Health and Social Care Committee

Meeting Venue:
Committee Room 1 - Senedd

Meeting date:
11 January 2012

Meeting time:
09:45

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

For further information please contact:

Llinos Dafydd
Committee Clerk
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Agenda

1. Introductions, apologies and substitutions

2. Inquiry into Residential Care for Older People - Discussion on the inquiry timetable and appointment of expert adviser (09.45 - 10.15)

HSC(4)-01-12 paper 1a - Inquiry timetable
HSC(4)-01-12 paper 1b - Appointment of expert adviser

3. Draft Food Hygiene Rating (Wales) Bill - Discussion on approach to consideration of Draft Bill (10.15 - 10.30)

HSC(4)-01-12 paper 2

4. Inquiry into the contribution of community pharmacy to health services in Wales - Evidence from the Minister for Health and Social Services (10.30 - 11.30)

HSC(4)-01-12 paper 3

Lesley Griffiths AM, Minister for Health and Social Services
Dr Gwyn Thomas, Chief Information Officer
Andrew Evans, Senior Policy Advisor
Roger Walker, Chief Pharmaceutical Adviser

5. Papers to note (Pages 1 - 2)

Minutes of the meeting held on 8 December

HSC(4)-13-11 minutes

Inquiry into Residential Care for Older People – Letter from the Deputy Minister for Children and Social Services
HSC(4)-01-13 paper 4

Letter from the Deputy Minister for Children and Social Services – Implementation of the First Steps Improvement Package
HSC(4)-01-12 paper 5

Inquiry into the contribution of community pharmacy to health services in Wales – Additional written information
Letter from the Chair to the Royal Pharmaceutical Society and Community Pharmacy Wales
HSC(4)-01-12 paper 6

Royal Pharmaceutical Society
HSC(4)-01-12 paper 7

Community Pharmacy Wales
HSC(4)-01-12 paper 8

Family Planning Association – follow up to oral evidence session on 16 November
HSC(4)-01-12 paper 9

Health and Social Care Committee

HSC(4)-01-12 Paper 1a

Inquiry into Residential Care for Older People: Timetable and key themes

To: Health and Social Care Committee

From: Committee Service

Date: January 2012

Purpose

1. This paper proposes an outline timetable for the Health and Social Care Committee's inquiry into residential care for older people.

Background

2. Given the wide scope of this inquiry, the Committee agreed that it would be helpful to consider a work plan for its approach to gathering of oral evidence. A proposed approach was agreed on 8 December 2011 (Paper: HSC(4)-13-11 paper 2).

3. In order to ensure that the Committee addresses all the issues listed in the inquiry's terms of reference, it was agreed that the gathering of oral evidence would be organised in accordance with two principles:

   (i) Oral evidence sessions to be arranged on the basis of interest groups; and

   (ii) Particular themes, as identified in the inquiry's terms of reference, to be allocated to specific Members to take forward for the duration of the inquiry.

Timetable

4. In order to ensure that the Committee considers a broad range of perspectives when undertaking this inquiry, it was agreed that witnesses would be invited to attend Committee on the basis of the interest group to whom they belong. A draft timetable of sessions and list of proposed witnesses is attached at Annex A, based largely on the written evidence received to date. Members may wish to suggest alternative or additional witnesses.

Allocation of key themes to Members

5. In order to ensure that all aspects of the inquiry are addressed comprehensively, it was agreed that each of the bullet points listed in the terms of reference (that is, each key theme) would be allocated to a member(s) of the Committee.

6. In practice, this would mean that the Committee would ask Member A and Member B to concentrate, for the duration of the inquiry, on gleaning information relating to the first bullet point in the terms of reference; Member C, on the other hand, may be asked to take responsibility for matters covered by bullet point two, etc.

   Such an approach would not in any way prohibit Members from asking questions outside their allocated themes but would ensure protection for all themes to be covered, relative to one another.

7. The inquiry's terms of reference (that is, each key theme) are attached at Annex B.

Proposal

8. The Committee is invited to:

   - consider and agree the draft timetable for oral evidence and proposed witnesses (Annex A);
   - consider and agree which Members will lead on each of the key themes identified in the inquiry's terms of reference (Annex B).

ANNEX A

Oral evidence timetable for the inquiry into residential care for older people

It is proposed that the sessions below are scheduled between February and July 2012. Opportunities for other Committee work will also be scheduled, including time for Members to undertake public engagement work on this inquiry.

Session 1: Scene setting

- Appointed expert adviser
- Social Care Institute for Excellence /Centre for Policy on Ageing/ Joseph Rowntree Foundation
- Older People and Ageing Research and Development Network (OPAN Cymru)

Session 2: Service users, their families, and carers:

- Older people's forums, e.g. Pensioners' Forum Wales
- Age Cymru groups
- Carers' groups and organisations representing them e.g. Wales Carers Alliance
- Older People's Commissioner

Session 3: Public sector bodies

- Local authorities/Welsh Local Government Association/Association of Directors of Social Services
- Local health boards/NHS Confederation
- Social Services Improvement Agency/ National Leadership and Innovation Agency for Healthcare

Session 4: Private sector providers

- Care Forum Wales
- Social Care Association
- Large care provider e.g. BUPA

Session 5: Third sector organisations and providers

- Crossroads
- Age Cymru/Age Alliance Wales
- Community Housing Cymru/Care and Repair Cymru
- Wales Co-operative Centre

Session 6: Professional and staff bodies

- British Association of Social Workers Cymru
- UNISON and/or Cymru/Wales Unison Social Services Forum.
- Health professionals, e.g. Royal College of Psychiatrists
- College of Occupational Therapists

Session 7: Regulators and inspectors

- Care and Social Services Inspectorate Wales / Health Inspectorate Wales
- Care Council for Wales

Session 8: Welsh Government

- Deputy Minister for Children and Social Services
- Lead officials

ANNEX B

Terms of reference for the inquiry into residential care for older people

The terms of reference for the inquiry, as agreed by the Committee on 20 October 2011, are as follows:

To examine the provision of residential care in Wales and the ways in which it can meet the current and future needs of older people, including:

- the process by which older people enter residential care and the availability and accessibility of alternative community-based services, including reablement services and domiciliary care.

- the capacity of the residential care sector to meet the demand for services from older people in terms of staffing resources, including the skills mix of staff and their access to training, and the number of places and facilities, and resource levels.

- the quality of residential care services and the experiences of service users and their families; the effectiveness of services at meeting the diversity of need amongst older people; and the management of care home closures.

- the effectiveness of the regulation and inspection arrangements for residential care, including the scope for increased scrutiny of service providers' financial viability.

- new and emerging models of care provision.

- the balance of public and independent sector provision, and alternative funding, management, and ownership models, such as those offered by the cooperative, mutual sector and third sector, and Registered Social Landlords.

Health and Social Care Committee

HSC(4)-01-12 paper 1b

Inquiry into residential care for older people – Appointment of expert adviser

To: Health and Social Care Committee

From: Committee Service

Date: January 2012

EXPERT ADVISER FOR THE INQUIRY INTO RESIDENTIAL CARE FOR OLDER PEOPLE — ROLE SPECIFICATION

Purpose

1. The National Assembly for Wales's Health and Social Care Committee agreed on 8 December to appoint an expert adviser for its inquiry into residential care for older people.

2. Annex A to this paper outlines a proposed specification for the role of expert adviser. Annex B lists potential candidates to undertake this work.

Background

3. The National Assembly for Wales's Standing Orders allow Committees to appoint advisers for the purposes of providing expert advice.[1] To facilitate this, the Assembly offers the opportunity for any expert, researcher or specialist to register as an external expert adviser for short-term research contracts via the website.

4. The purpose of expert advice is to:

   - complement the in-house expertise of the National Assembly for Wales's Research Service; and
   - add value to a Committee's consideration of any particular subject area.

   This is achieved by providing an additional source of information, advice and analytical capacity to a committee from an external party

[1]National Assembly for Wales, Standing Order 17.55 [accessed 15 December 2011]

with a specific and proven specialism in the subject area under committee consideration.

