3 January 2011

Mark Drakeford AM
Chair, National Assembly Health & Social Care Committee
National Assembly for Wales
CARDIFF
CF99 1NA

Dear Mark

INQUIRY INTO THE CONTRIBUTION OF COMMUNITY PHARMACY TO HEALTH SERVICES IN WALES

I refer to your letter dated 8 December 2011 in the above connection and seeking CPW's response to some of the points that have been raised during the various sessions at which the Committee has taken oral evidence. A detailed response to your specific questions is attached.

In addition, I would like to take the opportunity to draw the Committee's attention to two issues which were raised whilst the Committee was taking evidence but which were included in your specific questions.

First, the BMA Cymru Chair referred to CPW as the "trade union" of community pharmacy. That is not the case. Instead, CPW is a body recognised in statute - the National Health Services (Wales) Act 2006 - as the only organisation responsible for representing all of the 710 community pharmacies in Wales on all matters relating to NHS community pharmacy services. Like the Welsh Local Government Association, which acts on behalf of the collective body of Welsh county and county borough councils, CPW acts on behalf of the collective body of all Wales based community pharmacy contractors and works with Government and its agencies, such as local Health Boards, to help protect and develop high quality community pharmacy services and to shape the NHS community pharmacy contract and its associated Regulations. This removes the need for Government and its agencies to consult and negotiate with several hundred individual contractors.

Secondly, during the session with the BMA, it was suggested that the minor ailments service operated by community pharmacy required users of the service to pay for the medicines received. This is not the case. In Wales prescribed medicines are free to the patients irrespective of the NHS prescriber, which also applies to items prescribed as part of the minor ailments service such as the one operating in the Torfaen locality of Aneurin Bevan Health Board.

I trust that the information provided will be of assistance to your Committee during its final deliberations. I look forward to receiving a copy of the Committee Report in due course.

Yours ever

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CHIEF EXECUTIVE

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1. "Hard to reach" groups and MURs

Question

Given the information provided by PHW, do you have any additional information to support your assertion that community pharmacy can provide healthcare services to people who are often hardest to reach but who need it the most?

This would assist the Committee in understanding the extent to which the community pharmacy network could be utilised to engage hard to reach groups, and what services could be best used to do this.

Response:

Community pharmacy provides healthcare services to the harder to reach groups in four key ways:

a) **Structural tendency towards serving disadvantaged communities built into Community Pharmacy Contractual Framework**:

The current contractual mechanisms for remunerating community pharmacies for the services they provide result in contractors receiving the greater part of their income from the dispensing of prescriptions. This remuneration mechanism obviously results in a concentration of pharmacies where the flow of prescriptions is higher. Welsh Government data shows that prescribing per head of population is higher in areas where health needs are greater, for example in 2006-2007 there were 22.9 prescriptions per head of population in Merthyr Tydfil compared to 15.1 in Cardiff.

The most disadvantaged people tend to be less receptive to public health messages making them amongst the hardest to reach groups. The greater concentration of pharmacies in areas of deprivation where health needs are greatest, therefore provides Health Boards with significantly greater opportunities to offer additional community pharmacy based services to residents of those communities should the Health Board choose to do so. It is disappointing that, to date, most Health Boards have chosen not to do so.

b) **Rural communities**

The particular challenge of delivering services in rural locations is well documented in the Welsh Government"s Rural Health Plan. In rural areas people have to travel longer distances to access healthcare support and often with little or no public transport assistance. The nature of that support is often different to that available in more built up areas. In small rural communities the pharmacy is an integral part of the social fabric in

the community and the most regular interface with NHS Wales. The advice of the community pharmacist is regularly sought and valued, particularly in small isolated communities.

The numbers of patients accessing any particular rural pharmacy may be small but overall the pharmacy service constitutes the main NHS interface for such areas. Successive Welsh Governments have recognised the value of this healthcare facility b choosing to retain the Essential Small Pharmacies Scheme, which was abolished in England some years ago. This provides additional support for rural pharmacies where the local economy would not otherwise enable the business to be viable.

