THE A.R.T. OF COMMUNITY PHARMACY: ADVICE-ONLY, REFERRALS & TREATMENT

Advice Referral Treatment

OVER 2,100 PEOPLE

in Scotland are provided with advice-only from community pharmacy every hour, which would equate to 84,000 instances a week.

4/5 PEOPLE

accessing community pharmacy rated complete satisfaction of overall experience

3/4 BELIEVE

patients believe community pharmacists should have access to electronic health records

9/10 PEOPLE

want their GP and pharmacist to work closer together

6/10 PEOPLE

access community pharmacy because of the existing relationship with staff

2/5 PEOPLE

would go to their GP if community pharmacy was unavailable

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Executive Summary

Eight community pharmacies in Scotland participated in a research project to explore the value of professional services. Provision of these services was measured assessing: advice-only* instances (in the absence of an item being sold or prescribed) recorded using a handheld scanner, referrals which were manually logged, and treatment, where those receiving a medicine or item were provided with a questionnaire to report their experiences. Interviews with patients and staff were also conducted to provide perceptions and experiences of the service from both those who access the service and those who provide it.

- From the data it is estimated that 2,100 people in Scotland are provided with advice-only from community pharmacy every hour, which would equate to 84,000 instances a week. See Pages 10/11
- 4 out of 5 (80.5%) people accessing community pharmacy rated complete satisfaction of overall experience. See Pages 14/15
- 6 out of 10 (57%) people access community pharmacy because of the existing relationship with staff. See Pages 15/16
- 2 in 5 (41%) of people would go to their GP if community pharmacy was unavailable. See Pages 16/17
- 9 out of 10 (93%) want their GP and pharmacist to work closer together. See Page 20
- 3 out of 4 (74.5%) patients believe community pharmacists should have access to electronic health records. See Page 21

*advice-only refers to instances where the result of patient interaction has been the provision of advice in the absence of selling or dispensing a medicine or item.

Introduction

Community pharmacies in Scotland are accessed by an estimated 600,000 people per year with around 94% of the population using the services at least once every year[1]. The structure of the UK healthcare model places community pharmacy at the front line of healthcare delivery. This is made possible by an expanding range of services coupled with a delivery model that is designed to maximise accessibility through appointment free access and extended hours of opening. Treatment at community pharmacies can also provide medicines at a reduced cost compared to similar services offered by other healthcare services[2,3] and has the potential to alleviate other more pressured services such as those in General Practices. An increasing number of general practitioners have been shown to experience burnout and exhaustion due to the demands of service provision through high levels of patient demand[4] which community pharmacy has the potential to alleviate. Despite this, GP's awareness of community pharmacy services had been documented as low and collaboration with pharmacists reported as poor[5].

Community pharmacies provide the general public with a service that consists of 3 functions: advice-only, referral and treatment. Advice-only results in the provision of information based on staff knowledge and expertise that provides satisfactory care in the absence of medicines. Referral occurs where assessment has led to the informed decision to transfer the care of a patient to an appropriate alternative healthcare professional. Treatment is a situation where a medicine, medically related item, or service is provided to alleviate ill health or promote wellbeing. These three functions characterise the contribution that community pharmacy provides to the National Health Service (NHS). Community pharmacy is promoted as the first port of call for minor ailments, public health issues, and the care of people with long-term conditions. As both technology and legislation evolve, the provision of care at community pharmacies has grown to accommodate more services and treatments whilst managing an aging population with well-reported health inequalities that adds further demand to the service[6].

To address these evolving demands, patient-centred services such as the minor ailment service and chronic medication services were incorporated into the structure of community pharmacy beyond the traditional dispensing of medications. Treatment provision also extended to cover a greater variety of care, such as: emergency contraception, needle exchange, flu vaccinations, and smoking cessation. The development of independent prescribers also provides, for those qualified, the ability to prescribe medicines autonomously for any condition within their clinical competence and almost a quarter of community pharmacists in Scotland hold this qualification[7]. This opportunity for pharmacists has spurred the upskilling of the wider healthcare team where those in other roles engage in further training and education, such as the accuracy checking of dispensed items by accuracy checking technicians.

However, as the service and expectation of community pharmacy has evolved, it is argued that the general public are relatively unaware of the breadth of service provision. Evidence has shown that even in those with long-term conditions, awareness of community pharmacy capacity and regard for community pharmacy as a self-care resource are limited regarding the extended services available[8]. Low public uptake and awareness of the general public has also been attributed to the limited perception of community pharmacy services as 'dispensing only'[5] which has led to barriers to successful implementation of these services.

The quality of patient experience dictates not only repeated access of a service but also concordance with healthcare advice and treatments leading to enhanced clinical and cost effectiveness[9]. The understanding of these experiences is critical in demonstrating the capacity of the service and helps to inform future developments. A mixed methods approach to explore the contributions of community pharmacy from both patient and professional perspectives would fully demonstrate the role, contribution and potential that community pharmacy makes within the Scottish National Health Service (NHS).

Case Study Three (Pg.34)

"When you go in it's not like your being spoken down to but they speak with you, have a conversation….in a way I think they make me think more about it too because I'm actually speaking to people about my health and my arthritis which was a big thing to get used to."

Aims & Objectives

The aim of this study was to explore the contributions of community pharmacy by exploring the experiences and perspectives of both those who provide the service and those who access it.

The research objectives were to:

i) ADVICE-ONLY: Quantify the instances of 'advice-only' to determine the frequency, content and provider of these events.

ii) REFERRAL: Recording all instances of referrals made to other healthcare professionals.

iii) TREATMENT: Elicit experiences and perceptions of those receiving treatment, such as: overall satisfaction, perceptions of clinical empathy from consultations, reasons for the informed access to the service (identifying where other healthcare services had potentially been alleviated), overall perceptions and knowledge of community pharmacy, and attitudes towards electronic healthcare record access.

iv) PATIENT EXPERIENCES: Produce case studies that exemplify the unique and characteristic experiences of those accessing the service.

v) STAFF EXPERIENCES: Provide insight into the experiences of those providing the service.

Methods

Across Scotland, eight community pharmacies were selected for inclusion in the study. The study sites were sought to represent the diversity of community pharmacies based on several factors: relative deprivation of the pharmacy postcode, urban and rural locations of the pharmacy, and whether the pharmacy was independent or part of a larger multiple group (Table 1).

Table 1. Variable information of eight study sites

Location	Relative Deprivation*	Urban or Rural	Independent or Multiple
1	10	Urban	Multiple
2	3	Rural	Independent
3	4	Rural	Independent
4	1	Urban	Independent
5	4	Rural	Independent
6	1	Urban	Multiple
7	4	Urban	Multiple
8	5	Rural	Multiple

*Scores obtained from Scottish Index of Multiple Deprivation 2016

Sites were visited sequentially by the lead researcher (LB) between November 2019 and January 2020, except for site 8. This was due to the difficulty of travel to this location which led to the pharmacist at this location receiving a study pack and instructions via post. Each site had an appointed pharmacist who was contacted by the lead researcher (LB) to discuss the project and what it would entail so this could be communicated to their pharmacy teams. All site visits were arranged in advance with these pharmacists to ensure that a one-week participation in the study would not interfere with other commitments or overburden the existing workload. Participation in the study commenced on the same day as the visit from the lead researcher (LB) where all staff on-shift were informed of the purpose of the study, what their participation would require and a brief training and demonstration of the data

collection tools for the three arms of enquiry: advice-only, referrals and treatment, as shown in Figure 1. Staff were to engage in only one of these data collection methods based on the outcome of each unique patient interaction during their week of participation in the study; a barcode scanner collected data on advice-only instances, referrals were manually logged in a log book, and patients who had received treatment (through the sale or dispensing of a medicine) were provided with a questionnaire. All remaining study pack items were posted back to the lead researcher at the end of the one-week participation period in a prepaid envelope.