Role specification

5. To ensure that the Committee receives the additional expert support it requires, a role specification has been drafted to specify the key tasks to be completed by the expert adviser. This is attached at Annex A.
6. This specification must be agreed by the Committee prior to the appointment of an expert adviser in order to ensure that:
   - the correct individual is identified to undertake the role; and
   - the successful candidate has a clear understanding of the role he or she is expected to undertake in relation to the inquiry and the associated time commitment.

Candidates

7. The Committee's secretariat, in consultation with the Chair, has identified two possible candidates for the role of expert adviser based on the specification attached at Annex A.

8. Professor Judith Phillips (Professor of Gerontology and Social Work, Centre for Innovative Ageing, Swansea University), Professor Ann Netten (Professor of Social Welfare and Director of the Personal Social Services Research Unit at the University of Kent) and Professor Martin Knapp (Professor of Social Policy and Director of the Personal Social Services Research Unit at the London School of Economics) were also approached as possible candidates for this role. Due to the time commitment involved in this work, they were unable to put their names forward as prospective candidates.

9. Should the Committee wish to amend the specification, or the list of proposed candidates, alternative candidates can be sought. Members should be aware, however, that this will result in a delay in appointing an adviser for the inquiry and may limit his or her ability to complete some of the tasks listed in the specification.

10. Information about each proposed candidate is attached at Annex B.

Decision

11. The Committee is invited to:

- consider and agree the specification for the role of expert adviser for its inquiry into residential care for older people (attached at Annex A); and

- consider the suggested candidates (attached at Annex B) and agree a preferred and reserve candidate.

ANNEX A — ROLE SPECIFICATION

The individual appointed to the role of expert adviser would be asked to:

- **Provide one introductory briefing session for the Committee on Thursday 2 February 2012**
  Expected time commitment (preparation and delivery): 1 day

  The purpose of this 'scene-setting' session would be to provide an introductory perspective on the inquiry, its terms of reference and the written evidence gathered.

- **Work with the Committee's secretariat for the duration of the inquiry to prepare for (and, where necessary, attend) oral evidence sessions**
  Expected time commitment (all evidence sessions inclusive): 5 days

  This would include assisting with the preparation – or review of – background briefing and suggested areas for questioning on the dates to be agreed by the Committee.

- **Work with the Committee's secretariat for the duration of the inquiry to identify the inquiry's emerging themes**
  Expected time commitment: 5 days

  Identifying an inquiry's emerging themes, particularly in advance of any concluding scrutiny session with the responsible Minister, is key to ensuring that the Committee holds the Government to account on the main issues arising from its work. The expert adviser will be expected to work with the Committee's secretariat to identify and summarise key issues arising during oral evidence sessions.

- **Comment on – and contribute to – a paper identifying the inquiry's key issues as the inquiry draws to a close**
  Expected time commitment: 1 day

  The identification of the inquiry's key issues informs the drafting of the Committee's final report, conclusions and recommendations. The expert adviser will be expected to use his /her specialism to assist the Committee in distilling the information gathered during the course of the inquiry into clear, discreet themes and issues for further scrutiny and / or reporting.

- **Review and comment on the Committee's draft final report, including the Committee's key conclusions and recommendations**
  Expected time commitment: 1 day

  One of the most important tools at the disposal of an Assembly Committee is the ability to report on an inquiry. The Government is expected (and does) respond to all Committee reports – as such, a report's content, conclusions and recommendations need to be sufficiently robust and influential to ensure as positive an outcome for the inquiry as possible.

- **Provide such additional advice as the Committee's secretariat and Chair require**
  Time commitment to be agreed as and when necessary, and within the accepted terms of appointment.

  This would be discussed and agreed as necessary between the Committee secretariat and the appointed expert adviser.

ANNEX B — CANDIDATES

Dr Diane Seddon

Senior Research Fellow, Centre for Applied Research and Evaluation Sciences (CARES), Bangor University

Dr Seddon's research interests include: carers and caregiving; assessment and care management; dementia; the health and social care interface; and, nursing and residential care home provision. She has been involved in the development of a successful research programme relating to carers, which has attracted research grants from a wide range of funding bodies, including the Department of Health, Welsh Government and the Big Lottery Fund. Diane has advised on national policy development, including as a Specialist Advisor on domiciliary care to the Welsh Affairs Select Committee, House of Commons. She has also led reviews of national policy implementation, including the evaluation of the National Carers Strategies in England for the Department of Health and in Wales for the Welsh Assembly Government, as well as the Pan-Wales evaluation of the Unified Assessment Process.

Other roles:

- Module coordinator, Evaluating Research and Evidence Based Research Practice, BA Social Work, Bangor University.
- Chair and Trustee, Princess Royal Trust for Carers, Carers Outreach Service, North Wales.
- Departmental representative, College of Banking, Social Sciences and Law Research Ethics Committee, Bangor University.
- Specialist Adviser, House of Commons Welsh Affairs Select Committee (2009).
- Member:
    - Executive Steering Group, NEURODEM Wales.
    - Social Care and Housing Research Development Group for Wales.
    - North Wales Research Grants Committee.

University biography:

http://www.bangor.ac.uk/so/staff/seddon.php.en

Dr Catherine Robinson
Director, Centre for Applied Research and Evaluation Sciences (CARES), Bangor University

Dr Robinson's research interests include: social care and health care policy; policy implementation and practice development; assessment, care management and service provision; the interface between health and social care; family caring; evaluation.

Catherine Robinson is the Director of the newly formed Centre for Applied Research and Evaluation Sciences. This research team was formerly part of the All Wales Alliance for Research and Development AWARD.

Current research projects include:

- *Carers for people with mental health problems: needs assessment to service provision (Robinson, C.A., Seddon, D. and Bowen, S.)*

  This study addresses gaps in understanding of the needs, circumstances and support requirements of carers for people with mental health problems.

- *Unified assessment in Wales: older people with complex needs and their families (Seddon, D., Robinson, C.A., Tommis, Y and Woods, R).*

  This study will explore longitudinally service user and carer experiences of the Unified Assessment process (UA) and subsequent outcomes. Rhodri Morgan is a member of the research team.

Other roles:

- Welsh Assembly Government Social Care Research Advisory Group (2007-)

  Clinical Research Collaboration Cymru, Operational Steering Group (2006-)
- Wales Collaboration for Mental Health Steering Group (2005 -)
- Child Health and Social Care Research Network Steering Group (2006 -)
- Dementia and Neurodegenerative Diseases Research Network for Wales Steering Group (2006 -)
- North Wales Collaboration Joint Policy Board for Health and Social Care (2005-)
- North Wales Research Strategic Committee and Grants Committee (2001 -)

- Chair working group convened to consider the need of Speech and Language Therapists working with Welsh speaking and bilingual children and adults (2005).

University biography:

http://www.bangor.ac.uk/so/staff/robinson.php.en

Health and Social Care Committee

HSC(4)-01-12 paper 2

Draft Food Hygiene Bill – Approach to consideration

Purpose

1. This paper draws the committee's attention to the Draft Food Hygiene Rating (Wales) Bill and outlines some possible options should the committee wish to undertake pre-legislative scrutiny.

Background

2. The Draft Food Hygiene Rating (Wales) Bill was published for a 12 week consultation by the Minister for Health and Social Services on 14 December 2011.[1]

3. The Bill will make it compulsory for food businesses in Wales to display information on their hygiene standards (their food hygiene rating) in a position where it can easily be seen by customers. The Bill will also require local authorities to enforce the mandatory scheme in their area and ensure ratings are correctly displayed.

4. The subject matter of the draft Bill does not lie clearly within the remit of a specific committee. A decision as to which committee it will be referred to will be taken by the Business Committee once a Bill is formally introduced.

Discussion

The use of Draft Bills

5. Draft Bills are used by Government to consult the wider public or particular interest groups on specific legislative proposals. There is no requirement in the Assembly's standing orders for Assembly Committees to consider or scrutinise draft Bills.

