertaken between November 2006 and April 2007. The PCO for each site was asked to supply a list of all practices with individual GP names and a list of all pharmacies and, where known, the names of pharmacists who worked from the premises. GPs and pharmacists were sent a pack containing a covering letter, participant information sheet and consent form. The packs were sent by "signed for" post which guaranteed a signature on delivery in order to confirm delivery and drew attention to the study. Invitations to the pharmacists were sent approximately 14 days before the focus group. Participants agreeing to take part were asked to return a consent form in a reply paid envelope.

GPs were asked to provide a direct dial telephone number or email address which was used to schedule a convenient time for the telephone interview. The aim was to recruit approximately six participants from each PCO from each professional group. A focus group was abandoned if three or less participants confirmed attendance. Participants taking part in a focus group were paid £50 plus travel expenses, and those taking part in a telephone interview were paid £50.

PCO staff participants were identified from data the PCO had provided in the previous survey[7] about their contract implementation group. The membership of

this group was reviewed with the PCO contact who provided a name, telephone number and email address for each individual. In some PCOs the reorganisation of NHS PCTs in England meant that the individuals involved were no longer in post, which limited the number of potential participants. Staff invited to participate thus varied between PCOs but typically included the community pharmacy contract lead, the clinical governance or quality lead, primary care and finance representatives. Prospective PCO participants were emailed a pack which included a covering letter, participant information sheet and consent form. The pack set out the time and date for the meeting which was held at a room at the PCO.

A draft topic guide was developed for each stakeholder group by the research team, reviewed by the project advisory board and revised accordingly. The topic guides for the GPs, pharmacists and PCO staff broadly followed the following structure:

- Experiences of implementation of the contract
- Essential services (excluding dispensed medicines)
- Advanced services
- Enhanced services
- Inter-professional relationships
- Long-term conditions
- Monitoring
- Practice based commissioning (England only)
- Control of entry (England only)

The final topic guide was then adapted to provide an interview schedule to be used in cases where telephone interviews were used instead of focus groups. All interviews and focus groups were taped and fully transcribed. The data were subjected to thematic analysis using a framework approach[10]. A list of interconnecting themes and categories was developed from previous research and synthesized from discussions with an external stakeholder board and agreed by the research team. The majority of the focus groups and interviews were conducted by one author (GC). The transcripts were read by two of the authors (GC and NG), one of whom (NG) was the primary coder. Coding was undertaken using the agreed framework. The results were discussed and ultimately ratified with the other author involved (GC), including identifying emergent themes from the narratives of the participants. Constant comparison was used and important similarities and differences in respondents' accounts were identified. The transcripts were then systematically coded seeking both confirmatory and opposing evidence.

2.3 Ethical approval

Ethical approval was obtained from MREC. Any subsequent changes were approved as substantial amendments. NHS Research and Development approval was sought and was obtained from each of the 31 PCO areas.

3. Results

In this section we report findings from the community pharmacy survey integrated with in-depth information from the case study sites. In the reporting of

the survey data all numbers and percentages relate to the numbers responding to individual questions. The total number is clearly indicated in each table and valid percentages are reported. The denominator is also indicated, with 762 indicating that results are from the postal questionnaire and telephone interviews, 543 indicating postal questionnaires only and 425 indicating the early questionnaire responses.

3.1 Response rates

The final response rate was 50% for the full length postal survey (543/1080) and 71% (762/1080) for the postal survey plus the shorter telephone surveys. There was considerable variation in response rate by PCO area (range 48%-87%), with only three PCOs not reaching the target 60%. The response rate to the work study log was 50% (57/114).

In four of the case study sites a pharmacist focus group was conducted. In the fifth site telephone interviews with five community pharmacists were undertaken (40 community pharmacists altogether). GP interviews were held in each site (22 GPs in total). In four of the case study sites a PCO staff focus group was conducted, and in the fifth site telephone interviews with two PCO staff members were undertaken.

3.2 Pharmacist demography

The largest group of respondents to the community pharmacy survey was under 35 years old (33%), with 58% under 44 years. Fifty-nine per cent were male. Fifty-four per cent (410) reported holding one or more post-graduate qualifications, which included Medicines Use Review (MUR) accreditation (278), supplementary prescriber registration (107), a diploma (73), a PhD (60), an MSc (32), membership of the College of Pharmacy Practice (14), plus other miscellaneous certificates and short courses (for example, diabetes care, PGD). Thirty two per cent were self-employed and 66% were employee pharmacists. Most respondents (51%) worked for large multiples (>31 stores), 9% in medium chains (11-30 stores), 15% in small chains (2 to 10 stores), and 25% in independent single outlets. Almost 50% of respondents worked in management positions and 26% were owners. Nearly 15% classified themselves as ‘pharmacists’. The full details are reported in Table 1.

Table 1. Pharmacist and pharmacy respondents

Characteristic	Details	N=425, n (%)	N= 762, n (%)
Age Range	Under 35	138 (33)	242 (33)
	35-44	105 (25)	215 (29)
	45-54	12 (31)	206 (28)
	55-64	40 (10)	69 (9)
	Over 65	6 (1)	9 (1)
	Total	416	741
Gender	Male	244 (59)	425 (58)
	Female	177 (41)	314 (42)
	Total	415	739
Post-graduate qualifications	Yes	212 (53)	410 (58)
	No	185 (47)	297 (42)
	Total	397	707
Pharmacist Employment Status	Self-employed	133 (32)	251 (36)
	Employee pharmacist	273 (66)	433 (62)
	Other	11 (2)	13 (2)
	Total	417	697
Type of pharmacy worked in	Independent single outlet	107 (25)	220 (29)
	Small chain (2-10 stores)	63 (15)	107 (14)
	Medium chain (11-30 stores)	39 (9)	73 (10)
	Large multiple (≥31 stores)	215 (51)	355 (47)
	Total	444	756
Designated role	Owner	108 (26)	148 (20)
	Manager	206 (50)	294 (40)
	Pharmacist	62 (15)	145 (20)
	Locum	30 (7)	144 (19)
	Other	7 (2)	10 (1)
	Total	413	741
Average prescription items dispensed in the pharmacy per month	<2,000		27 (5.6)
	2,000-3,499		95 (19.8)
	3,500-4,999		93 (19.4)
	5,000-6,499		73 (15.2)
	6,500- 7,999		77 (16.0)
	8,000-9,499		50 (10.4)
	9,500-10,999		45 (9.4)
	>11,000		20 (4.2)
	Total		**480**

Female pharmacists and younger pharmacists were most likely to work for large multiples. Pharmacists who worked in large multiples were also more likely to have a post-graduate qualification.

3.3 Pharmacy demography

A few pharmacies had changed ownership in the last year (7%) or had changed their opening hours since the introduction of the new contract. The majority were in middle class areas (score 4-7 on the visual analogue score, max 10) and in a suburban/town centre setting.

Just over half of respondents (52%) stated they displayed the NHS logo within their pharmacies. Eighty per cent (339) reported having either a private or semi-private consultation/counselling area where they could talk to patients in private. Of these 339 respondents, 74%, indicated they had a separate consultation room, of which 85% indicated that their consultation room met all the

requirements for MUR accreditation. Thus overall 282 respondents (66% of the total sample) reported their pharmacy having a consultation facility meeting MUR requirements.

3.4 Workload

The largest proportion of respondents (47%) was working more than 40 hours per week. Only 12% stated they worked <30 hours a week, and 41% worked between 31 and 40 hours per week in the community pharmacy. Those working in independent single outlets were more likely to work 40 hours per week compared to those in other types of pharmacies. Nearly a quarter (24%) reported that they were working longer hours since the introduction of the new contract. Although nearly a quarter (23%) reported engaging in other pharmacy related work, only 4% worked in a medical practice, with the majority of those (52%) indicating they worked between 7 and 14 hours per week in that setting. Slightly over half of our sample (52%) indicated they participated in PCO activities, as shown in Table 2.