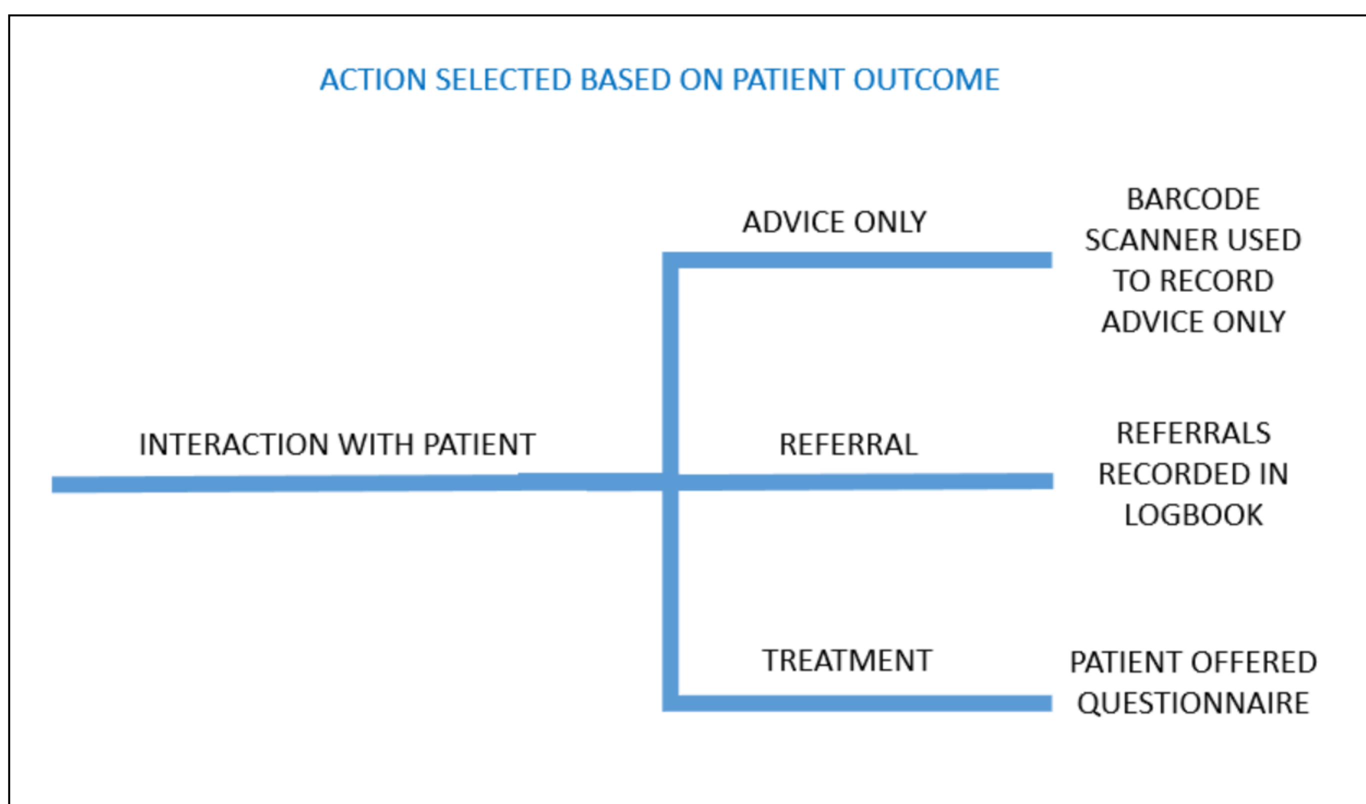


Figure 1. Model showing the three possible outcomes of patient interaction

ADVICE-ONLY

When the patient outcome was advice-only (no item was sold or prescribed nor was a referral made to another healthcare professional), the assigned data collection tool was a handheld scanner and barcode sheet with categories of potential advice categories.

The barcode scanners collected all the data which could only be accessed by the lead researcher at the end of the one-week data collection period.

The barcode sheet consisted of three pages where a scan was required for six consecutive questions relating to the particular outcome of advice with a patient. The questions ascertained the details of each advice-only consultation: the role of the staff member, the day of the week, the time of day, length of time spent giving advice, if the patient was registered to the Minor Ailment Service (MAS) or the Chronic Medication Service (CMS), and what type of advice was given. The first five questions were on the front page and the final question pertaining to type of advice provided filled the other two pages with twenty-two potential categories of advice, as exemplified in Figure 2, and one bar code that could be used to indicate a mistake had been made, allowing the researcher (LB) to know which string of scans to exclude.

Figure 2. Example of barcode

Staff could select more than one category if they felt that this represented the advice they had provided. These were added to the same string of six inputs without repeating answers to the first five questions and to differentiate from unique advice provisions. In instances where advice was given suggesting the potential visit to another healthcare professional, this was considered advice-only due to the outcome being a recommendation rather than a direct referral. Instances of advice-only were also recorded when this was the outcome of a telephone conversation as this was deemed to be of similar use of staff time and knowledge as face-to-face interactions.

Data were downloaded from the scanner to a secure computer. Each instance of a complete answer to all six questions was manually separated and any instance ending in the ‘Mistake’ barcode were excluded. This data was input and handled using the Statistical Package for the Social Sciences® (SPSS®) where each community pharmacy had a unique identifier so that data could be viewed as both site-specific and as an aggregate.

REFERRAL

Each study pack contained a hardback logbook in which staff recorded any instance of referral to another healthcare professional and both the date and specific occupation of the professional were noted. No personal details or reason for referral were recorded to protect the anonymity and confidentiality of referral outcome data.

TREATMENT

Where the outcome of patient interaction was neither advice-only nor referral but the provision of a treatment by medication, the patient was approached to participate in the study by providing feedback on their experiences of accessing the community pharmacy on that particular day. Herein, patients who participated in the research project through filling and returning a questionnaire or participating in a telephone interview will be referred to as 'participants'. Those who expressed an interest in taking part were provided with an envelope which contained an information sheet, questionnaire, and pre-paid addressed envelope with which to return the questionnaire to the lead researcher (LB). The questionnaire consisted of 17 items and took eight to ten minutes to complete. These items included questions relating to basic sociodemographics, day and time of access, satisfaction of overall experience, reasons for accessing community pharmacy, opinions on electronic health record access, which other services they may have accessed had community pharmacy not been available, existing knowledge of the services and competencies of community pharmacy, perceptions of community pharmacy as a whole, and experiences of consultation.

Case Study Five (Pg.36)

"They're sometimes the only person besides my husband I can speak to in a day and I can tell you I have some tough days too so it means a lot to me that I can be honest with them and for them to listen like they do."

'Experience of the consultation' was measured using the Consultation and Relational Empathy (CARE) Measure[10] which consists of questions that relate to ten facets of 'relational empathy' by which participants self-report their experiences of a healthcare consultation. The facets are: Making you feel at ease, Letting you tell your story, Really listening, Being interested in you as a whole person, Fully understanding your concerns, Showing care and compassion, Being positive, Explaining things clearly, Helping you to take control, Making a plan of action

with you. Each facet is accompanied by a brief description of what these behaviours may be to encourage an informed decision in reporting, for example Making you feel at ease is accompanied with "*Introducing him/herself, explaining his/her position, being friendly and warm towards you, treating you with respect; not cold or abrupt*".

This assessment tool has been used generally in relation to patient consultations in General Practice but can be applied to the community pharmacy environment[11]. All eight community pharmacies were provided with an initial 200 questionnaires and were able to request more should they distribute all of these before 50 were returned with the CARE measure completed. This was to ensure that each site provided a minimum of 50 responses as this is the number required for the CARE measure to be valid per location. Each community pharmacy was allocated its own unique identifier which allowed responses to be tracked individually for each site.

Each questionnaire was given a unique sequential identification number and responses were manually entered into an SPSS® file. To ensure accuracy of data input, 10% of responses were selected for manual rechecking by the lead researcher (LB) using a random number generator with each number corresponding to the matching identification number. The final page of each questionnaire allowed the participants to volunteer for a telephone interview to further explore their experiences.

PATIENT INTERVIEWS

Questionnaire participants could volunteer to be further involved in the study, as noted at the end of the questionnaire they were given. Those who volunteered, provided an address to which an information sheet and consent form, pertaining to a telephone interview, could be sent to with a pre-paid addressed return envelope. When a completed consent form was returned, the participant was contacted on the telephone number that they had provided and within any time parameters they specified.

Case Study Four (Pg.35)

"I know it sounds weird but you know when you make an appointment you know that it's now set at a time and you have to be there, it just, I can't deal with it. If I can go when I feel like I can then it's not like I'll let someone down."

The interviews were semi-structured to allow a focus to be maintained whilst providing the opportunity to explore any unexpected experiences that were captured by the set questions. The interview schedule was designed to further explore the responses given in the questionnaire and their personal experiences. A reflective and person-centred approach was used to interview participants to elicit deep and meaningful responses.

Transcript data was analysed hermeneutically and treated as lived experiences where personal stories were written first and then the consistent overarching themes they represented were identified. NVivo® was used to explore the data running a combination of frequency and count queries to identify general patterns.

STAFF INTERVIEWS

Community pharmacy staff were interviewed about their experiences and perceptions of the service. These interviews included all staff roles within community pharmacy and were initially planned to be conducted face-to-face on the day of the visit. Some sites however became too busy on these days, so some interviews were re-scheduled and conducted by telephone. The staff interviews were semi-structured, audio recorded and transcribed verbatim. The interview schedule was designed to explore staff roles in relation to their contribution, how their practice is shaped and informed, their perceptions of community pharmacy as a whole, and what they believe patients and the general public expect and know about the service.