6. Draft Bills have become common in the UK Parliament in recent years, and are often scrutinised by a Select Committee before being formally introduced. However, this practice has developed partly because there is no Stage 1 scrutiny process in Westminster while the later Committee stage may not include Members of the original Select Committee. In Scotland, although the Scottish Government does appear to publish some Bills in draft, there does not appear to be much scrutiny of these by Parliamentary Committees.

[1] Available from: http://wales.gov.uk/legislation/programme/assemblybills/foodhygiene/?lang=en

7. While it could be perceived as being counter-productive for Committees not to consider draft Bills, there is the risk that attempting detailed consideration at this stage could compromise or confuse Stage 1 consideration by Committee.

8. In addition, responding formally to the Government consultation could obscure the Committee's role, as well as give insufficient weight to its formal role.

Options

9. It is against this background that the following options are put forward for work that could be undertaken by the Committee:

i. do nothing – as indicated above, there is no requirement in standing orders for committees to undertake pre-legislative scrutiny of Bills and Stage 1 offers scope for consideration of the formally introduced Bill.

ii. invite the Minister to give evidence to the committee as a means of setting the scene for the Bill's introduction later on in the year; however, in this context the committee will wish to be aware of the recent exchange of correspondence between the First Minister and Presiding Officer (attached at Annexe 1) regarding the calling of Ministers to appear before committees in relation to Draft Bills.

iii. invite government officials to brief the committee about the draft Bill as a means of explaining the background to it and keeping the committee informed of developments so that it is fully prepared for Stage 1 scrutiny;

iv. undertake options ii. or iii. with other committees that are likely to have an interest in the Bill, namely the Communities, Equality and Local Government Committee and the Enterprise and Business Committee. This could be done by meeting concurrently or potentially through sub-committees

Action

10. The committee is invited to consider which of the options outlined in paragraph 9 it wishes to pursue in relation to the Draft Food Hygiene Rating (Wales) Bill.

Legislation Office
January 2012

Y Gwir Anrh/Rt Hon Carwyn Jones AC/AM
Prif Weinidog Cymru/First Minister of Wales

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: LF/FM/5121/11

Rosemary Butler AM
Presiding Officer
Chair, Business Committee
National Assembly for Wales
Cardiff Bay
CF99 1NA

17 October 2011

Dear Rosemary

I am writing to you to clarify the Welsh Government's position in relation to the handling of its White Paper and Draft Bill consultations.

The Welsh Government has made a commitment to consulting prior to introducing legislation, whether it be at policy stage, White Paper stage, or by way of a Draft Bill. We have already published a White Paper relation to the School Standards and Organisation Bill, and will shortly be publishing a White Paper on Organ Donation. Later this year we will also publish a number of Draft Bills for consultation.

While I consider both White Papers and Draft Bills to be primarily Government consultations, I have asked Ministers to ensure that Assembly Members are informed prior to publication by way of a Written Ministerial Statement. These consultations are however an exercise in listening to and engaging with stakeholders and the wider public.

We would of course welcome the views the Assembly may have in relation to the proposals outlined in these consultations, whether they come from individual Assembly Members or an Assembly Committee.

However, the appropriate time for the Assembly to properly scrutinise Ministers on Welsh Government legislative proposals is during the formal scrutiny stages once the Bill is formally introduced. We would not wish to undermine the Assembly's scrutiny of Government legislation by circumventing these proceedings.

As such, we would not expect Ministers to be called to appear before Committees during these consultations to discuss a White Paper or Draft Bill. We would however be happy to arrange for officials to provide technical briefings to Committees on individual White Papers or Draft Bills.

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English Enquiry Line 0845 010 3300
Llinell Ymholiadau Cymraeg 0845 010 4400
Ffacs • Fax 029 2089 8198
ps.firstminister@wales.gsi.gov.uk

It is of course for Committees to decide how best to consider these consultations, if they wish to do so, and they may wish to invite evidence from key stakeholders. The Government's position will be clearly set out in each White Paper or Draft Bill, on which we are seeking the views of stakeholders.

I hope that this letter clarifies the Government's position on this matter

Yours sincerely

CARWYN JONES

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Rt Hon Carwyn Jones AM
First Minister of Wales
Welsh Government
Cardiff Bay
CF99 1NA

Your ref: LF/FM/5121/11
Our ref: RB/AC/CJN/PO143

18 October 2011

Dear Carwyn

Thank you for your letter concerning the Welsh Government's position on White Paper and Draft Bill consultations.

Consultation on proposals for Government legislation is a welcome development and I sincerely hope that it will result in wider engagement with the process of making legislation and, ultimately, in better law.

I am pleased that you recognise the importance of the Assembly's formal scrutiny procedures and share your desire that these should not be undermined or circumvented by the process of legislative consultation. Thank you also for signalling the Government's willingness to provide committees with technical briefings from your officials. I am sure that this will be appreciated.

I will share these points with committee Chairs and members of the Business Committee for their information but I am afraid that I cannot guarantee that committees will never invite Ministers to attend committees to discuss White

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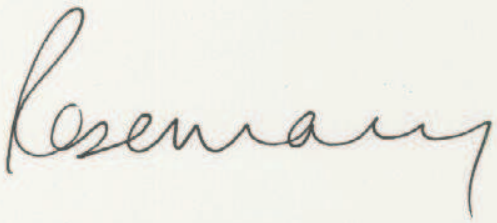
Papers and Draft Bills. It is not a matter for me to dictate to committees how they should approach their work and there might well be occasions when it is perfectly appropriate for them to hear from Ministers when major policy proposals are being formulated. That said, I agree that it would be undesirable for Ministers routinely to be called before committees during consultation periods only to go over exactly the same ground during the Stage 1 scrutiny process.



Rosemary Butler AC, Llywydd
Rosemary Butler AM, Presiding Officer

Health and Social Care Committee

HSC(4)-01-12 paper 3

Inquiry into the contribution of community pharmacy to health services in Wales – Written evidence from the Minister for Health and Social Services

i) This paper provides the Committee with my response to the questions posed in Mr Drakeford's letter to me of 16 August 2011.

Introduction

ii) There are 708 community pharmacies in Wales; 64% of these are multiples, i.e., having 6 or more branches nationwide. Fifteen community pharmacies are supported by the Essential Small Pharmacies Scheme (ESPS). The ESPS aims to ensure the proper provision of pharmaceutical services for individuals in rural areas who would otherwise have difficulties accessing a community pharmacy.

iii) The number of items dispensed by community pharmacies continues to increase every year, rising from 53.1 million in 2005-06 to 65.2 million in 2010-11[1].

iv) Welsh Government investment to support the development of community pharmacy services has increased substantially since the new pharmacy contractual framework was introduced in 2005. The current budget for 2011-12 is £145m, a 51% increase on the £96m provided in 2005; this excludes funding for the costs of medicines prescribed. In addition, the Welsh Government has a separate budget to tackle substance misuse[2]; in 2010-11, £2.3m of this budget funded the provision of needle exchange and the supervised administration of substitute medication for opiate addiction. A pharmacy specific budget of £4.3m is also provided for education and the training of pharmacists (paragraphs 4.16 – 4.17 refer).

1. The effectiveness of the community pharmacy contract in enhancing the contribution of community pharmacy to health and wellbeing services.

1.1 A new community pharmacy contractual framework was introduced in 2005 and signalled a step change in the role of community pharmacists. The framework introduced important advances in community pharmacy services which included:

[1] Welsh Government Statistics: Community Pharmacy Services in Wales 2010-11 – 26 October 2011

[2] Substance Misuse Action Fund (Revenue and Capital) allocated to Community Safety Partnerships of which LHBs are a statutory partner.

- Recognising for the first time the distinctive contribution that community pharmacy can make on a range of health issues;

- Introducing Medicine Use Reviews (MURs) in recognition of the expertise community pharmacists can contribute to improving the use of medicines by patients; and

- Establishing an audit and clinical governance framework that introduced common standards to promote professional, high quality, safe and effective services and mandatory standard operating procedures.

1.2 Key features included standardising information for the public about services offered, introducing patient satisfaction surveys, increasing opening hours to a minimum of 40 hours over 5 days, embedding self care services and signposting within the contractual framework along with mandatory monitoring and reporting of patient safety incidents. All of these have been achieved.