Other care organisations readily recognise community pharmacies as an outlet capable of reaching elements of Welsh society that they themselves find the least accessible. For example, Age Cymru is currently working with community pharmacy contractors in rural areas to distribute free thermometer leaflets as part of the Welsh Government‟s *Keep Well This Winter* campaign. Age Cymru have suggested that pharmacies "fill in the gaps" in the locations that they have not been able to cover. If this partnership proves effective in reaching such areas this winter then it may be extended as part of the 2012/13 Keep Well This Winter campaign.

c) **People not engaged with GP services**

Many of the NHS commissioned healthcare services are centred on the GP surgery. As a result, those hardest to reach are the significant section of the general population who do not engage with GP services on a regular basis. A number will not be even registered with a GP practice. As community pharmacies enjoy a high footfall and are visited on a regular basis by both those who are well and not just those who are ill, there is no better location to provide population screening and healthy living support. The recent trend towards locating GP practices from town centre locations to the outskirts of town, coupled with frequently reported complaints of people encountering difficulties in obtaining a GP appointment, creates additional barriers to people needing to access health services, particularly public health services. This is in marked contrast to the location of community pharmacies on every Welsh High Street and in locations where people live, work and travel.

d) **Busy people:**

Many people, particularly those of working age, find the opening hours and appointment arrangements in GP practices inconvenient. A number of pharmacies, particularly larger pharmacies and supermarket pharmacies offer more convenient opening hours providing significant additional opportunities for NHS Wales to roll out services. An example

of this in action, comes from a patient survey of over 2,500 patients receiving a flu vaccination in community pharmacy, where 50% of patients indicated that the pharmacy was more convenient than their previous provider and 37% would not have had the vaccination if it was not available at the community pharmacy.

e) **Specific services**

There are some services that are provided through community pharmacy precisely because it enables the services to be available to target groups in the population who have not been accessed by existing, traditional service design and locations. Two prime examples in Wales are (1) the Emergency Hormonal Contraception (Morning After Pill) services which started in April 2011 and where local pharmacies have proved to be a more than acceptable location for young women seeking emergency contraception, and (2) those involved in substance misuse seeking clean syringes and needles. .

f) **Other**

Other examples of the use of community pharmacy to reach out to hard to reach populations include the role of health trainers in Healthy Living Pharmacies in improving health literacy, outreach services from community pharmacy, such as the Healthy Heart initiative in Birmingham where pharmacy took health screening to local football grounds and community pharmacists delivering services to work places and schools. In addition evidence from the National Chlamydia Screening Service in England has demonstrated that the percentage of males that accessed the service through community pharmacy was noticeably higher than the percentage of males that accessed the service from other traditional service providers.

Community pharmacy provides services to all ages and all sections of the population. These factors make community pharmacy undeniably unique in its ability to deliver services to harder to reach groups.

6. Community pharmacy capacity

Question

The evidence above suggests that, although there may have been limited commissioning of services by LHBs, where services are commissioned, community pharmacy may not be taking the opportunities being offered. Do you have any data which indicates what levels of uptake there are for services already commissioned locally and nationally?

This would assist the Committee in understanding whether the alleged lack of additional pharmacy services is attributable in its entirety to a lack of commissioning activity, or whether there is a lack of interest or capacity on the part of pharmacists to deliver such services.

Response:

CPW believes it is completely disingenuous to argue that a lack of NHS services provided by pharmacies is due to lack of desire or interest by pharmacies in delivering the services rather than by lack of commissioning of these services by NHS Wales as a whole or by individual Health Boards. In addition, there are often other barriers in the way of the effective delivery of the services even where they are commissioned. There are many examples which prove this since the 2005 contract.

a) The Welsh Government has channelled all commissioning of pharmacy services through Health Boards and has therefore created a situation where the commissioning of pharmacy services requires the active engagement and support of the Health Board. Yet, as pharmacy is not represented on the Management Board of Health Boards, it does not have a direct voice in top level decision making.

b) Health Boards have a tendency to commission within the NHS and along traditional boundaries especially when financial resources are under pressure. This often precludes commissioning services from community pharmacy contractors even when overall costs will be lower for the public purse.

c) When new pharmacy initiatives are initiated by Health Boards they are often piecemeal and financed through small allocations of funds which for one reason or another has become available during the course of the year. All too often these initiatives take the form of very short term pilot projects which are not turned into sustainable services that patients can understand and rely on and on which pharmacies can plan ahead to build expertise and specialisms.