Case Study Six (Pg.37)

"She [pharmacist] took time out of her day to go above and beyond, and I know the service is their job but it wasn't like I was in asking about it or anything…I would go to the pharmacy now a lot more than I would have before and [pharmacist] and her staff are really friendly…they would do anything for you."

Staff interviews were analysed by NVivo® using a similar process of queries to identify patterns in the data. Overarching Thematic Analysis was applied to staff interviews as the focus was less on the lived experiences and was concerned primarily with their occupational experience and their own views towards community pharmacy.

Results

ADVICE-ONLY

A total of 657 advice-only instances were recorded via the handheld barcode scanners and corresponding barcode sheets. Table 2 displays the breakdown across the 8 sites and in relation to total hours open. Each instance answered the six questions relating to the provision of advice-only: the role of the staff member, the day of the week, the time of day, length of time spent giving advice, if the patient was registered to the Minor Ailment Service (MAS) or the Chronic Medication Service (CMS), and what type of advice was given.

Table 2. Breakdown of advice-only instances across study sites: Total and per hour open

Pharmacy Sites	1	2	3	4	5	6	7	8
Total Advice	37	78	146	84	85	85	80	62
Hours Open	53.5	47.5	50.5	40.5	41.5	62	55	51
Advice Per Hour	0.69	1.64	2.89	2.07	2.05	1.37	1.45	1.22

In most instances, the provision of advice lasted less than five minutes (n=438, 66.7%) or between five and nine minutes (n=198, 30.1%), with few instances lasting between ten and fourteen minutes (n=18, 2.3%) or over fifteen minutes (n=3, .4%). A registration for MAS was known more often (n=105, 16%) than CMS (n=16, 2.4%) but in most cases this detail was unknown (n=536, 81.6%).

Table 3. Percentage of advice provision by staff role (n=657)

Staff Role	n	%
Pharmacist	305	46.4
Technician	61	9.3
Counter Assistant	269	40.9
Student	22	3.3

Pharmacists provided advice most often (n=305, 46.4%), followed by counter assistants (n=269, 40.9%) (Table 3). Advice-only was given an average of 1.67 times every hour per pharmacy. With a conservative estimate of a 40-hour working week, this would result in 66.8 advice-only outcomes of patient interaction in one working week. This would equate to 2,100 instances of advice-only every hour a pharmacy is open across all community pharmacies in Scotland. This is approximately 84,000 instances of advice-only each week across the entire service during operational hours.

REFERRAL

Each of the community pharmacies recorded their referrals to other healthcare professionals during the one-week period. These ranged from 1 to 11 with a mean of 6.25 and median of 7. The most common referral was to the GP (n=29, 58%) and NHS 24 (n=10, 20%) (Table 4).

Table 4. Total number of referrals from each community pharmacy in one week

Pharmacy Site	1	2	3	4	5	6	7	8
Total Referrals	11	8	2	6	1	9	10	3

TREATMENT

In total, 446 questionnaires (Table 5) were returned across the eight study sites. Responses across all 8 sites remained consistent when separated by location, this was also true when the data was split based by census working age (Early: <24yrs n=14, Prime: 25-54yrs n=138, Mature: 54-64yrs n=102, Elderly 65+yrs n=192). Any discernible differences found across location or age are noted throughout the report.

Table 5. Total number of questionnaires returned from each community pharmacy (n=466)

Site Location	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
Total Questionnaires	70	55	59	53	60	69	55	25

The most common reason for accessing the services of community pharmacy was to collect prescribed medication (n=269, 60.3%), followed by buying medicines (n=104, 23.3%), seeking medical or health advice (n=61, 13.7%) and general shopping (n=12, 2.7%).

Most participants reported accessing the pharmacy for themselves (n=363, 81.4%); access for a child (n=42, 9.4%) and for another adult (n=41, 9.2%) were reported less frequently. Those of the prime working group were most likely to visit the pharmacy for a child (n=38, 27.5%) where the other three groups reported this less (Early: n=1, 7.1%; Mature: n=1, 1%; Elderly n=2, 1%) and the early working group was the only age group to not report visiting for another adult (n=0, 0%).

Case Study Two (Pg.33)

"They're all great. They smile and when I tell them something they listen…and I can see how busy they can be but they still take a time for me."

Participants reported both the day and time (Figures 3 & 4) they accessed their community pharmacy to explore the spread of responses across the longer opening hours of community pharmacies compared to other healthcare services. Each site participated for a week which started from the day when the lead researcher (LB) visited and the initiation of each pharmacy's participating week was therefore spread across different days.

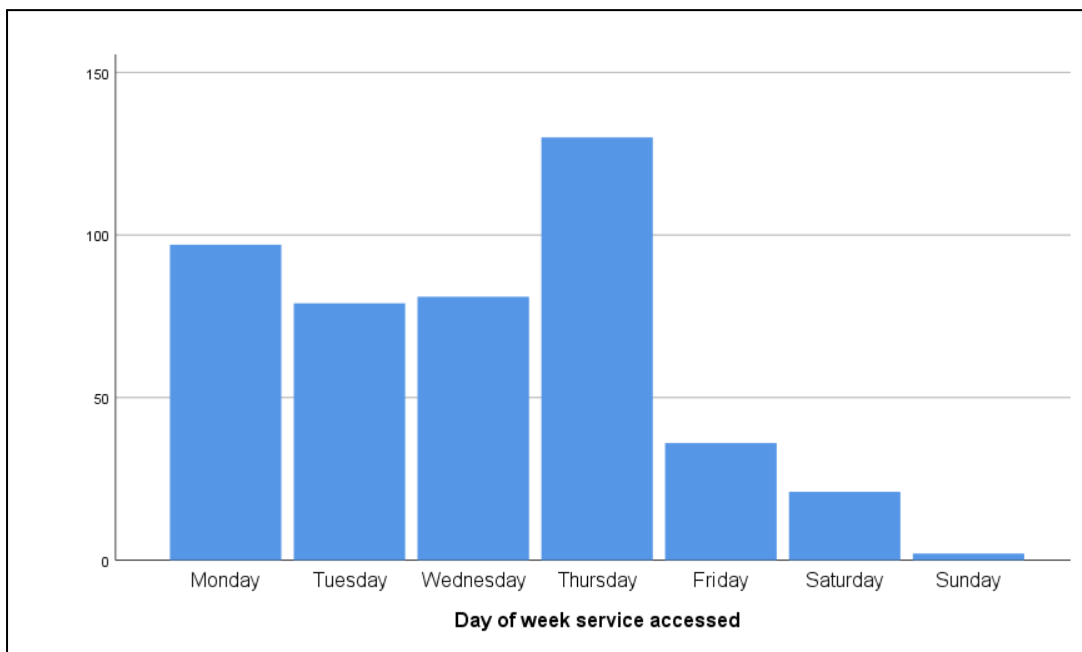


Figure 3. Total responses reported for day of community pharmacy visit (n=446)

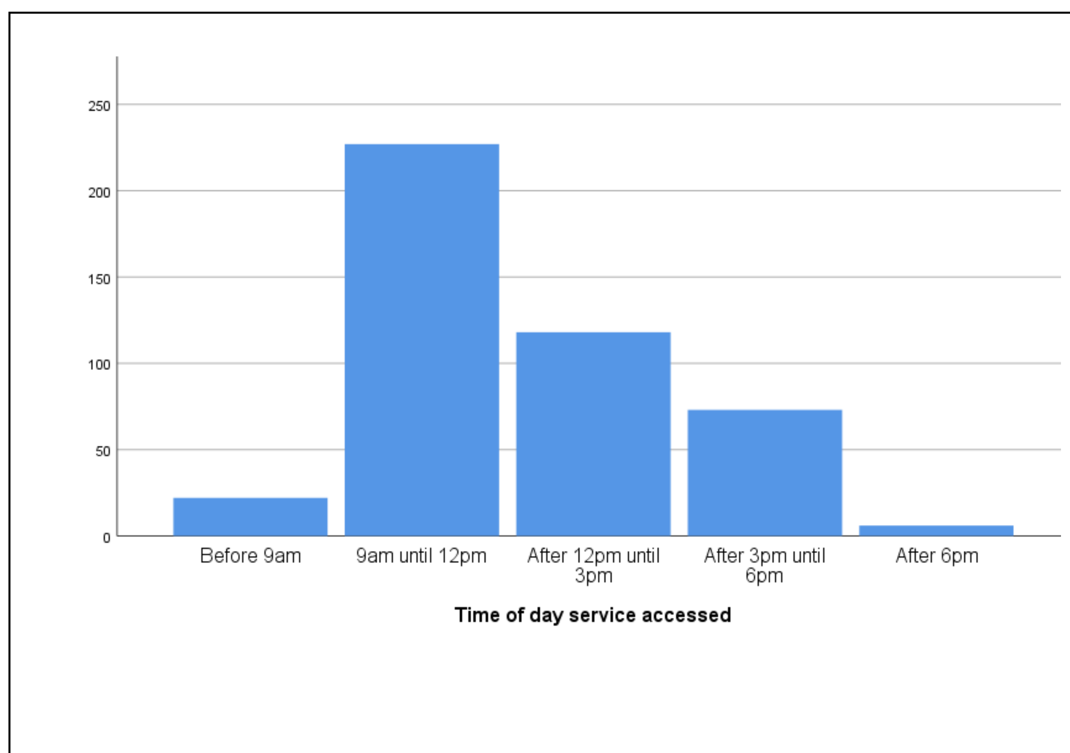


Figure 4. Total responses reported for time of community pharmacy visit (n=446)