1.3 To underpin the aspirations of the new contract framework, the Welsh Government made significant investment in developing the Information Technology infrastructures of community pharmacies.

1.4 Since 2005 we have provided £12.1 million specifically to support health informatics within community pharmacy services. The key objectives of this investment are to facilitate the transfer of information between healthcare providers and community pharmacy and improve patient safety. Key features include:

- Secure access to the NHS network;
- Electronic prescriptions claims; and,
- Electronic governance framework to facilitate the consistent and comprehensive assessment and monitoring of services throughout Wales.

1.5 The 2005 contractual framework was effective in standardising services and raising the profile of the wider role of community pharmacists; without it, it is doubtful that any progress would have been made and community pharmacists would still be focused almost entirely upon dispensing and not recognised as a major player in the wider health agenda. However, progress has not been quick enough. To energise and prioritise the agenda for community pharmacy the previous Minister for Health and Social Services established a Strategic Delivery Group. This group comprised senior NHS staff and was chaired by the Chairman of Hywel Dda Local Health Board (LHB). The Group were tasked with identifying the key areas for change. Their recommendations have been taken forward and are reflected in the work which has commenced to review the Pharmaceutical Services Regulations and the changes to the contractual framework which came

into effect on 1 November 2011. Further detail on the developments are outlined at paragraphs 3.6 – 3.9, 6.1 – 6.2.

2. The extent to which Local Health Boards have taken up the opportunities presented by the contract to extend pharmacy services through the provision of 'enhanced' services, and examples of successful schemes.

2.1 Enhanced services were enshrined in the 2005 contractual framework to provide an opportunity for a wide range of services to be commissioned from community pharmacists, in addition to core essential services such as dispensing. The opportunity to provide enhanced services was intended to enable LHBs to introduce services based upon an assessment of local healthcare need, and utilise community pharmacy when identified as the most appropriate provider.

2.2 Needle exchange, supervised administration of substitute medication for opiate addiction and smoking cessation are the enhanced services most commonly provided by community pharmacies. Smoking cessation services in particular are showing encouraging quit rates as demonstrated by Public Health Wales (PHW) in their evaluation of the services in North Wales, Powys and Merthyr Tydfil.

2.3 In April 2011, Welsh Government launched the first directed national enhanced service for emergency hormonal contraception. Since introduction 18,500 individuals have accessed a service which is now provided by 386 community pharmacies.

2.4 Annual data on the provision of enhanced services is collected from LHBs and published on the Welsh Government Stats Wales web-site[3].

2.5 In November 2011 NHS Wales Shared Services Partnership launched a new All Wales Pharmacy Database (AWPD) to collate information on services provided by each community pharmacy in Wales. The AWPD ensures there is a single central source of accurate information on community pharmacy services. In the future e-claims submitted by community pharmacists will be linked to this database to verify their individual accreditation status and that of the pharmacy from which the service was provided. AWPD will also provide a feed to NHS Direct to update public facing information.

2.6 In April 2011, to coincide with the launch of the national directed service for the provision of emergency hormonal contraception, the National Electronic Claim and Audit Form (NECAF) was launched. NECAF replaced existing paper based claims and simplified

[3] www.wales.gov.uk/statistics

arrangements for community pharmacists when making claims for providing emergency hormonal contraception services. This has reduced the administrative burden on pharmacists allowing them more time to focus on patient care. Importantly, for the first time it provides comprehensive information on service provision in a timely manner and will support needs assessment and future service planning.

2.7 To support LHBs in developing enhanced services, PHW has carried out a literature review to identify the evidence base and support LHBs in the development of enhanced services. They have also worked with LHBs to complete pharmaceutical needs assessments and thereby provide further information on which to base service planning.

2.8 To further support the delivery of high quality, consistent enhanced services across Wales, we are also finalising national specifications for smoking cessation, needle exchange and supervised administration of substitute medication for opiate addiction services. These specifications will be in addition to that for the emergency hormonal contraception service which is already in place.

3. The scale and adequacy of 'advanced' services provided by community pharmacies

3.1 Advanced services are national schemes for which accreditation is required before the service can be provided. Until the 2011 contract settlement Medicine Use Review (MUR) was the main advanced service provided, with each community pharmacy allowed to provide up to 400 MURs per annum.

3.2 A MUR involves reviewing the patients' use of their medicines to improve understanding of how it should be taken, identify problems that they may be experiencing and help those who may be at risk of not making effective use of their medicines. MURs have also provided pharmacists with an opportunity to formally engage with patients and provide a recognised role in supporting individuals to use their medicines in the most effective manner.

3.3 There are good examples of MURs being used to help patients manage conditions such as asthma by improving inhaler technique and asthma control.[4] Public Health Wales published a literature review on MURs in June 2011 which helped inform the direction of the 2011 changes to the contractual framework.

3.4 The level of participation has increased year on year with 88% of community pharmacies delivering MUR services in 2010-11. The number of MURs carried out has also increased with an average figure of 208 MURs undertaken per pharmacy in 2010-11.

[4] Price A, PCA 2009: Effectiveness of MURs in Asthma – South Wales & the South West.

3.5 As part of a range of changes to the contractual framework that took effect from 1st November 2011, the MUR service was revised to target specific groups of patients. Half of all MURs conducted must be carried out with the following groups:

- Patients taking antihypertensive medication,
- Patients taking medicines for respiratory disease
- Patients taking high risk medicines i.e. medicines known to be associated with patient safety problems
- Patients identified as being at risk of wasting their medicines

3.6 These groups reflect the Welsh Government's commitment, as set out in the Programme for Government, to improve health outcomes in those with circulatory disease, support the 1000 Lives Plus agenda around high risk medicines, address respiratory disease (the second most frequently reported condition from which people in Wales report suffering after circulatory disease[5]) and deliver the Welsh Governments' manifesto commitments to work with community pharmacy. In addition the MURs will seek to:

- Raise awareness of stroke risk; and support the correct use of anti-hypertensive medication; and,

- Significantly reduce the amount of waste medicines, cutting the waste of valuable NHS resources.

The new focussed MURs will also provide an opportunity for the pharmacist to provide advice on self care, tackle lifestyle issues and signpost other services.

3.7 In November 2011 a new advanced service, the Discharge Medicines Review (DMR) service, was launched. The DMR service is targeted at patients discharged from hospital or other care settings into the community. It comprises a two part intervention. The first part requires the community pharmacist to check that the medicines prescribed in the care setting (e.g. hospital) match those taken by the patient when they return to their home. The second part builds on the current MUR service and provides the opportunity for the pharmacist to discuss the patient's use and understanding of their medicines.

3.8 There is evidence that discrepancies arise between the medicines an individual is prescribed on discharge from hospital and the medication they are subsequently prescribed in primary care. Typically this occurs because of problems with the flow of timely and detailed information on their medicines.

[5] Welsh Health Survey 2010. Available at: http://wales.gov.uk/topics/statistics/headlines/health2011/1105191/?lang=en

The active engagement of community pharmacists in this process should help ensure patients receive the medicines intended, and improve both patient safety and health outcomes.

3.9 The continuation of the DMR service after April 2013 will be subject to completion of an evaluation and demonstration of significant patient benefit.

4. The scope of further provision of services by community pharmacists in addition to the dispensing of NHS medicines and appliances, including the potential for minor ailments schemes

New service provision

4.1 As outlined above, from November 2011 a DMR service was introduced to complement the restructured MUR service which now places more emphasis on targeting specific groups of individuals taking medicines. These developments have followed on from the introduction of the first National Enhanced Service for the provision of emergency hormonal contraception in April 2011. It is also planned to introduce three additional specifications for new National Enhanced Services in 2012:

- Community pharmacy based needle and syringe programme;
- Supervised administration of substitute medication for opiate addiction, e.g., methadone; and,
- Smoking cessation.

