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23 December 2011

Annwyl Mark,

Inquiry into the contribution of community pharmacy to health and well being in Wales

Thank you for your letter dated 8th December requesting additional information on points raised during the inquiry into the contribution of community pharmacy in Wales.

I am pleased to provide the attached information which I trust will support you and your Committee colleagues in your final deliberations.

Cofion gorau,

Mair Davies
Chair, RPS Wales

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Inquiry into the contribution of community pharmacy to health and well being in Wales

Additional information from the Royal Pharmaceutical Society

23rd December 2011

Hard to reach groups

Question 1: Given the information provided by PHW, do you have any additional information to support your assertion that community pharmacy can engage a range of groups and communities, particularly those groups deemed "hard-to-reach"?

Wales' 708 community pharmacies receive over 35 million visits each year[1] which we believe provides significant opportunities for community pharmacists to engage with the general public, including those who are considered 'hard to reach'[2].

Evidence is available which underpins the opportunities provided by community pharmacy. For instance, a study in 2009 analysed the characteristics and risks of Coronary Heart Disease of people who accessed the free Healthy Heart Assessment (HHA) operated by a large UK pharmacy chain between 2004 and 2006[3] and concluded that people from 'hard-to-reach' sectors of the population, men and people from less advantaged communities, accessed the HHA service and were more likely to return moderate-to-high CHD risk. It was also found that pharmacists prioritised the provision of lifestyle information above the sale of a product, clearly illustrating the public health role that community pharmacy can play.

Studies such as this support the notion that pharmacies can serve as suitable environments for the delivery of opportunistic screening services and that community pharmacy provides

[1] Community Pharmacy Wales (2011) *Good Health. Community Pharmacy: The Best Medicine for Healthy Lives in Wales*.
[2] We consider that hard to reach groups in this context relates to two distinct cohorts of people; those who require ongoing care but experience social exclusion such as the homeless, travellers, asylum seekers, refugees, people with disabilities, people living in deep rural areas, those living in deprivation and prisoners for example; and those who are able to access services but rarely engage with any health services due to their attitudes about health. Men traditionally fall into this second category.
[3] P Donyai, M Van Den Berg (2009) Coronary heart disease risk screening: the community pharmacy Healthy Heart Assessment Service *Pharmacy World and Science*, Vol. 31, no. 6, p. 643-647

opportunities to identify health risks among individuals who do not regularly access health services, such as men of working age.

Community pharmacy capacity

Question 2: Do you have any data which indicates what levels of uptake there are for services already commissioned locally and nationally?

No recent data is available to us so we are unable to accurately indicate levels of uptake of community pharmacy services already commissioned locally and nationally – these figures will be held by Local Health Boards.

Recent research, together with feedback from our members, indicates however that there is an appetite among the pharmacy profession for the development of new community pharmacy services and we would challenge the sentiments that the pharmacy profession may not deliver on their expanding role in sufficient numbers to allow the general public to access to equitable services across Wales. The introduction of local enhanced community pharmacy smoking cessation services in North Wales between 2006 and 2007 provides a good example of how community pharmacists can mobilise themselves to deliver services and an enhanced contribution to local health service developments. Public Health Wales' retrospective evaluation of this enhanced service recorded an initial uptake of 78 pharmacies in the then five LHB areas which illustrates the positive attitude and willingness of community pharmacists to deliver new services[4].

Despite the eagerness to deliver more patient-centred care through community pharmacy, our members have indicated that they have a number of concerns about the longevity of new services that are not part of formal contractual enhanced services. Previous experience of short lived projects and short term local enhanced services can deter some community pharmacists getting involved in new services. Some of our members have expressed concerns about inconsistency in commissioning across and between Health Board areas, poor communication about the development of new services and lack of support locally from Health Boards in implementing new services. Changes to the community pharmacy contractual framework in November 2011 and the introduction of new services provide a good example of this. We found that many of our members were ill informed about the implementation of the new services and therefore unable to support the new services on its implementation date. As the professional body we have supported our members working in community and hospital to find local solutions

[4] National Public Health Service for Wales (2009) Evaluation report: North Wales local enhanced community pharmacy smoking cessation services, NPHS.

to deliver the new medicine discharge service, our members concern being that their professional body was not involved in the planning of this service and thus unable to provide them with the necessary advice and support they needed to deliver the exciting new service.

Feedback from our members also indicates that current planning and commissioning activity is confusing in terms of which services their LHB are prioritising and consequently where they should be focusing their efforts. The default position as a result is to concentrate on dispensing medicines on the basis that income can be obtained under the current community pharmacy contract on the basis of volume of prescriptions dispensed – a position which we believe impedes the expansion and development of community pharmacy services. We advocate that imaginative and creative planning and commissioning activity at national and local levels is the key to getting the best from the community pharmacy contractual framework and from community pharmacists who are eager to deliver a range of new services.