Table 2. Work in Medical Practices/PCO Activities

Characteristic	Response	N=543, n (%)
Do any pharmacy related work other than in this pharmacy?	Yes	173 (32)
	No	362 (68)
	Total	535
Currently do sessional work in a medical practice?	Yes	20 (4)
	No	514 (96)
	Total	534
If yes, how many hours per week do you work?	< 7hours	9 (43)
	7-14 hours	11 (52)
	15-21 hours	
	>21 hours	1 (5)
	Total	21
Participate in Primary Care Organisation activities?	Yes	278 (52)
	No	230 (43)
	Not relevant	27 (5)
	Total	535

3.4.1 Essential services

The major percentage of time was spent by pharmacists dispensing prescriptions (median “51-75%”). Just over half the respondents (54.4%) were in pharmacies dispensing between 2,000 and 6,500 prescriptions per month (Table 1). Table 3 shows that respondents spent on average 10-25% of their time counselling patients and up to 25% on other management tasks. The work-study log data showed similarities with most time spent on dispensing prescriptions (median 50%) followed by patient counselling (median 9%), but these work-study log figures are lower than those from the main survey.

Table 3. Percentage of time spent on different types of work

Task	N=543 (n)	Median %	IQR	Work-study log N=57 median %	Work-study log IQR
Dispensing prescriptions	527	51-75	51-90	50	37-59
Counselling patients	526	10-25	<10-50	9	6-16
NHS contracted pharmaceutical services within community pharmacy	514	<10	0-<10	5	0-10
NHS contracted pharmaceutical care services external to the community pharmacy	509	0	0-<10	0	0
Communication with local GP	518	<10	<10	3	1.5-4
Staff training	523	<10	<10-25	2	0-5
Merchandising	521	<10	0-<10	0	0-1.8
Stock control	522	<10	<10-25	5	2-7
Other management/admin	518	10-25	<10-25	5.5	2-10
Other general duties	515	<10	<10-25	3.5	0-6
CPD/Education	517	<10	<10-25	0	0-1
Audit	516	<10	<10	0	0
Rest	511	<10	0-<10	3.5	0-7
Committees/meetings	506	<10	0-<10	0	0
Other	54	0	0-<10	0	0

Table 4 shows the number of pharmacist responders working in pharmacies which provided specific essential services. Ninety per cent of responders were in pharmacies providing four or more of the six essential services. Almost all those disposing of unwanted medicines, and the majority of those providing support for people with disabilities, did so before the new contract was introduced. There have been substantial increases post the 'new contract' in numbers delivering a repeat dispensing service.

3.4.2 Enhanced services

Thirteen per cent of respondents were not providing any enhanced services, and only a quarter were providing four or more. Table 4 summarises the numbers and percentages of community pharmacist responders providing enhanced services pre and post the implementation of the CPCF. Almost all those providing medicine supervision, needle exchange, medicines assessment and compliance and care home support, did so before the new contract was introduced. For newer, more clinical services, there has been a greater percentage increase but actual numbers are low.

Table 4. Delivery of services pre and post contract

.

	Service	Total no. currently providing N=425	Total no. currently providing N=762/543	No. already delivering before the new contract N=425 n (%) *	No. already delivering before the new contract N=762/543 n (%) *	No. only delivering after the new contract N=425 n (%) *	No. only delivering after the new contract n (%) * N=762/543 n (%) *
Essential services	Repeat dispensing	243	433 (60.0)	79 (43)	173 (51.0)	104 (57)	166 (49.0)
	Dispose of unwanted medicines	421	538 (99.8)	388 (99)	496 (98.8)	4 (1)	6 (1.2)
	Campaign based healthy lifestyle promotion activities	360	464 (87.4)	190 (70)	243 (70.6)	83 (30)	101 (29.4)
	Prescription linked healthy lifestyle intervention	270	355 (67.6)	196 (74)	259 (75.3)	69 (26)	85 (24.7)
	Signposting service	397	507 (94.6)	234 (76)	288 (74.2)	75 (24)	100 (25.8)
	Support people with disabilities	356	457 (86.1)	254 (85)	327 (85.4)	46 (15)	56 (14.6)
Enhanced services	Minor ailment service	113	180(25.4)`	72 (76)	108 (75)	23 (24)	36 (25)
	Stop smoking service commissioned	169	217 (43.6)	94 (75)	120 (75)	32 (25)	40 (25)
	Medicine supervision service	152	194 (39.2)	105 (87)	136 (87)	16 (13)	21 (13)
	Needle exchange service	66	88 (17.7)	52 (83)	66 (81)	11 (17)	16 (19)
	Medicines assessment and compliance service	113	145 (29.1)	71 (87)	90 (85)	11 (13)	16 (15)
	Support care homes services	82	105 (21.2)	55 (86)	73 (84)	9 (14)	14 (16)
	Patient group directions	168	211 (42.5)	95 (63)	115 (60)	56 (37)	78 (40)
	Supplementary prescribing service	7	9 (1.8)	1 (8)	1 (7)	12 (92)	14 (93
	Clinical medication reviews	13	18 (3.7)	4 (22)	6 (25)	14 (78)	18 (75)
	Pharmaceutical care for people with long term conditions in collaboration with local GPs	9	24 (4.2)	2 (50)	4 (36)	2 (50)	7 (64)

* Note: The denominator for these percentages is the sum of those responding and excludes missing values

3.4.3 Advanced services

Fifty-nine per cent were providing the advanced service of Medicine Use Reviews (MURs), and of the others 84% stated that they were planning to do so in the future. The average total time per MUR, including the preparation, patient consultation and subsequent paperwork was 51 minutes. Those respondents providing MURs were more likely to be providing more enhanced services compared to those who were not (Table 5).

Table 5. Association between provision of MURs and provision of enhanced services

MUR provision	Median no. enhanced services provided	IQR	Min. no. enhanced services provided	Max. no. enhanced services provided	p-value*
Yes providing	2	1-4	0	8	0.002
Planning to provide	2	1-3	0	6	
Not providing/not planning to provide	2	1-3	0	4	

*Kruskall Wallis test

3.4.4 Information from case studies

Qualitative data from the case studies underlined pharmacists' own perceptions of their professional role being dominated by dispensing and checking prescriptions. There were signs, however, that this would have to change in order to spend more time with patients:

Q: In the future, what do you see as the things that are most likely to change about the way you work as a pharmacist?
A: I think it's definitely going to be more seeing patients and moving away from checking.
Q: Is that a good thing, in your book?
A: Yes and no. I think it's letting go of your basic job, which checking prescriptions is. I think it's going to be letting that go, that - I know, sooner or later, that will happen. If the amount of work that we are doing now is going to increase, you just can't possibly keep doing everything.

[D: Pharmacist]

Whilst many recognised that the new contract still rewarded dispensing volume, and some felt that they were being asked to do more work for the same money, there was a recognition that role satisfaction came from delivering cognitive services to patients:

> *Well I think the main thing was that the workload didn't decrease i.e. the dispensing process and the volume of prescriptions have continued, and in my opinion for less money, and then we have been given the additional services so, in effect, it felt like money was being*

taken away in one hand and then we have had to work really hard to earn it back in the other hand. Having said that, I have had a lot of job satisfaction from doing things like MURs, because it has helped me to get to know my patients better, but it's finding time within the working day that's been the most difficult thing.