4.2 Going forward there is a need to recognise the increasing complexity of new medicines and the treatment regimens that patients must follow to obtain benefit from their prescribed medicines. Community pharmacists can provide a key role in supporting patients to gain maximum benefit, minimise side-effects and reduce medicines waste. With their expertise in medicines management, pharmacists need to be at the heart of new service developments in the community and take on greater responsibility and ownership for supporting patients with long term conditions and the vulnerable elderly.

4.3 At any one time[6] a typical community pharmacy can be providing medicines to:

- 8 people with a colostomy
- 20 people with cancer
- 50 people recently discharge from hospital
- 50 people with diabetes
- 150 people with asthma
- 500 people with increased blood pressure

[6] Remedies for success, A strategy for pharmacy in Wales. Welsh Assembly Government 2002

- 600 carers
- 750 pensioners

4.4 All the above benefit from the support and intervention of a community pharmacist. NHS Wales needs a community pharmacy network that is cost effective, located in the heart of the community and supports patients, the public and carers. Community pharmacy services have developed since 2005 and now provide a much greater range of services than just dispensing – important though this is. The Welsh Government is committed to strengthening primary and community care and community pharmacists have a valuable contribution to make alongside GPs and other healthcare professionals. It is important that the contribution of community pharmacists is considered within this context and not in isolation. All options are being explored and we will be consulting widely with healthcare professionals and most importantly, patients.

Minor ailments

4.5 Each year, a large number of GP consultations are for conditions that can be diagnosed by a pharmacist and do not need the intervention of a GP or a prescription only medicine. Minor ailments such as athlete's foot, constipation, cough, diarrhoea, thrush, warts and verrucas, sore throat, threadworm, head lice, headache, hay fever and indigestion are all conditions for which treatment can be supplied by a pharmacist.

4.6 However, research from the Proprietary Association of Great Britain (PAGB)[7] has shown that up to 40% of a GP's time is taken up dealing with patients suffering from minor ailments. This reduces the number of appointments available to patients with more complex conditions and may increase the length of time patients, who need to see a GP, have to wait. The research also identified the patients' own perspective of the barriers to using a community pharmacy for a minor ailment. These included privacy, the need for reassurance from their GP and the cost associated with non prescribed medication.

4.7 Advising on minor ailments is recognised as a core function of pharmacy and in many cases they are more accessible to the individual in terms of journey and waiting times than a visit to their GP. Overall, the evaluation of minor ailment schemes[8][9][10] have concluded they are a safe and effective service and generally well received by patients.

[7] Making the case for the self care of minor ailments – August 2009
[8] Vohra S. A community pharmacy minor ailment scheme-effective, rapid and convenient. Pharmaceutical Journal 2006; 276: 754-756.
[9] Blenkinsopp A; Noyce P. Minor illness management in primary care: a review of community pharmacy NHS schemes - Keele University 2002.
[10] Implementing a community pharmacy minor ailment scheme - National Pharmaceutical Association, 2003

4.8 We are exploring with stakeholders from across Wales a number of issues including:

- The potential range of medicines to be available on the NHS as part of a minor ailment service; and,

- The comparative benefits of a minor ailment service being available during normal opening hours or restricted to weekends and outside normal hours

Rurality

4.9 In our Programme for Government we have re-stated our commitment to a vibrant rural community with access to good quality health services. Rural communities benefit from a sustainable, reliable and effective community pharmacy network. There are good examples of pharmacies providing a range of health care services in our rural communities: smoking cessation (Powys), optimising treatment in heart failure (Hywel Dda) and providing cognitive behavioural therapy for depression in Gwynedd.

4.10 However, there remains a need to build new services based upon a clear understanding of pharmaceutical need that reflects good practice. We are currently exploring this further with PHW; in particular the potential impact of wider community pharmacy services such as MURs and minor ailment services could have on increasing access to services in rural areas.

Public health

4.11 The location, accessibility and foot-fall of community pharmacy puts them in a key position to promote the public health agenda. Whilst the public health contribution of pharmacists should remain focused on their contribution to medicines management, given that taking a medicine is the commonest intervention in health care, they also have roles in disease prevention, screening, monitoring, treating and supporting the population.

4.12 We have yet to realise the full potential impact of community pharmacy involvement in the public health agenda. However progress has been made this year. In June 2011, all community pharmacies in Wales had the opportunity to participate in the first, national, public health campaign. Over the two week period of the campaign, 17, 507 people were screened and 1, 478 found to be at high risk of developing diabetes. This was considered to be a successful campaign by participants and involved collaboration between Public Health Wales, Community Pharmacy Wales, Diabetes UK and Local Health Boards. We need to ensure all pharmacies participate in future

national campaigns; the campaigns for 2012-13 have already been identified and will embrace cardiovascular disease, the expert patient programme and respiratory disease .

4.13 Community pharmacists will also feature in other public health roles including the programme for annual health checks, provision of lifestyle advice and support, emergency contraception, methadone supply, needle and syringe programmes, reducing medicines waste and influenza vaccination.

Influenza vaccination

4.14 The Welsh Government is committed to ensuring influenza vaccination is widely available to those who need it. The location, accessibility, training and expertise of a pharmacist in the community is ideal for the delivery of the influenza vaccination. Although many pharmacists provide vaccination to individuals as a private service outside of the NHS, to date they have not provided an NHS service. It is therefore disappointing that plans to pilot a community pharmacy based NHS influenza vaccination programme in two LHBs for the winter of 2011/12 foundered. However, the LHBs concerned needed to take account of the fact that GPs had placed orders for their vaccine several months earlier and were at risk of having unused stock on their hands. The use of community pharmacists to deliver influenza vaccination will be progressed in 2012/13 with the early engagement of all parties.

Non-medical prescribing

4.15 At the present time there is a limited amount of non medical prescribing taking place in community pharmacy although several community pharmacists are appropriately qualified. Most non-medical prescribing for chronic conditions is undertaken in GP practices and primary care centres in pharmacy led clinics and reflects the desirability of having a clear separation of prescribing and dispensing. In addition, community pharmacists routinely prescribe and supply over the counter medicines, supply medicines in accordance with a Patient Group Directive or make emergency supplies to patients who have typically run out of their medication. All require the skills of a prescriber.

Education

4.16 Workforce development is integral to the delivery of high quality, professional services. The Welsh Government has invested significantly in supporting pre and post pharmacy registration

education and training. In total, £4.3m is invested each year to support a suite of education, training and resources through the Wales Centre for Pharmacy Professional Education (an operational unit of the Welsh School of Pharmacy, Cardiff University) and the National Leadership and Innovations Agency for Healthcare (NLIAH). This includes £3.2m to support students for pre registration training in both the hospital and community sectors and £1.1m to fund the development and delivery of continuing professional development to community pharmacists which is used, in part, to enable them to deliver enhanced services. The range of training available provided by the Welsh Centre for Pharmacy Professional education that is supported by Welsh Government can be accessed at www.wcppe.org.uk

4.17 We are also in early discussions to introduce a new 5 year degree course for pharmacy which will integrate clinical and practice training alongside academic studies. This will produce pharmacists with the clinical skills and knowledge required by the NHS and the citizens of Wales.

5. The current and potential impact on demand for NHS services in primary and secondary care of an expansion of community pharmacy services, and any cost savings they may offer.

5.1 A strengthened, high quality, primary and community care service in Wales delivered by multi disciplinary teams working across sectors will have a positive impact on the secondary care sector and allow them to focus on what they do best. Community pharmacy services have an important contribution to this agenda and are well placed to help deliver this along with GPs, other health care professionals and social services.

5.2 Ensuring the effective and appropriate use of medicines, providing expert advice on self care of long term conditions and other health issues, signposting sources of healthcare support, and the early identification of health problems are just a few examples of the contribution a community pharmacist can make to reduce avoidable admissions or re-admissions to hospital, and thereby deliver cost savings to the NHS.

5.3 Community pharmacy is one of the few healthcare providers that engage with people when they are well and this can be used to target potential vulnerable groups. Community pharmacies are the accessible beacons of the NHS located in the centre of towns and cities across Wales. Moreover, when people are away from home they know they can walk into a pharmacy and get sound health advice or even, in an emergency, medication they may have left behind or lost without incurring significant further costs for the wider NHS.