Participants were asked what the outcome of their treatment was: Advice, Treatment, or Referral (Table 6). Participants could select more than one response, if appropriate, or a combination of any of the three outcomes. As all staff were instructed to only provide patients with a questionnaire if they received a treatment or medicines, advice reported in the questionnaire is concurrent advice and not advice-only.

Table 6. Total number of responses indicating outcome of accessing community pharmacy (n=446)

Outcome of visit	n	%
Advice*	103	23.1
Referral	9	2.0
Treatment	424	95.1

*Advice that was provided *alongside* the provision of a medicine or item

Treatment was the outcome in most cases (n=424, 95.1%), with advice being delivered in almost a quarter of all interactions (n=103, 23.1%), followed by referrals being reported far less frequently than treatment or advice (n=9, 2.0%).

Participants were asked to rate their overall experience on a scale from 1 'Not at all satisfied' to 10 'Fully satisfied' (Figure 5).

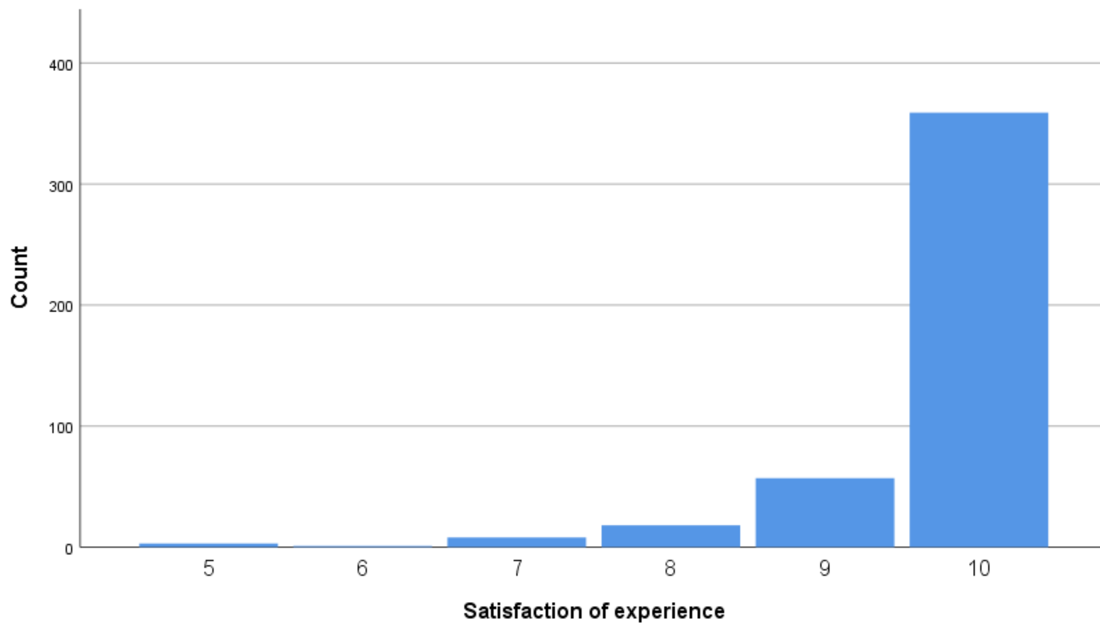


Figure 5. Reported satisfaction of overall experience (n=446)

Most participants reported a score of 10 ('Fully satisfied') (n=359, 80.5%) for overall satisfaction, with 12.8% scoring 9 (n=57), followed by scores of 8 (4%) and 7 or below chosen by 12 individuals (2.7%). No scores of 4 or below were reported.

Participants were asked their main reasons for choosing the services of community pharmacy (Table 7). Nine possible options were given; however, participants could choose several reasons to accommodate the multifaceted nature of the patient access selection and not mask potential co-influencing factors. The three most reported factors for accessing the services of community pharmacy were 'Convenient location' (n=277, 62.1%), 'Good relationship with the pharmacy already' (n=254, 57.0%), and 'Have used the service before' (n=246, 55.2%).

6/10 PEOPLE

access community pharmacy because of the existing relationship with staff

Table 7. Responses indicating reasons for accessing services at community pharmacy (n=446)

Day of Week	n	%
Convenient location	277	62.1
Good relationship with the pharmacy already	254	57.0
Have used the service before	246	55.2
Didn't have to travel far	138	30.9
No appointment needed	128	28.7
Not serious enough to go to a GP	98	22.0
Have seen/heard to visit pharmacy as a first port of call	48	10.8
No able to access a GP or nurse appointment in a reasonable timeframe	44	9.9
Open when other services are not	27	6.1

When asked if they would have accessed General Practice for treatment had the community pharmacy been unavailable, 183 (41%) participants stated that they would have accessed this service instead.

Participants were then asked if there were any other services they would have accessed or actions they would have taken (Table 8). The three most reported services/actions were 'No further action or service' (n=163, 36.5%), 'Purchasing medication independently' (n=140, 31.4%), and 'Calling NHS 24' (n=118, 26.5%). This suggests that 336 contacts with the NHS either via the GP, NHS 24 or Accident and Emergency visits had potentially been prevented in

a 7-day period in these 8 pharmacies. With an average of 42 potential contacts alleviated at each site, this would estimate, that community pharmacy services may divert over 52, 700 instances of treatment from other NHS services per week.

Table 8. Total number of responses of alternate access to services/ actions if community pharmacy not available. Note: Access to GP was asked dichotomously Yes/No. Other answers were responses to secondary questioning (n=446).

Service/Action	n	%
GP Practice	183	41.0
NHS 24	118	26.5
Accident & Emergency	35	7.8
Independent purchase of medications	140	31.4
Advice from family/ friend	44	9.9
Only advice	56	12.6
No further action	163	36.5

Of the returned questionnaires, 398 participants had fully completed the CARE measure indicating that they had perceived an interaction with at least one staff member during their visit that resulted in a dialogue or consultation (Table 9). The median responses for the first 9 facets of the CARE measure were 'Excellent', with Making a Plan of Action With You ranked as 'Very Positive'. When split by age, median ranking remained consistent with the exception 'Really listening' and 'Being positive' in the Elderly working group where the median was 'Very Good', and. When split by location, most pharmacies median scores were 'Excellent' with a minority scoring 'Very Good' across several facets.

Table 9. Responses to CARE measure: Percentages across response options (n=398)

CARE Measure Statement	% Excellent	% Very Good	% Good	% Fair	% Poor
Making your feel at ease	61.1 (n=243)	30.4 (n=121)	7.0 (n=28)	1.3 (n=5)	0.3 (n=1)
Letting you tell your 'story'	62.3 (n=248)	29.6 (n=118)	7.3 (n=29)	0.8 (n=3)	0.0 (n=0)
Really listening	56.5 (n=225)	35.9 (n=143)	6.5 (n=26)	0.8 (n=3)	0.3 (n=1)
Being interested in you as a whole person	64.1 (n=255)	27.1 (n=108)	7.8 (n=31)	1.0 (n=4)	0.0 (n=0)
Fully understanding your concerns	59.5 (n=237)	28.9 (n=115)	10.3 (n=41)	1.0 (n=4)	0.0 (n=0)
Showing care and compassion	56.8 (n=226)	31.7 (n=126)	10.6 (n=42)	1.0 (n=4)	0.0 (n=0)
Being positive	56.5 (n=225)	31.4 (n=125)	11.3 (n=45)	0.8 (n=3)	0.0 (n=0)
Explaining things clearly	60.3 (n=240)	29.6 (n=118)	8.3 (n=33)	1.8 (n=7)	0.0 (n=0)
Helping you take control	54.7 (n=218)	136.0 (n=34.2)	40.0 (n=10.1)	4.0 (n=1)	0.0 (n=0)
Making a plan of action with you	49.5 (n=197)	37.4 (n=149)	10.3 (n=41)	2.8 (n=11)	0.0 (n=0)

Whilst only those who experienced a consultation with a staff member could report their perceived reception of clinical empathy (n=375), all 446 participants responded to questions regarding their knowledge and perceptions of community pharmacy and their thoughts related to electronic health record access.