[D: Pharmacist]

Some pharmacists felt aggrieved that they were being asked to add extra tasks to their already heavy workload, and questioned whether others really understood what they already had to do during a normal day:

I feel I have been taken advantage of. People are asking me to do more and more things, and I have less and less time to do things in…People who don't work in pharmacies, I don't think they have any comprehension about how much we actually have to do during the course of our day.

[B: Pharmacist]

Interviews with other stakeholders, however, showed that there was some appreciation of the pharmacists' dilemma. Some of the GPs interviewed could reflect on a pharmacist's workload:

I think they are very, very busy, and obviously I sit in a room and I see what, 20 patients in a morning, but I have got four or five other doctors going at the same time, and so there is 100 patients…plus all the nurses and some people going through for prescriptions…and I am sure that they are absolutely snowed under in the morning, so I have got complete sympathy with them for their workload.

[D: GP]

Similarly, PCO staff recognised that the new contract had created a workload problem:

One of the things I have about the contract is that it still involves being paid on volume. So although all these additional services are on board, the pharmacists are expected to keep up the volume of prescriptions and increase that, plus do all these additional things. And that is huge for them, I think.

[A: PCO staff]

The new contract had contained the promise of measures that would create new methods of workflow management: repeat dispensing and electronic transfer of prescriptions (ETP). Some pharmacists expressed disappointment that these measures had not materialised:

A. There is only a finite amount of time to do the job and the more that you spend doing stupid administrative tasks, the less you spend doing the clinically significant part.

B. Yes I agree. And the bits that could have saved us time like ETP and repeat dispensing, they haven't materialised.

[A: Pharmacists]

Another method of managing workflow, and releasing the pharmacist for greater patient contact, was more imaginative skill mix and delegation in the pharmacy.

3.5 Delegation of work

Sixty-eight per cent of respondents indicated that they had delegated more work to non-pharmacist staff members since the introduction of the new contract; this is compared to 27% who indicated that they had delegated more work to other pharmacist staff. Thirty-four per cent of the sample indicated they planned to make other staff changes in the next year as a result of the 'new contract'. (Table 6)

Table 6. Workforce changes since the new contract

Staff change	Response	N=543, n (%)
Delegated more work to non-pharmacist staff since the 'new contract' was introduced	Yes	348 (68)
	No	166 (32)
	Total	514
Delegated more work to other pharmacist staff since the 'new contract' was introduced	Yes	136 (27)
	No	375 (73)
	Total	511
Plan to make any other staff changes in the next year as a result of the 'new contract'	Yes	168 (34)
	No	333 (66)
	Total	501

Pharmacists providing MURs were more likely than other responders to have devolved more work to non-pharmacists (Table 7). 23% had specifically employed a locum to either conduct MURs or provide cover for them to conduct MURs.

Table 7. Associations between MUR activity, job satisfaction, delegation of work and pressure from work

Factor		Overall satisfaction			
		More satisfied	**Less satisfied**	**Much the same**	**p-value**
Providing MUR service	**Yes**	95 (80.5)	114 (54.5)	207 (55.9)	**<0.001**
	No	23 (19.5)	95 (45.5)	163 (44.1)	
		Delegated more work to fellow workers (non-pharmacists)			
		Yes	**No**		**p-value**
Providing MUR service	**Yes**	232 (68.0)	85 (51.5)		**<0.001**
	No	109 (32.0)	80 (48.5)		
		Delegated more work to other pharmacists			
		Yes	**No**		**p-value**
Providing MUR service	**Yes**	91 (67.9)	224 (60.7)		0.140
	No	43 (32.1)	145 (39.3)		
		Satisfaction with role since the new contract			
		Dissatisfied (1-3)	**Much the same (4)**	**Satisfied (5-7)**	**p-value**
Providing MUR service	**Yes**	85 (56.3)	103 (57.5)	130 (71.4)	**0.002**
	No	66 (43.7)	76 (42.5)	52 (28.6)	
		Pressure from workload			
		No pressure (1-2)	**Some pressure (3)**	**High pressure (4-5)**	**p-value**
Providing MUR service	**Yes**	30 (65.3)	74 (62.7)	223 (62.3)	0.983
	No	16 (34.7)	44 (37.3)	135 (37.7)	

3.5.1 Information from case studies

The case studies revealed a spectrum of delegation and creativity, but action was widespread. Measures included giving administrative tasks to their staff, such as filing, and involving them with more complex services such as smoking cessation:

> *I have trained my staff. My assistant does the filing and I do the posting and sending of MURs to GPs. She helps me a lot with smoking cessation: she knows exactly what products we give, and who the patient is. So I have trained my staff a bit more after the new contract.*
>
> *[C: Pharmacist]*

Another pharmacist had looked at a range of new contract activities, and had appointed leads for different essential services – including a non-pharmacist clinical governance lead:

> *Certainly we looked at all the elements of the new contract, and I gave each member of staff some responsibility for it. So, for example, I have one member of staff that looks after health promotion: she would look out for the campaigns that are coming from the PCO and she would make sure that we were briefed and we had the correct leaflets on display; the posters were up; and we were gathering any data that the PCO wanted us to gather; and that the paperwork was sent in by the deadline. We have decided that we would have staff as our clinical governance leads, rather than it being the pharmacist, so I have delegated that role to another member of staff. So we have broken down each area of the contract that needed someone to be responsible, and I gave them coaching on what I wanted them to do in terms of that because I didn't want it all on my shoulders, and I wanted the staff to feel involved.*
>
> *[D: Pharmacist]*

Many pharmacists felt that delegation had been very beneficial, both for increasing the job satisfaction of other members of staff and for relieving the burden upon themselves:

> *Because as pharmacists we are just so engrossed in doing our own thing we never looked at the wider picture. I know, in my pharmacy, I have always trained my staff. When the new contract came out I started putting more money in it. And they feel better, especially the older staff who have been there a while, they have something new to do, and important to do, and they feel that much more important. And it is widening their role and taking some of the burden off us.*
>
> *[C: Pharmacist]*

3.6 Interprofessional relationships

A large percentage of respondents (88%) indicated that they have professional contact with GPs. However, the majority of those (80%) stipulated that their involvement has remained 'much the same' since the introduction of the 'new contract' and only 18% said it had increased. Only 41% of respondents stated

that they felt more part of the PCT/LHB as a result of the 'new contract' (Table 8).

Table 8. Contract with GPs and integration with PCO

Question	Details	N=543/762, n (%)
Have professional contact with local GPs	Yes	470 (88)
	No	63 (12)
	Total	533
What for	Prescription queries	88 (19)
	Patient query	3 (0.6)
	MUR	3 (0.6)
	Combination	372 (79.8)
	Total	467
Since the 'new contract' how would you describe your involvement with local GPs	Increased	130 (18)
	Decreased	16 (2)
	Much the same	590 (80)
	Total	736
Feel more part of the PCT/LHB as a result of the 'new contract'	Yes	286 (41)
	No	412 (59)
	Total	698

3.6.1 Information from case studies

The effect of the contract on relationships with GPs was complex, and really centred on the existing local relationships between individuals, as observed in this PCO:

> *I don't think it changed - pharmacies that already had a good relationship with their practices carried on, but I don't think it would have changed ones that don't generally.*
>
> *[B:PCO staff]*

Some pharmacists felt, however, that their relationship with GPs had not improved since the new contract, largely because of MUR and repeat dispensing:

> *I have done some conversations with the doctors from the six surgeries - they are not much in favour of MURs: they are not in favour of repeat dispensing.*
>
> *[C:Pharmacist]*

Others felt that developments such as formalised communication in MUR, or enhanced services that met the GPs' needs (for example, smoking cessation), had been positive:

> *I think with the GPs, certainly with the enhanced service, we are getting actual referrals now from the GP and people are saying "You know, you can go to your pharmacy, for smoking cessation - you don't have to come here for an appointment."*
>
> *[A:Pharmacists]*

One pharmacist with a good relationship with their local GPs reflected on the turmoil of the new GMS contract, and was sensitive to how the increased paperwork from pharmacies, through MUR, could increase GP workload:

I think that they are so engrossed in the changes that have occurred in their own contract, and the preparation for practice-based commissioning that, potentially, we give them extra work in the paperwork - that we have to copy them in on most of the things that we do, and because it's all paper-based we actually put more of an administrative burden on the GPs.