5.4 There is a clear and increasing requirement for community pharmacy to provide more services in a cost-effective manner against a background of increasing prescription numbers. I am confident community pharmacy can deliver these services and in the November 2011 contractual framework settlement I asked community pharmacy to target specific areas for improvement, e.g., the restructured MUR service and the new DMR service, and made the necessary monies available. Over the next 15 months I will be closely monitoring the contribution of these new services to patient care and expect community pharmacy to demonstrate robust evidence of benefit.

6. Progress on work currently underway to develop community pharmacy services.

6.1 This paper describes the progress that the Welsh Government has made on the development of community pharmacy services and sets out our challenging work programme for the year ahead. None of the achievements so far would have been possible without the commitment of the community pharmacy family in Wales and LHBs and I would like to thank everyone for their input to this agenda. In summary, the key health care service areas we are taking forward are:

- The 2012-13 Public Health campaign which targets the Welsh Government's health priorities of cardiovascular disease, the expert patient programme and respiratory disease;

- The introduction of targeted Medicines Use reviews and Discharge Medicines Reviews that focus on supporting our most vulnerable citizens;

- Ensuring the emergency hormonal contraception service is available in all of those community pharmacies where needed;

- Introducing the new national enhanced service specifications for community pharmacy based needle and syringe programme, supervised administration of substitute medication for opiate addiction and smoking cessation;

- Embedding community pharmacists in the delivery of the new annual health checks for everyone aged 50 plus;

- The development and promotion of community pharmacy as the first port of call for individuals with minor ailments; and,

- Establishing a community pharmacy based NHS influenza vaccination programme for winter 2012.

6.2 In support of these developments, Welsh Government will shortly consult on changes to the pharmaceutical regulations to streamline

and simplify the "Control of Entry" application, approval and appeal process. We are also looking to strengthen and integrate the planning of pharmaceutical services within the context of primary and community care planning at LHB and locality levels. In the longer term future, we will seek through legislation to make these plans the basis for LHBs to determine applications to open new pharmacies.

Agenda Item 5

Health and Social Care Committee

Meeting Venue:	**Committee Room 3 – Senedd**
Meeting date:	**Thursday, 8 December 2011**
Meeting time:	**09:30 – 11:20**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

This meeting can be viewed on Senedd TV at:
http://www.senedd.tv/archiveplayer.jsf?v=en_400000_08_12_2011&t=0&l=en

Concise Minutes:

Assembly Members:	**Mark Drakeford (Chair)** **Mick Antoniw** **Rebecca Evans** **Vaughan Gething** **William Graham** **Elin Jones** **Lynne Neagle** **Lindsay Whittle**
Witnesses:	**Dr Chris Jones, Welsh Government** **Grant Duncan, Welsh Government**
Committee Staff:	**Sarah Beasley (Clerk)** **Llinos Dafydd (Clerk)** **Naomi Stocks (Clerk)** **Catherine Hunt (Deputy Clerk)** **Joanest Jackson (Legal Advisor)** **Gregg Jones (Researcher)** **Stephen Boyce (Researcher)** **Victoria Paris (Researcher)**

1. Introductions, apologies and substitutions

1.1 Apologies were received from Darren Millar and Kirsty Williams. There were no substitutions.

2. Update on EU policy issues relevant to the Health & Social Care Committee

2.1 The Committee discussed the paper with Gregg Jones from the Research Service.

2.2 The Committee requested further information on health inequalities including any forthcoming legislation, the approval of drugs throughout the EU, and models of care for the elderly in EU countries.

2.3 The Committee agreed to consider EU policy issues again as part of a wider discussion on its future work programme.

3. Inquiry into Residential Care for Older People – Committee work plan

3.1 The Committee agreed the work plan for its inquiry into residential care for older people.

4. Organ Donation White Paper – Technical Briefing from Welsh Government officials

4.1 The officials responded to questions from members of the Committee on the Organ Donation White Paper.

4.2 The officials agreed to provide the following additional information, as requested by the Committee:

- a list of Third Sector organisations included in the consultation exercise on the White Paper;
- details of future public meetings on the White Paper;
- clarification as to whether the current arrangements for organ and tissue donation extend to England and Wales only, or also include Scotland and Northern Ireland.

4.3 The Committee agreed to hold a similar session at the end of the consultation process on the White Paper.

5. Papers to note

5.1 The Committee noted the minutes of the meetings held on 16 and 24 November.

5.2 The Committee noted the papers to note.

6. Motion under Standing Order 17.42(vi) to resolve to exclude the public from the meeting for items 7 & 8

6.1 The Committee agreed the Motion to resolve to exclude the public from the meeting for items 7 & 8.

7. Inquiry into Stroke Risk Reduction – Draft report

7.1 The Committee considered the draft report on its inquiry into stroke risk reduction.

8. Preparation for scrutiny session with the Minister for Health and Social Services

8.1 The Committee considered the issues it would raise with the Minister for Health and Social Services at the scrutiny session with her on 25 January 2012.

TRANSCRIPT

View the meeting transcript.

Gwenda Thomas AC / AM
Y Dirprwy Weinidog Plant a Gwasanaethau Cymdeithasol
Deputy Minister for Children and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref MBGT/7504/11

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

2nd December 2011

Dear Mark,

I have seen your letter of 24 October confirming that the Committee is to hold an inquiry into residential care for older people and which outlined the terms of reference of this inquiry.

I read with interest the wide-ranging nature of this inquiry, which I think the Committee should be congratulated upon. I note that you have also issued an invitation for evidence for this. For my part I am more than happy to provide written and/or oral evidence to the Committee to help inform this process when you feel this would be helpful.

As you will be aware I had intended to establish a task group that would consider over the next year the care and accommodation needs of older people. However, given the comprehensive terms of reference of the Committee's inquiry I have decided to hold this proposal in abeyance. As there would be a strong possibility of duplication I have concluded, on reflection, that it would be sensible to await the outcome of your inquiry before considering this proposal further.

Yours sincerely,
Gwenda.

Gwenda Thomas AC / AM
Y Dirprwy Weinidog Plant a Gwasanaethau Cymdeithasol
Deputy Minister for Children and Social Services

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Agenda Item 5b

Gwenda Thomas AC / AM
Y Dirprwy Weinidog Plant a Gwasanaethau Cymdeithasol
Deputy Minister for Children and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: SF/GT/6989/11

Mark Drakeford AM
Chair
Health and Social Care Committee
National Assembly for Wales
Cardiff Bay
Cardiff

12 December 2011

Dear Mark,

Update on the Monitoring of the Implementation of the First Steps Improvement Package

You will recall that during the Committee's scrutiny on 20 October of the Assembly's draft budget, I promised to write to share the outcome of the first half yearly monitoring exercise that I had put in place on the implementation of the First Steps Improvement Package. That Package was to introduce more consistency where local authorities decided to charge for the non-residential social services they provide, or for which they arranged the provision. This was in light of the wide variations in the level of charges and calculation of charges that operated across local authorities in Wales, often for the same services.

As part of my post implementation monitoring of this Package, during the first year of implementation two half yearly monitoring exercises are being undertaken to assess its impact. The first of these concluded recently and I am now able to share with the Committee the main outcomes from this. In providing these I should stress that given the limited nature of this first return (ie covering just the initial 6 months of implementation) these can only represent a snapshot of what has occurred to date and will need to be verified further by the second exercise to be undertaken at the end of the financial year.

The good news is that due to the legislation we introduced authorities are reporting that no service user in Wales is paying more than £50 per week for the non-residential social services they receive provided under the service provision powers referred to in the Social Care Charges (Wales) Measure 2010. This is a substantial benefit for some service users who, depending upon their financial means, would have been paying several hundred pounds per week for their services. This is especially so where their local authority had no maximum charge previously for these services. In terms of those receiving a service, authorities report that around 30,000 individuals are receiving a service for which a charge could be levied, but that only around 18,000 are charged. Some authorities also report an increase in those seeking a service for the first time, although depending upon their care needs and the authority's eligibility criteria for services, it is not always the case that this results in an increase in the overall number of service users an authority has. This is

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something to be expected on the implementation of such an initiative as this. Nevertheless it will be interesting to see from the end year exercise whether this issue is still occurring then or whether requests for services have levelled off.