Participants were presented with four aspects of community pharmacy service delivery and asked about their knowledge of it (Table 10).

Table 10. Responses to existing knowledge about community pharmacy services (n=446)

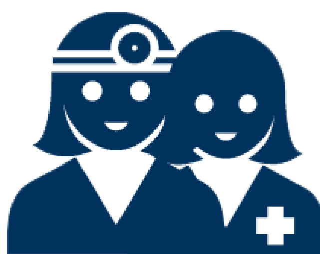
Service/Action	n	%
Community pharmacies are contracted by the NHS to deliver a range of services	318	**71.3**
Community pharmacy premises must have a private consultation room	336	75.3
Pharmacists are bound by 'fitness to practise' regulations and professional standards similar to those set for GPs	272	61.0
Pharmacists with an additional qualification can diagnose and prescribe for conditions within their area of competence	316	70.9

Participants stated the extent to which they agreed with six statements using a five-point Likert scale to ascertain their views and perceptions of community pharmacy as a whole. Participants could respond with strongly agree, agree, unsure, disagree, strongly disagree. These responses were aggregated into three responses for Agree, Unsure, and Disagree (Table 11).

Table 11. Responses to questions regarding perceptions of pharmacy services (n=446)

Service/Action	% Agree	% Unsure	% Disagree
I am confident that a community pharmacist will provide advice as safely as a GP	82.3	14.6	3.1
I would recommend consulting a community pharmacist to other people	84.5	11.7	3.8
Given the choice, I prefer to consult a GP rather than a community pharmacist	46.6	30.5	22.9
I want my community pharmacist and doctor/ GP to work together to make sure I am receiving the best treatment	93.0	4.9	2.0
I want the wider healthcare team including doctors, nurses and pharmacists to work together in providing my care	88.3	9.6	2.0
I am more interested in the quality of care I receive than who delivers it	84.0	7.6	8.3

9/10
PEOPLE



want
their GP and pharmacist
to work closer together

Participants were also asked to indicate the extent to which they agreed with five statements relating to community pharmacy access to electronic health records, using the same five-point Likert scale responses as the previous question (Table 12).

Table 12. Responses to questions regarding electronic health record access (n=446)

Service/Action	% Agree	% Unsure	% Disagree
Community pharmacists should have access to read and update relevant parts of my electronic health record	**74.2**	**14.8**	**10.9**
I trust the community pharmacist to protect my confidentiality	89.2	7.0	3.8
I would be concerned that my electronic health record could be read by other people in the pharmacy	41.5	26.2	32.3
I would feel more confident in the treatment I receive if the community pharmacist had access to my electronic health record	66.3	21.1	10.5
I would be more likely to view community pharmacy as my first port of call for health issues if the pharmacist had access to my electronic health record	62.3	22.2	15.5

3/4
BELIEVE

patients believe community pharmacists should have access to electronic health records

PARTICIPANT TELEPHONE INTERVIEWS

Of the 42 participants who volunteered for a telephone interview, 23 were successfully contacted on receipt of a signed consent form. Interviews occurred with all 23 individuals and lasted between eight and 32 minutes. Interviewees were asked about their experiences of accessing their community pharmacy and prompted for specific individual experiences. The experiences of seven individuals were purposively selected for construction into case studies due to their uniquely personal yet wholly representative narratives. Full details, illustrating the experiences can be found in pages 32 through 38. Key representations were used to qualify the patient experiences and produce the following: Equality of Access, Diversity of Services, Relationship with the Pharmacy Staff, Family First, and Unable to Access Care Elsewhere.

- **Equality of Access** highlights the accessibility of community pharmacy and access to care for those who may have found it difficult to do so elsewhere. This accessibility included not having to make an appointment which was most valued by those acting as informal caregivers, the elderly and those whom creating appointments creates a sense of obligation resulting in anxiety. Also noted was the consistency of staff and the environment which led to a comforting familiarity for some and the comparative quietness of the setting including the private consultation room.

- **Diversity Of The Service** refers to the extensive array of treatments, public health initiatives and advice that are provided through community pharmacies. In many instances, participants had been unaware of services, such as minor ailments and smoking cessation, and had been impressed and satisfied that such services were available and also recommended to them in addition to their original treatment. The services provided also exceeded expectation with provision of emotional support and encouragement being recognised.

- **Relationship With The Pharmacy Staff** encompassed a wide spectrum of patient-staff relationships that had developed over time. The close relationship forged with pharmacy personnel is represented in each of the case studies and embodies the

rapport that staff have built with patients and their families. Great emphasis was placed on the individualised approach that this facilitates, whereby patients feel like they are being treated as a person and view the staff as having genuine intentions to help them. This was seen by the way patients felt they, or those they cared for, were supported and understood and in many cases, had resulted in a reduction of perceived stigma when their care dependent's behaviours could be atypical due to their health.

Case Study One (Pg.32)
"They know us, they know me and they just want to help. Even if [daughter] is having a bad day they just take the time and when they help it's like it's because they want to, not just because it's their job…It makes such a difference to know that they're not going to judge [daughter] and they know her.".

- **Family First** alludes to a characteristic found among informal caregivers when they do not prioritise their own health. Those accessing the pharmacy with or for another demonstrated a clear bias in placing their care dependent's health above their own. The extent to which this had been perceived by staff is unclear due to the subjective nature and lower awareness patients displayed about their own health needs.

- **Unable To Access Care Elsewhere** refers to the patient's perception of the pharmacy being their only choice for access to care. This could be due to the convenient location or distance from their house but also to the nature of the service where patients felt less rushed and more able to discuss their health. The majority referring to this concept, believed that they would face longer waiting times for their particular needs from other healthcare providers and again cited the opening hours and lack of appointment as their reasons.

STAFF INTERVIEWS

Across the study sites, 14 members of staff were interviewed. These were five pharmacists, one pre-registration pharmacist, three technicians, two dispensers, and three counter assistant staff. Interviews ranged from eight minutes to 34 minutes. Staff were purposively sampled to achieve a representation of roles which also depended on staff availability. Eight themes emerged and saturation occurred prior to the conclusion of recruitment, with interviews ongoing to ensure a coverage across all staff roles. The eight themes were: (i) Perceived Workload, (ii) Pharmacists' Expectations, (iii) Public Perceptions, (iv) "I want to speak to the pharmacist", (v) Having Time To Engage With Patients, (vi) Keeping A Constant Standard, (vii) Up The Chain To The Pharmacist, and (viii) Contribution Of Community Pharmacy. Staff members across each role contributed to each theme with the exception of (iii) Pharmacists' Expectation's which was populated solely from interviews with pharmacists themselves.

(i) **Perceived Workload** refers to the appreciation of the critical nature of the breadth of services provided but also perceiving a high workload. Staff felt that when days were busier, due to demand, that time with patients could be sacrificed. This resulted in perceived pressure and a feeling of guilt that more one-on-one time could not be given to patients.

"The patient should feel like the most important person when they come through the door and you try to do that but in the back of your mind you're thinking of the other five things you have to do. You could be the only face they see that day so you want to spend time with them, it's hard." – Counter Assistant

"Taking that time to spend with patients shouldn't take a back step because it's the most important thing but when we're busy there's just so much other things that need to be done." - Pharmacist

(ii) **Pharmacists' Expectations** consists of the feeling that checking prescriptions is a general norm when patient-centred aspects of the job like engaging directly and being the front face of the pharmacy is what they had been trained to do. Being aware of 'what is still to be done', the pharmacists reported that patient

interactions were likely to decrease when workload was high and the pharmacy was busy.

"Some days you crave going out and being the person that people speak to and do services and you feel like that's what we went to Uni for." – Pharmacist

"We rely heavily on the rest of the staff to manage that front face and I'm like the checking robot." – Pharmacist

(iii) **Public Perceptions** define what community pharmacy staff felt the general public thought of their service and themselves. Staff thought that a great proportion of the general public were unaware of the diversity of services they provide and viewed the pharmacy as a collection point rather than a healthcare facility. Staff recognised that this could be improved by actively explaining what they are doing to provide care for patients but also felt that the general public were not as patient with them as they thought they would if they knew these things. It was also recognised that providing these services was a positive step in educating the general public and that many patients had been surprised at some of the services offered.