[D Pharmacist]

3.7 Satisfaction and Pressure

Respondents were asked to rate their satisfaction with various aspects of their job, on a scale of 1 (extreme dissatisfaction) to 7 (extreme satisfaction). When the mean scores were considered, most satisfaction was with colleagues and fellow workers (5.41) followed by patient contact (5.04) and amount of responsibility given (5.02). Least satisfaction was with their role (4.01), their remuneration (3.98) and respect received from GPs (3.83) (see shaded areas in Table 9 below).

Only 17% of community pharmacists stated they were more satisfied overall compared to before the 'new contract' was introduced, but of the small number of pharmacists not providing either MURs or enhanced services (n=27) this decreased to 7%.

There was no association between the type of pharmacy and satisfaction, but designated role strongly affected satisfaction, with locums and pharmacists being more satisfied than owners and managers (Pearson Chi square p <0.001). A range of other factors also appeared to be associated with increased satisfaction on univariate regression as follows. Univariate regression of those currently providing, and not providing, the MUR service showed that more of those providing the MUR service compared to those who were not, were overall more satisfied than before the new contract (23% compared to 8%), and more satisfied with their role (41% compared to 27%) (Table 10).

Table 9. Current Job Satisfaction

	N=543 n(%)								
	Extreme dissatisfaction						Extreme satisfaction		
	1	2	3	4	5	6	7	Total	Mean/SD
Colleagues & fellow workers	6 (1.1)	14 (3.8)	30 (9.5)	76 (14.4)	130 (24.6)	166 (31.4)	105 (19.9)	527	5.41/2.22
Patient contact	3 (0.6)	22 (4.2)	33 (6.2)	103 (19.5)	165 (31.2)	137 (25.9)	66 (12.5)	529	5.04/1.29
Amount of responsibility you are given	9 (1.7)	25 (4.8)	35 (6.7)	118 (22.5)	111 (21.2)	143 (27.3)	83 (15.8)	524	5.02/1.45
Freedom to choose own method of working	14 (2.7	42 (8.0)	60 (11.4)	99 (18.8)	111 (21.1)	129 (24.5)	71 (13.5)	526	4.83/2.39
Physical working conditions	18 (3.4)	28 (5.3)	59 (11.2)	96 (18.2)	134 (25.4)	132 (25.0)	61 (11.6)	528	4.78/1.52
The effectiveness of community health activities from your pharmacy?	10 (1.9)	24 (4.7)	65 (12.7)	127 (24.8)	146 (28.5)	100 (19.5)	41 (8.0)	513	4.64/1.37
Opportunity to use your abilities	22 (4.2)	40 (7.6)	71 (13.4)	118 (22.3)	140 (26.5)	101 (19.1)	35 (6.6)	527	4.52/2.35
Professional self esteem	14 (2.7)	42 (8.0)	64 (12.2)	126 (24.0)	142 (27.0)	101 (19.2)	37 (7.0)	526	4.50/1.45
Amount of variety in your job	22 (4.2)	52 (9.8)	64 (12.1)	133 (25.2)	133 (25.2)	91 (17.2)	33 (6.3)	528	4.44/2.63
Your hours of work	37 (7.0)	54 (10.2)	60 (11.3)	114 (21.6)	123 (23.3)	104 (19.7)	37 (7.0)	529	4.31/1.65
Relationship with GP	28 (5.3)	48 (9.1)	81 (15.3)	151 (28.6)	102 (19.3)	87 (16.5)	31 (5.9)	528	4.20/1.53
Recognition you get for good work	44 (8.4)	56 (10.7)	68 (13.0)	130 (24.8)	113 (21.6)	79 (15.1)	34 (6.5)	524	4.12/1.64
Your role since the 'new contract'	35 (6.7)	49 (9.4)	69 (13.3)	184 (35.5)	102 (19.7)	66 (12.7)	14 (2.7)	519	4.01/1.44
Your remuneration	65 (12.4)	59 (11.2)	76 (14.4)	118 (22.4)	114 (21.7)	63 (12.0)	31 (5.9)	526	3.98/1.71
Respect received from GPs	53 (10.1)	68 (12.9)	86 (16.3)	143 (27.1)	86 (11.3)	68 (8.9)	23 (3.0)	527	3.83/1.62

Table 10. Overall satisfaction and attitudes to the new contract

Question	Details	N=425, n (%)	N=762, n (%)
Ever feel stressed about job	Yes	237 (57)	306 (58)
	No	30 (7)	39(7)
	Sometimes	149 (36))	186 (35)
	Total	416	531
Taking everything into consideration, compared to before the 'new contract' are you	More satisfied	40 (10)	122 (17)
	Less satisifed	175 (43)	216 (30)
	Much the same	194 (47)	380 (53)
	Total	409	718
Impact has the 'new contract' had on how likely to stay in community pharmacy	More likely	47 (11)	140 (19)
	Less likely	142 (35)	188 (26)
	No change	222 (54)	393 (55)
	Total	411	721
Still working in community pharmacy in next five years	Highly likely	218 (53)	366 (52)
	Highly unlikely	75 (18)	105 (15)
	Unsure	122 (29)	231 (33)
	Total	415	702
Still working in community pharmacy in next ten years	Highly likely	144 (35)	231 (33)
	Highly unlikely	132 (32)	178 (25)
	Unsure	139 (33)	293 (42)
	Total	415	702

Table 11 shows which job satisfaction related items were significantly associated with age at the 5% level on univariate regression. In particular, a greater proportion of younger pharmacists were more likely to be satisfied with their role since the new contract and their job overall since the new contract was introduced although for all age groups the biggest proportion reported 'much the same' to these two questions.

Table 11. Significant associations between age, and job satisfaction in terms of: hours of work, amount of variety in job, their role since the new contract and taking everything into consideration, compared to before the new contract are you now more satisfied, less satisfied or much the same

Factor		Overall satisfaction			
		Hours of work			
		More satisfied (5-7)	**Less satisfied (1-3)**	**Much the same (4)**	**p-value**
Age	**Under 35**	48 (26.7)	19 (10.0)	113 (62.8)	**0.006**
	35-44	40 (32.8)	18 (14.8)	64 (52.5)	
	45-54	34 (21.0)	40 (24.7)	28 (46.7)	
	Over 55	18 (30.0)	14 (23.3)	28 (46.7)	
		Amount of variety			
		More satisfied (5-7)	**Less satisfied (1-3)**	**Much the same (4)**	**p-value**
Age	**Under 35**	34 (18.9)	37 (20.6)	109 (60.6)	**0.023**
	35-44	32 (26.4)	17 (14.0)	72 (59.5)	
	45-54	45 (27.8)	13 (8.0)	104 (64.2)	
	Over 55	12 (20.3)	6 (10.2)	41 (69.5)	
		Role since the new contract			
		More satisfied (5-7)	**Less satisfied (1-3)**	**Much the same (4)**	**p-value**
Age	**Under 35**	40 (22.9)	25 (14.3)	110 (62.9)	**0.018**
	35-44	17 (13.9)	18 (14.8)	87 (71.3)	
	45-54	20 (12.4)	27 (16.8)	114 (70.8)	
	Over 55	3 (5.4)	14 (25.0)	39 (69.6)	
		Taking everything into consideration are you now….			
Age		**More satisfied (5-7)**	**Less satisfied (1-3)**	**Much the same (4)**	**p-value**
	Under 35	49 (21.2)	59 (25.5)	123 (53.2)	**0.017**
	35-44	41 (19.7)	55 (26.4)	112 (53.8)	
	45-54	25 (12.6)	75 (37.9)	98 (49.5)	
	Over 55	7 (9.6)	25 (35.6)	40 (54.8)	