As a result a minority of authorities are at present reporting an above average increase over their original estimate of the income they will forego as a direct result of implementing the Package. That original estimate they provided last year to inform the £10.117 million p.a. that we included from 2011-12 in the RSG to local government to reimburse authorities for this lost income. Working with those authorities who have reported such increases to establish the nature of these, inconsistencies have been found in some authorities' calculations, leading in those cases to reductions in their estimates of income foregone provided.

Nevertheless it is important that we have a true reflection of the income that authorities are foregoing as a result of the Package's implementation. As a result I am asking authorities who continue to identify an increase in their income foregone in the second monitoring exercise to be undertaken at the end of the financial year to verity this with their section 151 officer. This is to ensure that authorities have calculated these estimates in the correct manner and that we have reliable data upon the full year financial effect on authorities in order to base decisions upon. (Under section 151 of the Local Government Act 1972 every authority is to make arrangements for the proper administration of their financial affairs and requires one officer to be nominated within the authority to take responsibility for this. This officer is usually the authority's treasurer and must be a qualified accountant belonging to one of the recognised chartered accountancy bodies). We will then, on the basis of this end year exercise, be able to take stock as to full impact of the Package's implementation and what further action, if any, we may need to take.

I trust the Committee will find this summary of the current monitoring exercise undertaken with local authorities informative.

Yours sincerely

Gwenda Thomas.

Gwenda Thomas AC / AM
Y Dirprwy Weinidog Plant a Gwasanaethau Cymdeithasol
Deputy Minister for Children and Social Services

Health and Social Care Committee

HSC(4)-01-12 paper 6

Inquiry into the contribution of community pharmacy to health services in Wales – Request for further information from Community Pharmacy Wales and the Royal Pharmaceutical Society

Attached as annexes to this paper are letters from the Chair of the Health and Social Care Committee to Community Pharmacy Wales and the Royal Pharmaceutical Society requesting further information as part of the Committee's inquiry into the contribution of community pharmacy to health services in Wales.

Committee Service

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Health and Social Care Committee

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Russell Goodway
Chief Executive
Community Pharmacy Wales

8 December 2011

Dear Russell,

As you will be aware, the Health and Social Care Committee's inquiry into the contribution of community pharmacy to health services in Wales will draw to a close shortly. The final oral evidence session will take place on Wednesday 11 January 2012 when we will scrutinise the Minister for Health and Social Services on this subject.

The Committee is grateful for the evidence you have provided for this inquiry to date. As you appeared before the Committee during its first oral evidence session on community pharmacy, we would like to seek your views on a number of points which have been raised in subsequent sessions. These points are listed in Annex A to this letter.

It would be most helpful to receive your response by **Friday 23 December** so that the information you provide can be considered when we scrutinise the Minister early in the new year. Please could you contact the Clerk on the details below should you foresee any problems with providing the information by this date.

Cofion gorau,

Mark Drakeford

Mark Drakeford AM
Chair of the Health and Social Care Committee

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ANNEX A

During the Health and Social Care Committee's gathering of evidence for the inquiry into the contribution of community pharmacy to health services in Wales, issues in relation to the four points below have been raised. The Committee would be grateful to know the views of CPW in relation to each of these points.

1. "Hard to reach" groups and MURs

Community Pharmacy Wales's 2011 manifesto states that:

> "Community pharmacies are especially well placed to capture those hard to reach groups and to work with them to address these challenges."[1]

The manifesto also says:

> "…community pharmacies operate at the heart of the community, and yet provide healthcare services to people who are often hardest to reach but who need it the most."[2]

Public Health Wales (PHW) told us, however, that the uptake of MURs, for example, is lower in areas where one would expect it to be higher,[3] citing a study in England that suggests lower take-up in poorer areas.[4] PHW noted that community pharmacy colleagues would have a better understanding of what drives uptake of such services (e.g. whether it is an issue of patients not coming forward, or not being encouraged to do so; whether pharmacists are not in a position to encourage uptake because of other pressures they face).

Question 1

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.

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[1] National Assembly for Wales, Health and Social Care Committee, Consultation response: CP 24 – Community Pharmacy Wales, page 9 of the manifesto document [accessed 7 December 2011]

[2] Ibid, page 11 of the manifesto document

[3] National Assembly for Wales, Health and Social Care Committee, Record of Proceedings, [para 28], 10 October 2011

[4] Bradley F et al. *Determinants of the uptake of medicines use reviews (MURs) by community pharmacies in England: A multi-method study*. Health Policy 2008; 88: 258-68

2. Community pharmacy capacity

Figures on the uptake for the national diabetes campaign delivered via the community pharmacy network indicated that a quarter of the network did not provide an evaluation of their work on this campaign, suggesting that some may not have participated at all.[5] The figure for non-responders rises to 40% in Pembrokeshire and Ceredigion.[6]

When asked about this during the oral evidence session, CPW rejected the notion that there are fewer locally enhanced services because pharmacists simply do not wish to provide them. Instead, you argued that this is attributable, in the main, to a lack of commissioning on the part of local health boards.[7]

When talking about the future potential for community pharmacy, however, Mr Chris Martin, Chair of the Hywel Dda Local Health Board and a pharmacist by profession, told us that:

> "…[his] greatest fear is that [his] profession will not deliver on this expanding role in sufficient numbers to provide fair and equitable service provision."[8]

Question 2

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.

[5] Nuala Brennan, Public Health Wales, Community pharmacy diabetes risk health promotion campaign, 24.8.11, page 5 [accessed 7 December 2011]
[6] Ibid, page 6
[7] National Assembly for Wales, Health and Social Care Committee, Record of Proceedings, [paras 140 - 141], 28 September 2011
[8] National Assembly for Wales, Health and Social Care Committee, Record of Proceedings, [para 199], 2 November 2011

3. Provision of services at a national level

CPW's supplementary written evidence on the Scottish contract states that:

> "…the national nature of the Scottish contract makes it more akin to there being a range of national enhanced services. This is what CPW has supported for many years."[9]

RPS's written evidence also welcomes national service provision via the community pharmacy network.[10] Representatives from local health boards told the Committee on 2 November that the national approach to commissioning services adopted in Scotland "…is definitely the way in which we should be going."[11]

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.

4. Community pharmacy contractual framework

During the oral evidence session on 28 September,[12] Community Pharmacy Wales told the Committee that you believed "…that part of the problem is the contractual arrangements that exist". RPS also told us in their written evidence that "…the community pharmacy contractual framework has the potential to support a more integrated and clinical role

[9] National Assembly for Wales, Health and Social Care Committee, HSC(04)-12-11 - Paper 4: Inquiry into the contribution of community pharmacy to health services in Wales - Additional evidence from Community Pharmacy Wales, 24 November 2011 [accessed 7 December 2011]
[10] National Assembly for Wales, Health and Social Care Committee, Consultation response: CP 6 - Royal Pharmaceutical Society, section 6 [accessed 7 December 2011]
[11] National Assembly for Wales, Health and Social Care Committee, Record of Proceedings, [para 228], 2 November 2011
[12] National Assembly for Wales, Health and Social Care Committee, Record of Proceedings, [para 162], 28 September 2011

for this workforce"[13], but that there have been missed opportunities and barriers to its utilisation, including a lack of synergy with other primary care contracts.[14]

LHB representatives also told us there is a need to scope out the capacity and resource needed to develop a new Welsh contract for community pharmacy.[15] This, they argued, was due to the fact that the current contract is volume-based[16] and means that medicines in Wales are delivered "in silos".[17]

Despite these alleged contractual limitations, evidence also suggests that opportunities already provided via the existing contract are not being utilised (cf. section 2 of this Annex).

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.

If there is any additional information of relevance to the inquiry which is not mentioned in this letter but you would like to raise, please feel free to include this in your response.