"People expect it all to happen automatically and the majority of patients don't realise what goes on. " - Technician

"I know they don't know what we do. When you say what you do they say 'Oh, do you do that? That's really weird.' They think we just pop medicine in a bag and hand it out." - Dispenser

(iv) "**I want to speak to the pharmacist**" represents a bias some patients showed when only wanting to interact with the pharmacist. Non-pharmacist staff reported that they felt undermined as the training they undertake and the skills they possess are not recognised sometimes. Pharmacists also recognised this and felt that some staff expertise was not recognised when patients could insist on only talking to them for potentially minor queries.

"When you say is it something I can help you with some people put their barriers up 'Absolutely no way, I want the pharmacist.' And it can be something as simple as a tickly throat." – Technician

"If they ask for the pharmacist and I'm busy the [other pharmacy staff] say 'I can help', nobody wants to use them and I think that's a shame because they've all been trained to answer lots and lots of questions." - Pharmacist

(v) **Having The Time To Engage** with patients embodies the occupational satisfaction that staff gain from interacting with patients. When seeing patients regularly, staff felt able to foster professional relationships with patients and monitor their health over time. In doing so, staff felt it demonstrated their wide skills and increased the potential role/utility of community pharmacy.

"When you're offering advice, prescribing, or referring, or alleviating someone's worry then you do feel much more like 'I am a pharmacist', someone who can provide a good service." – Pharmacist

"We see people so regularly, some of them, and you do build up a rapport with them and it really helps treat them as an individual because you know them." – Counter Assistant

(vi) **Keeping A Constant Standard** refers to the staff concern at the repercussions of inconstancy across pharmacies and/or pharmacists. When a patient has previously received a form of treatment or care elsewhere but which was deemed inappropriate in another instance, it was reported by staff that those who stick closer to guidelines and rules were more likely to experience patient anger or dissatisfaction. Most staff reported the desire for tighter standards to be followed to allow for consistency across the service. Staff believed that a constant standard in procedures would increase consistency and therefore manage patient expectation.

"The patient suffers and the front staff get the abuse for the inconsistency. And it's so hard when you're training someone to explain how there are so many ways." – Pharmacist

"It's the pharmacist's decision if they'll prescribe things or not but patients get annoyed when they get a treatment from one person and then another pharmacist doesn't feel comfortable prescribing it." - Dispenser

(vii) **Up The Chain To The Pharmacist** refers to the perceived internal hierarchical staff structure. Initially counter assistants will enquire the nature of help requested and provide help where they are able to. The gathered information is then passed on to technicians and dispensers with a similar approach based on perceived seriousness and complexity until it is escalated to the pharmacist where needed. Staff recognised that their own gathering of basic information and standard questions could be quickly passed to the pharmacist and reduce their engagement to provide them time to do other things.

"You have to know your limits, if the front shop staff feel out of their depth, they come to us, and then if we need to, we can pass it on the pre-reg or if need be we give all the information we've gathered to the pharmacist and it saves their time." – Technician

"They don't expect counter staff to ask them anything but we have to say that we can help and then we pass it up to more qualified staff the more serious it is." – Counter assistant

(viii) **Contribution Of Community Pharmacy** represents the staff's views and experience of what the service is capable of offering. Services such as Minor Ailments Service and Medicines Care Review were seen as time saving and well-structured components. They also recognised their potential to alleviate general practice with a large number of issues being treatable within community pharmacy. Staff also recognised that the personal things they can do for patients contribute to the service, such as remembering their name and aspects of their personal life like family and jobs, can create a natural and personal feel to their treatment.

"I think with all the services we have and can offer them they are surprised but we can open up doors just by chatting to patients. It's crazy how much pharmacy has changed and what we can do." – Pharmacist

"Sometimes there will be certain patients that get to know you and they build up a trust with you and can ask for you the next time because you treated them last time." – Counter Assistant

Discussion

KEY FINDINGS & INTERPRETATION

ADVICE-ONLY

Quantifying instances of advice-only outcomes of care from community pharmacy has revealed the previously unrecognised component of what the service provides. These advice-only instances demonstrate the capacity of community pharmacy whereby the skills and knowledge of the staff can avoid unnecessary treatments and provide support for self-care. These efforts are not remunerated and generally unrecognised despite requiring both staff time and knowledge. The evidence from this report suggest that nationally, community pharmacies across Scotland could have approximately 84, 000 instances of advice-only outcomes with patients in one working week.

REFERRALS

The number of referrals reported from each site was consistently low. This would suggest that community pharmacy is able to manage and appropriately provide care for those accessing its services and evidencing itself as the appropriate first point of call in most cases. Low referrals also reflect faster access to care for patients through not having to access other healthcare services and that those accessing care from community pharmacy are doing so appropriately according to their health and wellbeing needs.

TREATMENT

The overall satisfaction reported by participants evidences that the experiences of those accessing care from community pharmacy are strongly positive with 4 out of 5 reporting that they were fully satisfied. With consideration to the questions asked regarding existing knowledge of community pharmacy (i.e. being NHS contracted, having a consultation room, 'fitness to practice' regulations, and independent prescribers), most participants still rated their experiences as fully satisfied despite at least 1 in 4 not being aware of the extent and content of the service itself.

Overall consultation and relational empathy were highly scored as Excellent in all facets with the exception of Making A Plan With You which scored Very Good. When separating the data for each individual location some facets scored Very Good but did not appear to be due to relative deprivation of location or the nature of urban/rural locations as variation existed across other sites with the same factors.

The three highest rated reasons for choosing to access care from community pharmacy were: convenient location, existing relationship with the pharmacy already, and having accessed the service before. This would suggest that the relationship with community pharmacy staff is recognised by patients as a key factor alongside ease of access. Given the high rates of consultation and relational empathy, community pharmacy staff and their interactions with patients are a key factor of the patient perception of the service.

Opinions on Electronic Health Records (EHRs) showed strong approval for community pharmacists to have access to these and be trusted to maintain confidentiality should this access be granted. However, some concern around who would be able to see these records was reported by some participants when agreeing with the statement 'I would be concerned that my electronic health record could be read by other people in the pharmacy'. The wording of the question does not specify who 'other people' may be, such as non-pharmacist staff within the community pharmacy or those accessing care there.

Case Study Seven (pg. 38)

They do not rush you which is nice because you feel like you have time to think before you speak…They have been very helpful to me since I moved here and hopefully now I can explain when I'm not well [laughs]."

Most participants agreed that they would like to see their community pharmacy and GP work more closely together and 41% of participants reporting that they would have otherwise accessed their GP had community pharmacy not been available. This evidenced alleviation of general practice supports national initiatives to make use of the extensive services of community pharmacy to direct more serious illness to general practice and keep community pharmacy as the first point of call.

PARTICIPANT TELEPHONE INTERVIEWS

The case studies produced from the participant telephone interviews provides insight into the narratives and experiences of patients accessing care at community pharmacies. The two themes of Diversity Of Services and Relationship With The Staff were consistent across all case studies, which again demonstrates the impact that community pharmacy staff have both as a combined service and as individuals. Participants were pleasantly surprised at the services available having been unaware of the capacity of community pharmacy in many cases. The case studies provide a representation of the range of care provided by community pharmacies where both interpersonal consultation and prompt problem solving are required. Participants discussed the contribution that the staff at their community pharmacies provide to their health and wellbeing.

STAFF INTERVIEWS

Interviews with staff demonstrated the staff structure within community pharmacies where counter staff, technicians and dispensers recognise a hierarchy of expertise and can appropriately assess self-competency and personal knowledge. Some pharmacists felt that they were sometimes limited in their face-to-face interactions with patients, which they reported as one of the most rewarding aspects of the job, and instead feeling that other tasks limited this. Non-pharmacist staff also reported the reward of patient interaction but felt that the general public were not very aware of the services community pharmacy can provide but also the capacity and roles of non-pharmacist staff. It was recognised by all staff that they can demonstrate the services community pharmacy can provide by being proactive with patients and changing public opinion on a case to case basis but felt that those not already accessing community pharmacy services would continue with limited knowledge and understanding.

STRENGTHS/LIMITATIONS

This study is the first of its kind to demonstrate a national snapshot of the services provided by community pharmacy having separated the three unique functions of advice-only, referrals, and treatment. The evidence provided used novel methods to capture advice-only instances which had previously been unrecognised. Exploring the composition of services regarding the outcomes of advice-only, referrals, and treatment provides a robust and

comprehensive representation of its contribution to the NHS. This is coupled with interview data from both patients and pharmacy staff to report the experiences of not only those accessing the service, but also by those that provide it.

It should be recognised that, as with all patient self-reported research, social desirability responses may occur and participants may be inclined to provide more positive feedback to protect an institution they believe to be at their benefit. Eight community pharmacies were included in the study which may not be fully generalisable, however, the locations were selected to be representative of the diversity in both location and relative deprivation.