Community pharmacy therefore suffers badly from „pilotitis" where one pilot follows another and where despite robust outcomes the pilot funding invariably dries up and there is a period of time before the next pilot raises its head. A patient may be able to access a service at one time that is not available a few months later or in the next town. This piecemeal approach adds costs to pharmacies in establishing a service then winding it down. It also builds scepticism amongst pharmacies that Health Boards are not driven by sustainable healthcare for patients.

Contractors are often expected to undertake additional accreditation which is complex and way over what is reasonably required to provide the service, which is not always guaranteed. This is a requirement that is demanded of community pharmacists at their own cost and is not required of other healthcare professionals. For instance, many pharmacies across Wales invested heavily in accreditation for independent prescribing. But there are very few instances of Health Boards delivering any services that used these skills. Pharmacies were keen to use this skill and provide the services to patients but Health Boards failed to commission them.

d) Community pharmacies are independent contractors and, as such, any investment in premises and staff training is borne by the contractor. As with all businesses, there is a reasonable expectation that an investment by the business produces a reasonable return. Without this, the community pharmacy network would simple not exist.

While it is excellent for NHS Wales, that the risk is borne by the contractor, it is perhaps understandable that contractors are sometimes not enthusiastic to make the investment when the funding available is transient in nature. In order to invest in their business, contractors require a degree of confidence about future revenue streams and if this is available will happily make a personal and business investment into the successful delivery of the service. This has been clearly demonstrated by the launch of the Medicines Use Review Service (MUR), where from a standing start community pharmacies across Wales are delivering over 130,000 MUR interventions each year. For a contractor to deliver the MUR service they were required to take away sales floor space and to use that space for the establishment of private consultation areas and to undertake significant additional accreditation to provide the service. The fact that the vast majority of contractors across Wales fully embraced this service demonstrates, beyond any reasonable doubt, that when the commissioning arrangements are appropriate and a degree of stability is ensured, community pharmacy will rise to the occasion.

e) Arrangements for national enhanced services are a step in the right direction and where there is an improved degree of security of service. In the case of national enhanced services many more contractors are willing to provide the services when their Health Boards provided the opportunity. For example CPW have periodically registered with Cardiff & Vale Health Board a list of contractors wanting to deliver substance misuse services if the Health Board commissions them. However, this HB still declines to commission this service. Thus, despite well recognised gaps in substance misuse service provision in the Health Board area, a substance misuse client cannot access clean syringes and needles from community pharmacy in the capital city of Wales. This is due to lack of willingness by the Health Board not by the community pharmacy contractors.

f) In relation to the level of uptake of services across Wales this data is now captured on the All Wales Pharmacy Database. CPW assumes the committee research team has obtained reports in whatever format they require from the NHS Wales Shared Services Partnership. CPW would draw to the Committee‟s attention that this public data is not highlighted or distributed in the Welsh Government Stats service and so does not receive the level of transparency or publicity that other NHS funded services receive. The Committee may wish to address this in their recommendations.

7. 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?

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?

This would assist the Committee in understanding the extent to which the commissioning of national services could address some of the issues raised during the inquiry, and what challenges could arise.

Response:

The two main groups of private contractors with NHS are GPs and community pharmacy. It would be reasonable, and easier for the public to understand, for these two groups of contractors to be funded on an equal basis. The provision of services from GP practices is via additional and enhanced services and although the provision of these services by any GP practice is voluntary, where they are provided by the GP practice they are commissioned against a national service specification, with national standards and a nationally agreed remuneration rate.