Table 12 compares 'early questionnaire', 'late questionnaire' and 'telephone' responders. Adjusted regression strategy showed that 'early' responders, compared to 'late' responders were less satisfied with the 'new contract', and less likely to remain working in community pharmacy. This pattern persisted when 'late' responders were compared with 'telephone' responders who were most likely of all the groups to feel the new contract had increased their likelihood of staying in community pharmacy. Additionally, 'late' responders (compared to 'early' and 'telephone' responders) were more likely to be under 35 years of age, and 'telephone' responders were more likely to be between 35 and 44 years of age. 'Early' and 'late' responders were more likely to be owners or managers, and 'telephone' responders were most likely to be locums.

‘Telephone’ responders were more likely to be working in independent pharmacies, compared to those answering the postal form.

Table 12. Comparison of early, late and telephone responders by selected characteristics

Variable		Early n (%)	Late n (%)	Telephone n (%)	P-value
Sex	Male	244 (58.8)	65 (57.0)	116 (55.2)	0.692
	Female	171 (41.2)	49 (43.0)	94 (44.8)	
Age	Under 35	138 (33.2)	43 (37.4)	61 (29.0)	**<0.001**
	35-44	105 (25.2)	18 (15.7)	92 (43.8)	
	45-54	127 (30.5)	38 (33.0)	41 (19.5)	
	55-64	40 (9.6)	13 (11.3)	16 (7.6)	
	Over 65	6 (1.4)	3 (2.6)	0 (0)	
Type of pharmacy	Independent single outlet	107 (25.2)	28 (23.7)	85 (39.9)	**0.001**
	Small chain	63 (14.9)	19 (16.1)	25 (11.7)	
	Medium chain	39 (9.2)	8 (6.8)	26 (12.2)	
	Large multiple	215 (50.7)	63 (53.4)	77 (36.2)	
MUR	Yes	250 (60.1)	82 (69.5)	103 (51.5)	**0.006**
	No	166 (39.9)	36 (30.5)	97 (48.5)	
Future intention to provide MURs	Yes	135 (87.7)	30 (88.2)	55 (75.3)	**0.047**
	No	19 (12.3)	4 (11.8)	18 (24.7)	
Overall satisfaction with ‘new contract’	More	40 (9.8)	25 (22.1)	57 (29.1)	**<0.001**
	Less	175 (42.8)	30 (26.5)	11 (5.6)	
	Much the same	194 (47.4)	58 (51.3)	128 (65.3)	
Likelihood of staying in community pharmacy	More	47 (11.4)	22 (19.3)	71 (36.2)	**<0.001**
	Less	142 (34.5)	33 (28.9)	13 (6.6)	
	Much the same	222 (54.0)	59 (51.8)	112 (57.1)	
Desginated role	Owner	108 (25.3)	25 (21.2)	15 (6.8)	
	Manager	206(48.5)	57 (48.3)	31 (14.2)	
	Locum	30 (7.1)	12 (10.2)	102 (46.6)	
	Other	69 (16.2)	23 (19.4)	63 (28.8)	

On multivariate logistic regression including gender, age, type of pharmacy, designated role, MUR provision, essential service provision, pressure of work, working with GPs and responder type (early/late/telephone), pharmacists providing a MUR service were more than three times more likely to be satisfied with the new contract (OR 3.4) and their role since the new contract (Table 13) compared with those who were not. Late responders (including telephone and late postal replies) were over twice as likely to be satisfied compared to early responders (OR 2.3).

Table 13. Multivariate logistic regression: analysis of overall satisfaction compared with age, gender, type of pharmacy, designated role, early/late/telephone responders, MUR provision, essential service provision, pressure and working in general practice

Contributory factor	p-value	95% CI	df	OR
Early/late/telephone	0.008	1.24-4.25	1	2.3
MUR provision	0.001	1.62-7.16	1	3.4

Of those who were overall *'less satisfied'* when *'taking everything into consideration compared to before the 'new contract'* a quarter (25%) were neither satisfied nor dissatisfied with their *'role since the 'new contract''* (1= extreme disatisfaction to 7= extreme satisfaction) (Table 14).

Table 14. Comparison of absolute satisfaction with role since the new contract compared to increase or decrease satisfaction n (%)

Relative satisfaction with role since new contract		Absolute satisfaction with your role since the new contract		
		Very satisfied Score 6-7	***Ambivalent Score 5-3***	***Very dissatisfied Score 2-1***
	More satisfied	28 (43.1)	37 (56.9)	0 (0)
	Much the same	44 (18)	183 (74.7)	18 (7.3)
	Less satisfied	7 (3.5)	129 (63.9)	66 (32.7)

Nearly half the respondents (45%) felt that their remuneration under the new contract was less fair than the previous contract, and that their pharmacy was now worse off (57%) (Table 15); few indicated they had applied for an exit payment[c] but just over a third were unsure.

[c] For pharmacies with low dispensing volumes that wished to close, PSNC secured agreement to limited exit payments. Pharmacies had the option of relinquishing their contract and receiving the Global Sum professional allowance they would have earned had they remained open for a further year subject to a minimum payment of £10,000. Conditions applied. Detailed information can be found in Part XI of the Drug Tariff. This option was only available for the first year of the new pharmacy contract.

Table 15. Financial implications of 'new contract'

	Response	N=543 n (%)
Compared to the previous contract, do you think the 'new contract' is?	Fairer	117 (22.5)
	Less fair	233 (44.8)
	Same as old one	48 (9.2)
	Don't know	122 (23.5)
	Total	520
Financially, do you feel your pharmacy is?	Better off	73 (14.7)
	Worse off	281 (56.7)
	The same	142 (28.6)
	Total	496
Did this pharmacy apply for an exit payment?	Yes	3 (0.6)
	No	321 (61.7)
	Not sure	196 (37.7)
	Total	520
Was this pharmacy an ESPS pharmacy before the 'new contract'?	Yes	16 (3.1)
	No	371 (71.1)
	Not sure	135 (25.9)
	Total	522
Did you or the pharmacy owner apply for ESPLPS?	Yes	27 (5.3)
	No	267 (52.0)
	Not sure	219 (42.7)
	Total	513

3.7.1 Information from case studies

Data from the case studies showed satisfaction coming from greater contact with patients, and with the PCO:

A. *I think meeting with actual patients is being rewarded now – for example, with MURs. Before, there was no form for counselling patients. There was no set structures.*
B. *I think there is more rapport between customer and pharmacist now, especially because of MURs. And there is more trust in the pharmacist.*
C. *There was communication before, but not as much communication as now. We communicated before but, with doing MURs and everything, we are doing it more…We perhaps did MURs in the past, but we didn't call it MURs. We talked to patients about the medication in the past, but we didn't label it MUR - now we label it, and suddenly it has another aspect to it.*

[C: Pharmacists]

Yes, I think from our area there is a one-to-one with the PCT and the pharmacies and all the pharmacies are invited to meetings, nobody is ever left out, which is a major plus, and I think they have very good…communication relationships which is very important.