FURTHER WORK

The dichotomy of positive favour for community pharmacists to have access to EHRs and the concern that others may read them, should be further explored to determine whether patients feel that potential access should be solely granted to pharmacists, or if concerns exist around the potential for other patients to see them. This could inform the procedure of access to EHRs in community pharmacies and the information provided to the general public in relation to confidentiality and information handling.

The contribution of community pharmacy staff to the overall service is evident and further research that could determine what specially constitutes the favourable relationship between staff and patients as to whether these stem from training, individual differences, or both.

CONCLUSION

Community pharmacy in Scotland is highly regarded by the patients that access their services and provides alleviation to General Practice services. Perceptions of both the service and interactions with staff were highly reported and the staff-patient relationship appears to be at the cornerstone of patient experience. Instances where advice-only is the outcome of patient consultation should receive greater recognition in its contribution to the services community pharmacy provide due to the time it occupies and the staff knowledge demonstrated therein. The service provides full satisfaction to most of those who access it, despite a limited public knowledge of the capacity and diversity of community pharmacy.

Case Study One
Name: Emily
Age: 25-54 Prime Working
Occupation: Full time informal caregiver

Unique representation: Equality of access, Relationship with pharmacy staff, Family first

Emily is a mother to three children under the age of ten. Her eldest child has a neurodevelopmental disorder that requires full-time care that Emily provides from their own home. With a perceived lack of respite services, the burden Emily feels when everyone in her family is well, is greatly amplified when any of her children become unwell. Originally planning on a long-term career following University, when Emily's daughter was diagnosed with a lifelong condition, her role was now set as family caregiver.

Equality of Access is represented as the ease to which Emily feels she can access her community pharmacy, "*[My daughter] doesn't cope well with waiting in the GP surgery and you never really know how long it's going to take. With the pharmacy you can just show up when there's a problem and they [the community pharmacy staff] will see you."*. Emily's circumstances mean that the drop-in and no appointment nature of service accommodate the specific needs of her daughter and contribute to a faster access to care. This was furthered explored in regards to setting and environment: *"It's the noise in some places that she [daughter] can't cope with. If there's other kids there making noise then you just have to forget it. The pharmacy she is used to* (sic) *and even if we have to wait, they let us in the consultation room which is great.*". The relative familiarity of the community pharmacy and access to a private and quiet consultation room eases the experience for Emily and her daughter.

Relationship with pharmacy staff is represented through Emily's trust and perception of non-judgement from the staff. Emily can be reluctant to go out in public for fear of stigma and reactions of others, *"It ranges from people giving a look or you see them whispering with each other or having them actually come up to you and telling me to control my child…it's horrible because they don't know what we are going through and [daughter] really can't help how she reacts in certain places like if it's busy or it's noisy."* When asked how this related to accessing her community pharmacy Emily responded with *"They know us, they know me and they just want to help. Even if [daughter] is having a bad day they just take the time and when they help it's like it's because they want to, not just because it's their job…It makes such a difference to know that they're not going to judge [daughter] and they know her."*. The interaction with the pharmacy staff is perceived as understanding and empathic to her experiences and Emily feels supported and that her daughter is not being misunderstood or judged.

Family first is represented as the priority that Emily's children's health has over her own. While Emily feels the pharmacy is *"-the best place for us to go if anyone is unwell",* when prompted on her own health Emily would reply that *"I'm not allowed to be ill. If I'm unwell then nothing happens. I just have to keep on going."*. This self-sacrificial behaviour may be driven by both the role Emily has as a mother compounded by her identity as a caregiver. This highlights a potential onus on those caring for others to engage in self-care and assistance.

Case Study Two
Name: Malcolm
Age: 65+ Elderly
Occupation: Retired

Unique representation: Relationship with pharmacy staff, Equality of access, Diversity of services

Malcolm has family across the country but has lived alone since his wife died over ten years ago. Retired from a public service background he enjoys the company of other but has found it difficult to engage with his community and spends a lot of time at home. Community pharmacy has been one of the few places Malcolm feels that he has had support and company and can be the only place he will visit in a day. His repeat prescriptions can be the focal point to which he will structure the rest of his day.

Relationship with the pharmacy staff is represented as the genuine connection Malcolm feels with the staff, *"They're all great. They smile and when I tell them something they listen…and I can see how busy they can be but they still take a time for me."*. Malcolm can appreciate that the staff can at times be busy and feels recognised when someone takes the time for him. *"When you're out[side], you see people but it's not the same as talking with someone. You end up just blending in and your near people but you're not, in the same way, with people you know."*. Malcolm can feel isolated from others but finds the relationship with staff to be a constant source of company and to an extent, self-affirmation.

Equality of access is represented as the almost social nature of the drop-in that Malcolm makes use of, *"It becomes part of the day – I go for a walk, I'll get a chat with them and then maybe past [convenience store] on the way back. I just pop in and my prescriptions there."*. The lack of need for appointment can give the experience an informal feel for Malcolm which may have enabled this social relationship to have grown when it has not in other places. Although Malcolm will build his day around the visit, the ability to choose when this can be somewhat empowering and create an internal locus of control, *"I can just think, I'll go now, or I can go later if I feel like it. If it's not ready they know I'll be there a lot longer chatting their ear off [laughs]."*

Diversity of services is represented as the palliative care that Malcolm received following the death of his wife. Malcolm found it very difficult to overcome and the staff at his community pharmacy gave him the space to make sense of things, *"That time is a bit of a blur. I was just trying to make sense of things, [my wife] did a lot of things and all of a sudden I don't know what's going on." "[The pharmacist] said to me how I was* (sic) *and told her and then we went in to the consultation room and had a chat. I really don't think I would have been able to get through things had it not been for the help I got here."* While community pharmacy staff are expected to deal with a wide variety of conditions and presentations, the care that Malcolm received is perceived as invaluable and *"up and beyond the duty of care and what you would expect."*

Case Study Three
Name: Helen
Age: 55-64 Mature Working
Occupation: Part-time

Unique representation: Diversity of services, Unable to access care elsewhere, Relationship with the pharmacy staff

Helen was diagnosed with arthritis several years ago and finds that she is unable to do a lot of the things she used to enjoy with pain, such as knitting and cycling. She accesses the pharmacy for herself, her husband and sometimes for her grandson who she spends a lot of time with. Helen still works but has taken reduced hours as she feels unable to cope with the impact of full-time hours on her physical health. Helen and her husband live in a relatively rural community with somewhat limited access to healthcare.

Diversity of services is represented through the person-centred approach that pharmacy staff took with Helen to explore the effects of her arthritis and changes to her normal routine in both her professional and personal life, *"It felt like it was almost overnight that I went from feeling fine to feeling like an old lady. Everyone said to try swimming but we don't have a pool near us. It wasn't until [counter assistant] told me about these exercises her own Mum did at home that I looked in to it…I quite enjoy it and it does seem to help, even just stretches on days I don't have time for the whole thing.*". Exploration by staff taking an interest in Helen led to self-care that controls some of the discomfort from her arthritis and while unable to engage in everything she previously did she feels able to more than what she would have been able, had it not been for starting exercises at home.

Unable to access care elsewhere is represented by Helen's perception of other services having long waiting times and limited time to spend with patients. *"I can't tell you how long I've waited for an appointment before, weeks and weeks and weeks. Once you get one you feel like you're in and out as quick as you can and you don't get a chance to speak."*. Helen's perception of community pharmacy is that of a less rushed one-to-one interaction that she appreciates, *"They ask you lots of questions and even if I say 'No, I've tried that', they think of something else or they ask the pharmacist and she'll come speak to me."*. Helen views her community pharmacy as "invaluable" due to the remote location in which she lives and the relatively fewer services she is able to access.

Relationship with the pharmacy staff is represented by the way Helen views the staff and how she feels like their approach make her more open, "*They've got a nice way about them, you know? They aren't jumping down your throat the minute you open your mouth and I can that they listen because they'll ask me on things I spoke about the time before like what's being going on with [my grandson] or if I've been doing up the garden."* When probed further to explain what she meant by what makes them nice, Helen said *"When you go in it's not like your being spoken down to but they speak with you, have a conversation….in a way I think they make me think more about it too because I'm actually speaking to people about my health and my arthritis which was a big thing to get used to.".* Helen agreed that the staff help her to think about her condition and have been a support to her in adapting her life, "*They come up with ideas for things I wouldn't have thought of if you paid me…It's been a great help. You cannot beat them."*

Case Study Four
Name: Naomi
Age: <25 Early Working
Occupation: Unemployed

Unique representation: Relationship with the pharmacy staff, Diversity of services, Equality of access

Naomi had been attending college to learn Culinary Science when her mental health declined, forcing her to drop out of her course. She has accessed many different services in regards to her mental health and feels that there is a big difference through how certain services and people have treated her. Naomi has since tried to start a career several times but feels like there is a countdown above her head until the next time she can't leave the house and said that this particular symptom of her mental health is why she has lost previous jobs. Naomi likes to keep herself busy and walks to her pharmacy to collect her regular prescription.