This approach contrasts with the arrangements for the commissioning of pharmacy services where variations in commissioning, service design and payments are common place. This approach to commissioning is confusing and operationally difficult especially as pharmacies often operate across Health Board boundaries. In all the Plenary Session debates during the Third National Assembly the point was made by speakers from all political parties that they did not support one set of services being available for the population of, say, Swansea and a completely different set for the population of say, Llandudno. The fact that Level 3 smoking cessation services are available to patients in North Wales and Powys, or that a minor ailments service is only available in one part of one Health Board in South East Wales, or that NHS Emergency Contraception was only available in the nation‟s capital when it became a national service is unacceptable.

It is also inappropriate from a professional standpoint as each service specification purports to be based on best practice and there simply cannot be seven versions of best practice.

The recently launched Welsh Government *'Together for Health'* strategy clearly lays out the need for consolidated and integrated services based on the best available evidence and this is what CPW is seeking in terms of community pharmacy services.

CPW were hopeful that the recently launched EHC service would be commissioned on this basis. Disappointingly despite considerable movement in the right direction even this recent service implementation has not been introduced as a Directed Enhanced Service and is, as a result, open to a degree of local interpretation and variation in commissioning. This is confusing for patients. One of the advantages of national services is that the overall national messages and communication about the service can be made very clear and is more effective – patients find out what they are entitled to and are able to request a service. This fits well with the information and web savvy patients of today. But if there is still local variation to what has been officially publicised as a standard national service, then patient confidence in NHS information is undermined.

CPW has recently been working constructively with Welsh Government and its officials to put community pharmacy services on a national footing. However, the ultimate barrier would appear to be the lack of ring-fenced funding for community pharmacy services. Thus, in times of budget stringency it is too tempting for Health Boards to use the money released to them by Welsh Government for community pharmacy services either for other work in their area or just to offset their deficits. While Health Boards are allowed to do this for community pharmacy services, such as for the new hospital Discharge Medicines Service, they are likely to continue to do so. Community pharmacy therefore becomes a source of income for Health Boards rather than also a source of health care provision. This contrasts with GP services, the funding for which is ring fenced by Welsh Government and so cannot be dispersed elsewhere by Health Boards. The Committee may want to look at this is considering its recommendations.

8. Community pharmacy contractual framework

Question 5

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

- If so, what changes would you wish to see to the contract?

- If not, to what would you attribute the main challenges facing the expansion of enhance and advanced services?

- Do you have any further comments on the relationship between the community pharmacy contractual framework and other primary care contracts?

This would assist the Committee in understanding the extent to which changes to the contractual framework might address the challenges of expanding the role of community pharmacy.

Response:

The Community Pharmacy Contractual Framework, as introduced in Wales in 2005, was designed to support the development of community pharmacy through the Enhanced and Advanced Services elements of the contract. There is nothing in the current contract structure that would prevent the development, commissioning and roll-out of any potential new community pharmacy service. The tools have been there since 2005, albeit Regulations have been introduced in a rather “heath robinson” fashion that often require some ingenuity to implement smoothly.

The failure to take the opportunity for the development of new Welsh Community Pharmacy Service has rather been due to a lack of a clear strategic view of the roll that the Welsh Government wishes community pharmacy to undertake in the medium to long-term, coupled with the lack of a clear delivery vehicle, no dedicated funding and the inability for national policy to be effectively delivered through apparently semi-autonomous local structures.

The Committee has seen that in Scotland over the same period the opportunities have not been missed as there has been a clear national policy in the role to be played by community pharmacy in delivering health to the nation. CPW noted the irony of Community Pharmacy Scotland saying in their oral evidence to the Committee that Scotland is too small a country for community pharmacy services to be delivered effectively at less than national level. Scotland is twice the size of Wales.

However, it is now too late to seek for the Welsh government to produce the promised consolidated regulations to implement the 2005 agreement. The direction of Government policy in England will have a significant impact on the ability to deliver community pharmacy services through the existing Wales – England contract. England‟s Secretary of State for Health has declared his intention in the Health & Social Care Bill to produce a separate community pharmacy contract for England based on a national commissioning arrangement. It is important to understand the Welsh Government intentions in response to that announcement. CPW would support the future development of the contract in Wales so that it is a more effective framework tool for the delivery of Welsh Government policy and so mirrors the focus and priorities of NHS Wales.