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[13] National Assembly for Wales, Health and Social Care Committee, Consultation response: CP 6 - Royal Pharmaceutical Society, section 2 [accessed 7 December 2011]
[14] National Assembly for Wales, Health and Social Care Committee, Consultation response: CP 6 - Royal Pharmaceutical Society, section 5.1.1 [accessed 7 December 2011]
[15] National Assembly for Wales, Health and Social Care Committee, Record of Proceedings, [para 198], 2 November 2011
[16] Ibid, para 209
[17] Ibid, para 210

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Health and Social Care Committee

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Mair Davies
Chair, Welsh Pharmacy Board
Royal Pharmaceutical Society

8 December 2011

Annwyl Mair,

As you will be aware, the Health and Social Care Committee's inquiry into the contribution of community pharmacy to health services in Wales will draw to a close shortly. The final oral evidence session will take place on Wednesday 11 January 2012 when we will scrutinise the Minister for Health and Social Services on this subject.

The Committee is grateful for the evidence you have provided for this inquiry to date. As you appeared before the Committee during its first oral evidence session on community pharmacy, we would like to seek your views on a number of points which have been raised in subsequent sessions. These points are listed in Annex A to this letter.

It would be most helpful to receive your response by **Friday 23 December** so that the information you provide can be considered when we scrutinise the Minister early in the new year. Please could you contact the Clerk on the details below should you foresee any problems with providing the information by this date.

Cofion gorau,

Mark Drakeford.

Mark Drakeford AM
Chair of the Health and Social Care Committee

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During the Health and Social Care Committee's gathering of evidence for the inquiry into the contribution of community pharmacy to health services in Wales, issues in relation to the four points below have been raised. The Committee would be grateful to know the views of RPS in relation to each of these points.

5. "Hard to reach" groups and MURs

During the oral evidence session on 28 September[18] and in written evidence,[19] RPS told the Committee that community pharmacy delivers services to - and engages with – cohorts of the population who were previously difficult to reach. It was suggested that this was due not only to the location of community pharmacies but to the accessibility and openness of community pharmacy services.[20]

Public Health Wales (PHW) told us, however, that the uptake of MURs, for example, is lower in areas where one would expect it to be higher,[21] citing a study in England that suggests lower take-up in poorer areas.[22] PHW noted that community pharmacy colleagues would have a better understanding of what drives uptake of such services (e.g. whether it is an issue of patients not coming forward, or not being encouraged to do so; whether pharmacists are not in a position to encourage uptake because of other pressures they face).

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"?

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.

[18] National Assembly for Wales, Health and Social Care Committee, Record of Proceedings, [paras 8 – 12], 28 September 2011
[19] National Assembly for Wales, Health and Social Care Committee, Consultation response: CP 6 - Royal Pharmaceutical Society, section 3 [accessed 7 December 2011]
[20] National Assembly for Wales, Health and Social Care Committee, Record of Proceedings, [para 10], 28 September 2011
[21] National Assembly for Wales, Health and Social Care Committee, Record of Proceedings, [para 28], 10 October 2011
[22] Bradley F et al. *Determinants of the uptake of medicines use reviews (MURs) by community pharmacies in England: A multi-method study.* Health Policy 2008; 88: 258-68

6. Community pharmacy capacity

In your written evidence, you state that RPS's vision for community pharmacy would include community pharmacies as "the walk-in health care centres for great public health service provision".[23]

When talking about the future potential for community pharmacy, however, Mr Chris Martin, Chair of the Hywel Dda Local Health Board and a pharmacist by profession, told us that:

> "…[his] greatest fear is that [his] profession will not deliver on this expanding role in sufficient numbers to provide fair and equitable service provision."[24]

In addition, figures on the uptake for the national diabetes campaign delivered via the community pharmacy network indicated that a quarter of the network did not provide an evaluation of their work on this campaign, suggesting that some may not have participated at all.[25] The figure for non-responders rises to 40% in Pembrokeshire and Ceredigion.[26]

Question 2

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.

7. Provision of services at a national level

RPS's written evidence welcomes national service provision via the community pharmacy network.[27] Representatives from local health boards also told the Committee on 2 November that the national approach to

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[23] National Assembly for Wales, Health and Social Care Committee, Consultation response: CP 6 - Royal Pharmaceutical Society, section 7 [accessed 7 December 2011]
[24] National Assembly for Wales, Health and Social Care Committee, Record of Proceedings, [para 199], 2 November 2011
[25] Nuala Brennan, Public Health Wales, Community pharmacy diabetes risk health promotion campaign, 24.8.11, page 5 [accessed 7 December 2011]
[26] Ibid, page 6
[27] National Assembly for Wales, Health and Social Care Committee, Consultation response: CP 6 - Royal Pharmaceutical Society, section 6 [accessed 7 December 2011]

commissioning services adopted in Scotland "…is definitely the way in which we should be going."[28]

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.

8. Community pharmacy contractual framework

During the oral evidence session on 28 September,[29] Community Pharmacy Wales told the Committee that they believed "…that part of the problem is the contractual arrangements that exist". RPS also told us in your written evidence that "…the community pharmacy contractual framework has the potential to support a more integrated and clinical role for this workforce"[30], but that there have been missed opportunities and barriers to its utilisation, including a lack of synergy with other primary care contracts.[31]

LHB representatives also told us there is a need to scope out the capacity and resource needed to develop a new Welsh contract for community pharmacy.[32] This, they argued, was due to the fact that the current contract is volume-based[33] and means that medicines in Wales are delivered "in silos".[34]

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[28] National Assembly for Wales, Health and Social Care Committee, Record of Proceedings, [para 228], 2 November 2011
[29] National Assembly for Wales, Health and Social Care Committee, Record of Proceedings, [para 162], 28 September 2011
[30] National Assembly for Wales, Health and Social Care Committee, Consultation response: CP 6 - Royal Pharmaceutical Society, section 2 [accessed 7 December 2011]
[31] National Assembly for Wales, Health and Social Care Committee, Consultation response: CP 6 - Royal Pharmaceutical Society, section 5.1.1 [accessed 7 December 2011]
[32] National Assembly for Wales, Health and Social Care Committee, Record of Proceedings, [para 198], 2 November 2011
[33] Ibid, para 209
[34] Ibid, para 210

Despite these alleged contractual limitations, evidence also suggests that opportunities already provided via the existing contract are not being utilised (cf. section 2 of this Annex).

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.

If there is any additional information of relevance to the inquiry which is not mentioned in this letter but you would like to raise, please feel free to include this in your response.

ROYAL CYMDEITHAS PHARMACEUTICAL FFERYLLOL SOCIETY FRENHINOL
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Chair, Health and Social Care Committee
National Assembly for Wales
Cardiff Bay
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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

ROYAL CYMDEITHAS PHARMACEUTICAL FFERYLLOL SOCIETY FRENHINOL
Wales Cymru

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.

Community Pharmacy Wales
Fferylliaeth Gymunedol Cymru

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

RUSSELL GOODWAY
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.

Health and Social Care Committee

HSC(4)-01-12 paper 9

Inquiry into the contribution of community pharmacy to health services in Wales – Additional information from the Family Planning Association

siarad synnwyr am ryw
talking sense about sex

December 2011

Health and Social Care Committee Inquiry into Community Pharmacy – Additional Information from FPA

FPA is one of the UK's leading sexual health charities. Melanie Gadd, Project Co-ordinator for Jiwsi in North Wales appeared before the Committee to give oral evidence on Wednesday 16 November 2011. This is our briefing on additional information the Committee asked for.

Figures on the number of pharmacies across Wales that are participating in the Emergency Hormonal Contraception (EHC) scheme

Community Pharmacy Services that offer emergency hormonal contraception (EHC) 2010 – 11[1]

Local Health Board (LHB)	Number of services that offer EHC
Betsi Cadwaladar University LHB	101
Powys Teaching LHB	13
Hywel Dda LHB	67
ABM LHB	86
Cwm Taf LHB	41
Aneurin Bevan LHB	78

[1] Source: Statswales Community Pharmacy Services 2010-11
http://www.statswales.wales.gov.uk/TableViewer/tableView.aspx?ReportId=26599

Cardiff and Vale LHB	0
	TOTAL IN WALES: 386