[D: Pharmacist]

Perceptions about the impact of the new contract on the 'bottom line' of the pharmacy differed, as discussed by one group of pharmacists including employees and owners:

A. *As a contractor I am perceiving that money being - it is not even the same amount of money, it is being whittled away because the margins are getting tighter and tighter. Finding profits out of purchases is getting tighter; it is proving more and more difficult.*

B. *We gave a lot away by having the M category. But it looked on paper like double the amount of money.*

C. *Although when I look at my bottom line, at the moment it is no different.*

D. *But then we are working much harder for it. We are dispensing more and more every year. At least we are.*

C. *But presumably you don't see your bottom line whereas I see my bottom line. There are some reasons why my bottom line is better: part of it is because I get paid for the rotas I do… that is an enhanced service that I am being paid for.*

[B: Pharmacists]

There was an interesting reflection from some PCO pharmacists that pharmacists had not initially realised that there was no new money in the contract,

> *I don't think pharmacists realised this either, with the pharmacy contract…basically the money is recycled money and they are actually only being paid the same to do an awful lot more…And some of them really feel that they were pushed into agreeing, and voting for this contract, when they didn't really understand the implications of it. And it was basically – "Well if you don't vote 'Yes' for this contract, then you are stuffed, guys!"*
>
> *[C: PCO staff]*

3.8 Pressure, stress and long term plans

The pressure experienced by respondents from various job related factors was also assessed on a scale of 1 (none) to 5 (high pressure). Demands from the 'new contract' (3.96) were reported to provide most pressure at work, followed by actual workload (3.89) and paperwork (3.89). Least pressure was linked to 'fear of assault at work' (2.13). (Table 16)

Table 16. Pressure at work

N=543 n (%)	No pressure				High pressure		
	1	2	3	4	5	Total	Mean/SD
Demands from the 'new contract'	8 (1.5)	35 (6.6)	108 (20.5)	197 (37.4)	179 (34.0)	527	3.96/0.97
Workload	13 (2.5)	35 (6.6)	118 (22.3)	196 (37.0)	168 (31.7)	530	3.89/1.01
Paperwork	18 (3.4)	52 (9.8)	90 (16.9)	184 (34.7)	187 (35.2)	531	3.89/1.10
Insufficient time to do justice to the job	23 (4.4)	45 (8.5)	130 (24.7)	182 (34.5)	147 (27.9)	527	3.73/1.09
Training/CPD/ CE requirements	13 (2.5)	56 (10.6)	135 (25.5)	198 (37.4)	128 (24.2)	530	3.70/1.03
Increased demands from patients	16 (3.0)	45 (8.5)	166 (31.4)	221 (41.8)	81 (15.3)	529	3.58/0.95
Inappropriate demands from patients	19 (3.6)	82 (15.5)	147 (27.8)	202 (38.2)	79 (14.9)	529	3.45/1.04
Long working hours	55 (10.4)	105 (19.8)	133 (25.1)	126 (23.8)	111 (20.9)	530	3.25/1.28
Insufficient resources	49 (9.3)	105 (20.0)	171 (32.5)	129 (24.5)	72 (13.7)	526	3.19/1.78
Dividing time between work and spouse/family	68 (12.9)	94 (17.8)	144 (27.3)	137 (25.9)	85 (16.1)	528	3.15/1.26
Professional isolation	55 (10.4)	111 (21.0)	175 (33.1)	121 (22.9)	66 (12.5)	528	3.06/1.16
Emphasis on business ethics	60 (11.4)	101 (19.2)	193 (36.6)	114 (21.6)	59 (11.2)	527	3.02/1.15
Disturbance of home/family life by work	81 (15.3)	125 (23.7)	131 (24.8)	134 (25.4)	57 (10.8)	528	2.93/1.24
Working environment	53 (10.0)	128 (24.2)	188 (35.5)	123 (23.3)	37 (7.0)	529	2.93/1.07
Worrying about finances	100 (18.9)	140 (26.5)	135 (25.5)	89 (16.8)	65 (12.3)	529	2.77/1.28
Fear of assault while at work	191 (36.0)	187 (35.2)	96 (18.1)	45 (8.5)	12 (2.3)	531	2.10/1.44

When asked if they ever felt stressed about their job, 58% stated they were, with a further 35% indicating they were sometimes. Nineteen per cent overall said they were more likely to stay in community pharmacy, with 55% stating 'no change'. Just over 52% of pharmacists are likely to still be working in the community within the next five years. This drops to 33% for likelihood of still working in community pharmacy in the next ten years (Table 10).

3.8.1 Information from case studies

The demands from the new contract were summarised by one group of pharmacists, reflecting the collective views of many others that it would add more pressure to their daily workload, including more paperwork and multi-tasking. It was tempered by the reflection of one group member that it might result in greater role satisfaction. This was, again, representative of the mixed feelings with which pharmacists viewed these developments:

Q: How has the way you work changed as a result of the contract?
A. Greater pressure to achieve more in my working day.
B. More paperwork and less time to do the job.
C. A lot more multi tasking, doing a lot of different things at the same time, thinking about different things at the same time.
D. I suppose, to be fair, also the opportunity to provide a more comprehensive service and get a little bit more from what we do.

[A:Pharmacists]

Stress from increased paperwork was a subject commonly discussed by pharmacists. One independent had taken the opportunity to fund extra pharmacist cover through MURs in order to cope with the extra demands of other aspects of the contract:

> *I can't keep track of the paperwork that keeps coming through, and I am fed up of taking it home. As an independent you have to take so much home, and it is really getting to me now. I cannot do what I need to do in my working day, and I object to having to take the computer home at a weekend to write up audits or whatever else has to be done. So I am going to use the MURs to fund the locum, so I have got time to do it that morning, on the premises. That is my reason, not for money-making* (from the fees for MUR) *but just to cover the extra cost of the contract.*
>
> *[B:Pharmacist]*

Some employee pharmacists expressed frustration that they had had no voice in the decision to implement a new contract. Some contractors felt that they were not given the full details and implications of the contract before they had to vote upon it.

> *A. And also, contract I voted for is not the contract we have got.*
> *B. That is the general opinion. It was not what we thought we were buying into.*
> *C. The timescale from when they produced that document to when it was approved was just far too short. They didn't consult - it was one document sent to each pharmacy, or pharmacy chain - so I don't think the pharmacists who are on the ground didn't have a chance to actually say whether this is going to work or not…And when you actually looked at it, if you really read it properly - I said to my employers – obviously there was just one vote – "Don't vote for it, it is not right. It is really not right." But I don't think that pharmacists were given an opportunity to express their opinions, because a lot of employee pharmacists didn't see that document.*
>
> *[B: Pharmacists]*

Linked to this issue, some PCO pharmacists were disgruntled that pharmacists blamed them for the shape of the new contract, when they were just implementing something that contractors had voted for, whether they were aware of the full ramifications or not:

> *I don't know, we're trying to implement a national contract that they voted for. OK, individuals might not have voted, but generally the membership voted for a new contract. So we've not really had any input into what that contract is, or what it entails: it's just basically our job to implement it and support them. So if they're not happy with the content of it they shouldn't really be moaning at us, because it's not been part of our job.*
>
> *[B:PCO staff]*

This juxtaposition of views illustrates the complexity of the process by which the new contract has been planned and implemented.

3.9 Training

Respondents were asked in which areas of their new work they would like further training. The responses are shown in Table 17. The three areas where there was strongest agreement for receiving further training were 'Clinical Research and Audit' and 'Clinical Governance'. All suggested areas were agreed with by half or more of the responders.