In addition, it is also becoming clear that the general public, as well as other health professionals, are not aware of the range of NHS services that can be accessed from community pharmacies across Wales. Furthermore we are concerned that community pharmacy services are often not recognised as a part of the NHS family by the general public, health professionals and even health service planners and commissioners, and we are concerned that this may act as a significant barrier to the successful expansion of pharmacy services.

A recent study into the view of the general public on the role of pharmacy in public health for instance found that there is little awareness of pharmacy's involvement in providing services designed to improve public health[5]. This study also recommended that more effective marketing is needed to help the general public understand what these services are. The Welsh Government is aware that any service change must be supported locally by patients and other NHS service providers and new service models delivered through community pharmacy are no exception to this. Hence we believe that national and local campaigns should be undertaken to increase awareness of community pharmacy services.

[5] J Krska, CW Morecroft (2010) Views of the general public on the role of pharmacy in public health *Journal of Pharmaceutical Health Services Research* Mar 2010;1(1):33-38

Provision of services at a national level

Question 3: Do you have any further evidence of work underway amongst key bodies in Wales in relation to the commissioning of services on a national basis?

We are aware that some discussions are underway in Wales with regard to the development of national community pharmacy services but we have not been invited to these discussions and would be unable to comment further. We are disappointed in general however that there appears to be little work being taken forward formally by key bodies in Wales in relation to national commissioning.

Question 4: What issues in particular do you think would be addressed by commissioning more services at a national level? Would there be any challenges if such an approach were adopted?

We believe that national commissioning could address a number of key challenges to the delivery of community pharmacy services across Wales. The development of nationally commissioned community pharmacy services in Wales should help:

- standardise the delivery of specific services within a clear national framework
- ensure a common educational framework is developed by post graduate education providers
- improve governance arrangements for the delivery of specific services by creating and maintaining a centrally held database of community pharmacists who have the relevant competencies to deliver specific new services
- integrate and establish community pharmacy services as an important part of the broader NHS family
- ensure community pharmacists are well informed prior to the introduction of new services
- reduce variance in service delivery and the potential of post code lotteries of care.
- Inform members of the public which services they can access consistently at community pharmacies wherever they live in Wales (provided this is supported by an effective national public awareness raising campaign).

Our colleagues in Scotland have indicated that the development of the National Minor Ailment Service has helped, not only to standardise the role of community pharmacy in delivering minor ailment services across Scotland, but has provided increased opportunities for patients and the general public to access health services and professional advice in the most appropriate setting.

Similarly the development of a national pharmacy patient group direction (PGD) in Scotland for out of hours emergency supply of medication has increased opportunities for patients to access their community pharmacist who can prescribe the full cycle of the patient's repeat medication when their GP is not available out of hours. We believe that this kind of service innovation on a national basis can vastly improve access to a health professional and has the potential to help reduce pressures on other parts of the health system as a result.

Community pharmacy contractual framework

Question 5: In your view, are the challenges that have arisen in relation to rolling out enhanced and advanced services via the community pharmacy network attributable to the current contractual framework?

We believe that the current contractual framework for community pharmacy has not been used creatively by Government or Local Health Boards and as a result opportunities have been missed to deliver improved and integrated care for patients. This has meant the contract is still proving to be a volume based supply model rather than one based on outcome focussed clinical services. Our colleagues in Scotland indicated in their submissions and oral evidence that by placing the patient at the centre of care, not the product or prescription, the key performance indicator was no longer the prescription issued/dispensed but the care received thus taking the role of pharmacist further. To place the patient at the centre of the contract may require changes in planning and financial management of the contract and supporting frameworks.

In devising a viable community pharmacy contractual framework there must be founding principles, namely an underpinning infrastructure and making patient pharmaceutical care needs a priority.

Firstly, we believe that in order to provide the best clinical pharmaceutical care for patients, a more formalised relationship should be adopted between patients and the pharmacy of their choice; this formalised relationship would not restrict access to pharmaceutical care in another pharmacy, but it would enable pharmacists to provide a more structured pharmaceutical care plan, particularly for those patients with chronic conditions, enabling continuity of care for these patients. This is an example of where a contractual change is not needed to improve care but where the NHS would need to be creative and develop a new service model for delivery.

Secondly, NHS IT systems in Wales need to be planned to underpin all new services. There needs to be appropriate access from community pharmacy to patient records, and mechanisms to be able to transmit and share information between different healthcare providers.

In order for relationships between the different primary care contracts to be improved, the planning of services needs to be based on a whole-systems approach rather than one which focuses on individual professions or contracts. Pharmaceutical care should feature more prominently in Local Health Board planning with models of care developed that make use of community pharmacy services through the provisions of the contractual framework.