Relationship with the pharmacy staff is seen through Naomi's perceived understanding of the pharmacy staff in regards to her mental health "*I get bad days, and I know we all get bad days but when I have a bad day I don't even feel like talking to anyone, eating or nothing. But when I go to them [the pharmacy] they treat me just the same."* Naomi recognises that the staff are patient with her and do not judge her when her mental health affects her interactions with them "*I'm pretty sure it looks rude and people with think 'what's wrong with her' but [pharmacist and staff] they don't push me to speak and they don't act any different than normal, it really makes me appreciate what some people can do for you."*

Diversity of services is exemplified through the experiences Naomi has had when she has received support specifically for her mental health *"They [the pharmacy staff] are all really good and I remember one time I was in a really bad place and [counter assistant] got [pharmacist] because she was in the back bit and she asked me if I wanted to have a chat and I was so close to saying no but she's always been so nice so we had a chat and she even made me a coffee which meant so much".* Naomi found the responses of pharmacy staff to be very supportive for her mental health and while she asked that the specifics of these remain undocumented, she wanted this experience known to recognise her gratitude for her community pharmacy team. The relationship is further demonstrated through Naomi's commitment to her pharmacy when she said "*I moved flat last year and there's another pharmacy a lot closer but I still go to [pharmacy] because I just don't think I could go anywhere else."*

Equality of access is represented by Naomi's ability to go to the pharmacy without an appointment which she sees as an obligation which can trigger her anxiety "*I know it sounds weird but you know when you make an appointment you know that it's now set at a time and you have to be there, it just, I can't deal with it. If I can go when I feel like I can then it's not like I'll let someone down.".* Naomi experiences less anxiety as an appointment for her creates a formal obligation whereas the relative ease of access via community pharmacy allows her to access the service when she most feels able to, on her own terms.

Case Study Five
Name: Lorraine
Age: 65+ Elderly
Occupation: Full-time carer

Unique representation: Relationship with pharmacy staff, Equality of access, Unable to access care elsewhere

Lorraine was a senior receptionist for most of her life until she and her husband retired. For the last seven years she has provided informal care for her husband who developed dementia. Lorraine finds it hard to leave the house with her husband as the caring role has become increasingly difficult as she has gotten older, and conversely, she dislikes leaving her husband in the house alone due to the worry and uncertainty of not being with him. Lorraine finds things to do around the house instead and enjoys spending time in her garden when she can.

Relationship with the pharmacy staff is represented by the way Lorraine feels the pharmacy staff treat her and her husband "*They really are a lovely bunch. And there so good with* [husband], *they take the time with him to really speak at the level he's at on that day…I think it's patience and just a genuine care for people.*". Lorraine feels that the pharmacy staff have built up a genuine connection with her and her husband and give her caring circumstances, she is not able to leave her house a lot "*They're sometimes the only person besides my husband I can speak to in a day and I can tell you I have some tough days too so it means a lot to me that I can be honest with them and for them to listen like they do.*"

Equality of access is seen through the way that Lorraine appreciates that she can go the pharmacy at any time when they are open rather than at a set time which can prove challenging "*It can be very difficult to get both of us ready to leave the house with a deadline hanging over us, I can get very flustered with myself and my husband trying to get everything sorted. He tells me I take a lot of time getting myself ready but it is definitely longer getting him ready [laughs].*" When asked more about the comparative ease of accessing the no-appointment system of community pharmacy, she added "*It is a big relief that we can drop in by. I know some times of day are more busy than others so we tend to go when we know it will be a bit quieter too, less things going on.*"

Unable to access care elsewhere is demonstrated through Lorraine's perceptions of other services and their locality "*The GP surgery is quite a bit away from our house and because of where we live it would be faster to walk as the crow flies but when we do take the bus [husband] doesn't do well waiting.*" Lorraine feels like the walk can be quite tiring too and recognises that her husband does not react well to waiting for public transport and the two of them stopped driving many years ago which means that the relatively closer pharmacy is their preference "*I would always go to the pharmacy first, unless it very serious of course, but for so many things they can help you with.*" Lorraine continued to explain how she feels that a longer wait for an appointment can hamper her caring responsibilities "*If I'm unwell I still have a husband to looks after. We do have a carer who visits twice a week but even for things like making a cup of tea, if you're not well it can be strenuous, so I very much prefer to be seen to as soon as possible.*".

Case Study Six
Name: Jennifer
Age: 55-64 Mature Working
Occupation: Full-time employed

Unique representation: Diversity of services, Relationship with pharmacy staff, Equality of access

Jennifer has used the same pharmacy for as long as she can remember and had used it relatively infrequently for minor ailments such as colds, earache or when one of her grandchildren caught headlice and they spread through the family. On a recent visit to the pharmacy to seek advice on a sore throat, the pharmacist had enquired about her smoking habits and whether she was aware of the smoking cessation programme which she had not and then a few weeks later decided to try.

Diversity of services is represented through Jennifer's update in the smoking cessation service, a service she was not aware of until her pharmacist took the opportunity to discuss her smoking in relation to her sore throat "*I didn't know that they did that in the pharmacies, up until then I'd used it here and there if we were unwell or that but I think it's great. I'd been thinking about stopping [smoking] but I'd tried before and it didn't last too long [laughs].".* Jennifer's previous attempt to stop was unsupported but she felt that the input and support she received was the reason she has been successful so far "*I chatted with [pharmacist] for a bit and we started with patches but when I went back I said I didn't really like them and I got the mouth spray instead. I didn't know the mouth spray was even a thing and it's really helped. [Pharmacist] has been really supportive…and to think I didn't even know about the service!".*

Relationship with pharmacy staff is seen through the dynamic and rapport that Jennifer experiences with her pharmacist "*She is just so down to earth and I feel like I can be honest with her. When I tried stopping before I didn't really feel there was much support out there to help people to stop [smoking] and if it wasn't for* [pharmacist]*, I don't think I would have.".* Jennifer has since been more forthcoming in using the pharmacy feels a sense of trust with her pharmacist "*She took time out of her day to go above and beyond, and I know the service is their job but it wasn't like I was in asking about it or anything…I would go to the pharmacy now a lot more than I would have before and [pharmacist] and her staff are really friendly…they would do anything for you."*

Equality of access is seen through Jennifer's preference for accessing her pharmacy due to the hours they operate and that she can drop in when she can "*Between work and the grandkids it's hard to find time through the week so being able to go on the weekend is great…it's just easy to nip in and out and your done – not waiting for a set time to go see them.".*

Case Study Seven
Name: Elena
Age: <25 Early Working
Occupation: Full-time employed

Unique representation: Equality of access, Diversity of services, Relationship with the staff

Elena moved to Scotland from Eastern Europe after completing her Beauty Therapy course. When she first moved country, as she admits, her English was still quite limited. Elena made friends and had clients that primarily spoke the same language as her so when it came to seeking healthcare advise and treatment she would be less forthcoming in doing so as she felt embarrassed that she had trouble speaking English, even compared to her friends.

Equality of access is demonstrated through Elena's experience of community pharmacy when she thought she had contracted an illness after feeling feverish and tired "*I went first to the GP because that is where I would have gone first back home. The GP was very nice but I felt like [the appointment] was so quick that he could not take the time for me to try and find the right words."* When Elena went to the community pharmacy to pick up her medication she found herself speaking to the counter assistant "*She could see that I could not communicate very well but she was speaking to me anyway, to start with it was mostly just little things and she was asking about where I was from…She was asking then about how I was feeling and she used her hands and acted different symptoms and I could understand this."*. Elena's symptoms were then passed on the pharmacist who then contacted her GP and resulted in Elena receiving a different prescription.

Diversity of services is demonstrated through the range of advice Elena went on to receive from the pharmacy staff "*I remember I asked them about how to get access to more support because to start with I really did not have much money to live on and they told me about a place I could go to get food parcels from which was really much appreciated at that time."*.

Relationship with pharmacy staff is seen through Elena's appreciation for pharmacy team "*They do not rush you which is nice because you feel like you have time to think before you speak…They have been very helpful to me since I moved here and hopefully now I can explain when I'm not well [laughs]."* Elena perceives the pharmacy team to be integral in how she has managed to successfully adapt to moving country "*They made it easier for me…I did not expect the help that I got but I really am grateful for their help."*

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