Table 17. Respondents' perceived training needs

N=543 n (%)			
	1-2 Agree n(%)	**3-4-Disagree n(%)**	**Total**
Clinical	460 (90)	52 (10)	512
Management	281 (55)	227 (45)	508
Communicating with other health professionals	255 (50)	257 (50)	512
Communicating with patients and carers	267 (52)	343 (48)	511
Structuring the consultation	299 (59)	205 (41)	504
Research & Audit	354 (70)	154 (30)	508
Training / Supervision	259 (51)	246 (49)	505
Time management	250 (49)	257 (51)	507
IT	302 (59)	207 (41)	509
Health Promotion/ Lifestyle/Public Health	305 (60)	204 (40)	509
Clinical Governance	351 (69)	157 (31)	508

Table 18 shows the barriers restricting participation in training and CPD. Lack of time and fatigue were the ones most respondents reported as restricting their participation, followed by information overload, insufficient locum cover and lack of funding.

Table 18. Barriers to obtaining training

N=543 (n, %)					
	Greatly restrict			**Not at all**	**Total**
Lack of time	364 (70.1)	111 (21.4)	34 (6.6)	10 (1.9)	519
Insufficient locum cover	199 (39.6)	129 (25.6)	93 (18.5)	82 (16.3)	503
Lack of funding	203 (39.7)	130 (25.4)	110 (21.5)	68 (13.3)	511
Lack of quality educational activities	71 (14.0)	142 (28.0)	185 (36.4)	110 (21.7)	508
Information overload	168 (32.8)	186 (36.3)	128 (25.0)	30 (5.9)	512
Remoteness from education centres	79 (15.6)	150 (29.7)	166 (32.9)	110 (21.8)	505
Lack of motivation	72 (13.9)	137 (26.4)	195 (37.7)	114 (22.0)	518
Fatigue	176 (34.1)	194 (37.6)	106 (20.5)	40 (7.8)	516

3.9.1 Information from case studies

Staff in one PCO had looked at pharmacy training plans during their monitoring visits, to gauge whether pharmacists would have the staff and capacity to implement all necessary services:

> *We were looking there at training plans really, how were they [pharmacists] training their staff to meet the requirements of the new contract, how were they looking at trying to free up pharmacists to do extra services, looking at are they training technicians or are they training ACTs, have they got enough staff on the shop floor?*

[A:PCO staff]

One independent pharmacist, when questioned about their readiness for the new contract in terms of skills and training, responded that their combined skills were probably as yet incomplete, although they perceived that multiple pharmacists might have been more prepared:

> *If an assessment was made, and someone independent came in and questioned us, they would find that it [skill set] wasn't complete. The pharmacist probably needed training in particular areas: could be in time management, retail, whatever it was, communication etc. etc. - and the staff equally. If you look at other organisations, perhaps even the multiple sector, that they will have been given different sets of competencies and completed them with training.*
>
> *[C:Pharmacist]*

There was also a report from a multiple employee that their managers were seeking attendance at PCO training events above all other forms of CPD, and they felt that this was not necessarily reasonable:

> *I was informed by my new area manager that because they hadn't really decided how to assess people's CPD, and whether they had done enough CPD, they were taking the viewpoint that if you had attended all of the meetings on offer from the PCO to accredit enhanced services, they would consider you to have done enough CPD. And conversely if you didn't attend any of those they would consider you to have not done enough CPD. Regardless of what other CPD you had done and could prove you had done. Which strikes me as a little bit unreasonable.*
>
> *[A:Pharmacist]*

4. Discussion

Overall the main effects of the new contract on the pharmacy workforce are an increased workload, with increased delegation of tasks from pharmacist to non pharmacist staff and a slight increase in employment of additional locum pharmacists to support specific services such as MUR provision. Our work indicates that the new CPCF has not resulted, so far, in increased job satisfaction among most of the pharmacist workforce and many respondents reported that the contract had had a negative effect on their job satisfaction, and may even have resulted in increased stress. Over one third of respondents say they are currently less likely to stay in community pharmacy as a result of the new contract. However these high level findings mask differences across sub groups of pharmacists which are discussed in more detail below.

This survey is the largest to date undertaken since the introduction of the new contract. It achieved a good response rate and thus its findings can be considered representative of the total population of community pharmacists. The proportion of those responding from independent single outlets compares well with national data, as does the age distribution, but male pharmacists were over represented in our data compared to national data[11] (58% compared to 49%), and locums were under-represented (19% compared to 24%).

A further strength of the research is the multi method approach and the in depth exploration of the issues identified in the survey through the qualitative case study work. Nonetheless the results from the survey have to be interpreted with some caution. The survey was logistically complex involving many national pharmacy companies and small independent multiples. As we sought to engage their support before contacting their respective individual pharmacies, as a strategy to increase response rate, this resulted in the survey being mailed out in successive tranches as individual head office approval was secured. Thus overall the survey data was gathered over a total period of approximately 6 months. The survey was undertaken 18 -24 months after the introduction of the new contract, when initial problems might have been expected to have been resolved, and equilibrium achieved, but this may not in fact have been the case. As we report in the results, those pharmacies responding later via the telephone survey were more satisfied than those responding by mail. They were also more likely to be locums, younger, not providing MURs, working in independent pharmacies, and more likely to remain working in community pharmacy. However, it is possible that some of these effects, for example on satisfaction and the related likelihood of staying in community pharmacy are a longitudinal effect of increasing satisfaction as the new contract was embedded rather than reflecting an inherent difference in the groups. They might also reflect the fact that those more dissatisfied took the early opportunity of expressing this via our survey.

The additional workload reported reflects the new services provided and additional requirements within essential services, with much of the latter possibly reflecting increased recording requirements rather than a change in service provision, for example the recording of significant OTC purchases. Although many pharmacists report they were already doing 'campaign based healthy lifestyle promotion activities' (70%), 'prescription linked healthy lifestyle interventions' (75%) and 'signposting' (75%) prior to the new contract they may be referring to meeting the previous requirement to display leaflets rather than the interaction with patients and carers explicit in CPCF. This may explain the apparent contradiction in findings of perceived increased workload and the reports of already doing things. So whilst much of the new contract, including the locally commissioned services, were being provided before the new contract, and the new contract was more intended as a new model for payment to recognise this work, rather than specifically to increase work, the reality is that workload has inexorably increased, including steadily increasing dispensing volume.

In response to this increased workload most pharmacists have delegated work to non-pharmacist staff and many to other pharmacists. Furthermore, a substantial minority are planning further staffing changes. Thus a better more appropriate skill mix may be emerging, although detailed exploration of this would be needed to identify the tasks delegated, the competencies of those now delivering them, and the outcomes.

Many pharmacists report they are working longer hours since the new contract. Nearly one half of pharmacists were working more than 40 hours per week. Over a quarter were not satisfied with their hours of work, a third reported that they experienced pressure due to their home life being disturbed by work, over

forty per cent reported difficulties dividing time between work and family, and experienced pressure from the long working hours. The European Working Time Directive (EWTD)[12] implemented by regulations in the UK in 1998 and 2003 state that 'a worker's working time, including overtime, in any reference period which is applicable in his case shall not exceed an average of 48 hours for each seven days', although this limit does not apply if the worker has agreed with his employer in writing that it should not apply in his case. Whilst we have no definite data from our survey of how many of the responders working more than 40 hours were in fact exceeding the recommended 48 hours, it seems likely that at least some would have been. This calls into question a pharmacist's ability to work effectively when clearly stressed and potentially fatigued.

Data from the survey shows pharmacists still spend most of their time dispensing and checking prescriptions, and this is corroborated by the prospective detailed work study logs. Although the balance between technical and clinical activities in relation to dispensing was not explored it would appear that the new contract may not yet have achieved the desired shift from technical to cognitive roles for pharmacists. It may be too early for this to have emerged, as in order for staff changes to be made, pharmacists would need reassurance on the stability of levels of new service provision and the income streams associated with them.

Current and planned provision of the new MUR service shows a high level of engagement. A quarter of pharmacists have hired a locum to support MUR provision. If this pattern extends to new MUR providers it will increase pressure on the locum pool. Whilst this engagement has contributed to the increased workload and working hours, the pharmacists report it being rewarding to deliver. This is reflected in the fact that when all things are taken into account, providing MURs is the most important factor in increasing pharmacists' satisfaction. However, for the benefits of the MUR service to patients to be maximised, more cooperation is required with GPs, in both targeting the patients most likely to benefit, agreeing goals and jointly implementing actions. Nearly a fifth of our respondents indicated that the new contract had improved their relationships with GPs, and the qualitative data suggest this could sometimes be as a result of the MUR service. As the MUR service becomes more widely established and positive outcomes from formal evaluations are disseminated it would be expected that the numbers reporting improved working relationships with GPs would increase. A similar scenario exists for the repeat dispensing service where, for it to be most successful, GPs should ideally be involved, yet poor current relationships will be a barrier to more widespread implementation of the service.

Overall effects of CPCF on pharmacists' job satisfaction are mixed and on balance there are more negative than positive impacts. Whilst on univariate analyses several things seemed to be associated with an increased likelihood of increased satisfaction, such as designated role (those in non managerial/ownership positions were more likely to be satisfied) and age, the multifactorial analysis showed that the only important predictors were engagement in MUR services and responding later to the survey. However, although overall nearly a third were less satisfied since the new contract had

been introduced the majority felt it had made little difference to their satisfaction. In absolute terms, over two thirds were neither satisfied nor dissatisfied with their role. Although some had hoped that the new contract might improve recruitment and retention in community pharmacy it is probably too early to say to what extent this has happened. As noted above it seems likely that it is still too early for attitudes to have stabilised and the longer term effects to be established. If the indications of the chronological analysis of responses are fulfilled then as time goes on pharmacists will have had time to adjust to the new roles and appreciate the increased professional rewards of increased patient contact and greater clinical responsibility.

Issues of training and pharmacist self confidence to deliver new roles are also inextricably linked. The services witihin the new contract provided opportunities for a much greater clinical role for community pharmacists, so it is not surprising that whilst a need for training was identified across all suggested areas of activity, clinical training was the one requested by most responders (90%). Given the reported increased workload it is also not surprising that lack of time was reported to be the biggest barrier to obtaining training. Perhaps the competing demands and interests of different pharmacists and staff members also require more flexibility and guidance from their managers and PCO contacts, and targeting multiple pharmacy companies to explain local requirements. With time, and as the new contract becomes the normality, pharmacists should be gradually able to access the training they need to deliver the new roles confidently and competently, with increased professional satisfaction and financial reward. However, it may also be relevant to consider to what extent protected training time should be incorporated into future contract revisions.

Demands from the new contract, generally increased workload and specifically increased paper work have resulted in increased stress. The effects of the CPCF on pharmacists' stress are however difficult to disentangle because we do not have the before/after CPCF data in the same way as we do for satisfaction. However, based on evidence of increased workload it seems reasonable to assume that the contract is likely to have increased pharmacists' stress, at least in the short term.

5. Overall conclusion

The vast majority of community pharmacies are engaging well with the new contract and there has been a general increase in the range and extent of delivery of innovative new services. Participation in the MUR service was associated with increased pharmacist satisfaction. Pharmacists reported increased workload associated with the new contract, in response many had delegated work to other staff and a substantial percentage were planning other staffing changes. Many said they were often stressed by the daily demands of their work and a large minority reported the new contract had had a negative effect on their job satisfaction. However overall the majority are neither particularly satisfied or dissatisfied and the new contract has had little overall effect on the job satisfaction of the majority of pharmacists.

References

1. Hassell K, Shann, P. Overview of main census Pharmaceutical Journal 2003; 270:314-315
2. Mullen, R., Hassell, K The primary care pharmacy workforce in Britain Pharmaceutical Journal 2003; 271: 326-327
.3. Pharmaceutical Services Negotiating Committee (2006)

   http://www.psnc.org.uk/index.php?type=page&pid=108&k=2
4. Anonymous Community pharmacists vote “yes” to new contract Pharmaceutical Journal 2004; 273: 773
5. The electronic prescription service Connecting for Health NHS 2006
6. Testing of EPS release 2 at least six months behind Pharmaceutical Journal 2008; 280: 167
7. Blenkinsopp, A., Bond, C., Celino,G., Inch, J., Gray, N. national Evaluation of the new community pharmacy contract June 2007 Report to Pharmacy Practice Research Trust
8. Bond, CM, Inch J, Grant A, Scott A, Lee AJ. Examining alternatives for the remuneration of community pharmacy Final report to the Scottish Pharmaceutical General Council Research Trust. University of Aberdeen 2005.
9. Warr,P., Cook, J. & Wall,T. (1979) Scales for the measurement of some work attitudes and aspects of psychological well-being. Journal of Occupational Psychology, 52, 129 -148
10. Ritchie, J and Lewis, J. Qualitative Research Practice: A Guide for Social Science Students and Researchers. Sage 2003.
11. Hassell K, Seston L, Eden M, Pharmacy Workforce Census 2005: Main findings. Royal Pharmaceutical Society of Great Britain:London 2006
12. Statutory Instrument 2003 No. 1684 The Working Time (Amendment) Regulations 2003 Statutory Instrument 1998 No. 1833 The Working Time Regulations 1998

Box 1. New Work in Essential Service Provision

Service	Provided before 'New Contract'	Additional requirements of 'New Contract
Repeat Dispensing	Piloted in 20 "pathfinder" PCOs prior to the new contract	Pharmacist ascertains the patient's need for a repeat supply and communicates any clinically significant issues to the prescriber. The pharmacist also securely stores a patient's repeatable prescription.
Disposal of unwanted medicines	No. Although most PCOs had in place some arrangements to collect waste from pharmacies before the new contract, these arrangements provided pharmacists with a mechanism to safely dispose of medicines but did not place an **obligation** on the pharmacist to inform patients of this service and to accept waste for disposal.	PCOs need to have in place suitable arrangements for the collection and disposal of waste medicines from pharmacies. Pharmacies obliged to accept and to advertise service to patients.
Campaign based healthy lifestyle promotion activities	No. Although pharmacies were obliged to hold and display a selection of leaflets for patients.	Pharmacy to pro-actively take part in National and Local campaigns determined by the PCO. This service has to be provided to the PCO for up to 6 campaigns per year. The pharmacy has to record the number of patients who receive advice if requested by the PCO.
Prescription linked healthy lifestyle intervention	No. Although pharmacies were obliged to hold and display a selection of leaflets for patients.	Pharmacy to provide opportunistic advice as appropriate on specified healthy living/public health topics to people presenting prescriptions for diabetes, those at risk of CHD, especially patients with high blood pressure, those who smoke and patients who are overweight. Advice to be recorded on the patient's medication record.
Signposting service	No. Although pharmacies were obliged to hold and display a selection of leaflets for patients.	Pharmacy to inform or advise people visiting the pharmacy of other health and social care providers and support groups. A written referral may be provided if appropriate and a record kept if the patient is known in the pharmacy. PCOs need to provide details of health and social care providers.
Support for self care	Yes	Recording of OTC purchases for regular patients / of clinical significance.
Clinical governance	No previously specified requirements	Many aspects that could be regarded as new including participation in two audits per year.

Support for people with disabilities was withdrawn before the new contract was agreed.