**National Assembly for Wales**
Health and Social Care Committee

# The contribution of community pharmacy to health services in Wales

May 2012

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Health and Social Care Committee
National Assembly for Wales
Cardiff Bay
CF99 1NA

Tel: 029 2089 8403
Fax: 029 2089 8021
Email: HSCCommittee@wales.gov.uk

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## Health and Social Care Committee

The Committee was established on 22 June 2011 with a remit to examine legislation and hold the Welsh Government to account by scrutinising expenditure, administration and policy matters encompassing: the physical, mental and public health of the people of Wales, including the social care system.

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# Chair's foreword

This inquiry on the contribution of community pharmacy to health services in Wales has been the longest completed by the Committee during our first year. All political parties represented at the Assembly went into last year's election with positive Manifesto commitments to enhance the role of community pharmacists. It seemed, therefore, a very suitable topic for an early, detailed Committee investigation. I am very grateful to all those who have helped us in doing so – the many individuals and organisations who have provided oral and written evidence, the Minister and her officials for keeping us in touch with the steps being taken by the Welsh Government, as well as the Committee's own staff.

As with our first Inquiry into stroke risk reduction, the Committee has been anxious to focus this Report on a small number of key conclusions and recommendations. These appear at the start of the Report, in a format which we hope will make our work accessible to the large number of people who take an active interest in this important area of devolved responsibility. Our recommendations focus on the core, priority actions which we believe the Welsh Government should take over the coming period. The body of the Report contains a set of further propositions which we put forward for the Government to consider. Together, they provide a substantial policy prospectus which, we believe, can help make up for some lost time, and some lost opportunities, in making the most of community pharmacy here in Wales.

While our main conclusion has been to endorse the basic proposition that there is a greater contribution which community pharmacy could, and should, make to the future of health services in Wales, it is important to note that not everything is as rosy in the community pharmacy garden as its most enthusiastic advocates might suggest. Coverage is more patchy than it first appears – geographically and in terms of opening hours and services provided. In addition, the financial savings which are sometimes claimed to arise from increasing the scope of community pharmacy are not as easy to substantiate, or realise, as advocates suggest – although we are convinced that scope for savings does exist.

Finally, we welcome the steps which have already been taken by the Welsh Government in this area, including new pharmacy services in the community which have come into being during the period of our Inquiry. In the pages which follow, we identify a set of issues – technical, contractual, financial and, particularly, professional – which need to be addressed, in order that this process can be taken even further, to the benefit of Welsh patients. It is a topic to which we intend to return, during the lifetime of this Committee, in order to monitor progress against the recommendations contained here.

**Mark Drakeford AM**

Chair of the Health and Social Care Committee
May 2012

# The Committee's key conclusions and recommendations

The Committee's key conclusions and recommendations to the Welsh Government are listed below. They are **not** listed in the order that they appear in the report - please refer to the relevant pages of the report to see the supporting evidence. A list of additional propositions made by the Committee in this Report is provided at Annex A.

### Key conclusions

The Committee is convinced that there is more community pharmacy can do to contribute to health services in Wales.

**(Key conclusion 1, page 22)**

The Committee endorses the proposition that community pharmacies have a reach into communities across Wales that other services can find difficult to penetrate. This, in our view, is a key strength of the network. **(Key conclusion 2, page 22)**

Significant barriers to realising the full potential of community pharmacy lie both within the profession and between professional groups in the health service. It is our view that work needs to be done within community pharmacy to bring the standard of the whole network up to the standard of the best. We also believe that there is a considerable inter-professional responsibility to resolve some of the issues between professions which were illustrated during our inquiry as barriers to the future development of community pharmacy.

**(Key conclusion 3, page 78)**

### Recommendations

The Committee recommends that the Welsh Government provides a clear national lead for the future development of community pharmacy services to ensure that the necessary policies and structures are in place to secure its delivery. This should include nationally agreed priorities for the service and a centrally driven direction for its development. **(Recommendation 2, page 30)**

The Committee recommends that the Welsh Government promotes further enhanced services with a national specification for community pharmacy, including a national Chronic Conditions Service, and follows the incremental model proposed for the introduction of the National

Minor Ailments Scheme to ensure robust monitoring, evaluation and improvement of services. The Committee recommends that where there are clearly *national* health conditions, the service should be *nationally* specified, but that some continuing scope should be allowed for the volume and location of such services to be determined locally. **(Recommendation 4, page 56)**

The Committee recommends access by community pharmacists to summary patient records where patients are registered with a community pharmacy. **(Recommendation 7, page 79)**

The Committee recommends that the consistent participation of community pharmacies across Wales is secured for the next round of public health campaigns, whether national or local. Close monitoring of community pharmacy's participation is required by Local Health Boards to ensure that those failing to deliver on their contractual obligations are called to account for their non-compliance. **(Recommendation 5, page 63)**

The Committee recommends that the Welsh Government improves the communication mechanisms it uses to inform the general public about the services available at any individual community pharmacy. To this end, we recommend that the Welsh Government makes it an obligation for all community pharmacies to place a prominent notice in their premises identifying the range of services available in that pharmacy. **(Recommendation 1, page 27)**

The Committee recommends that the Welsh Government should take the opportunity afforded by the recently announced national minor ailments scheme to consider changes to the way in which community pharmacies are remunerated, including a transition to capitation-based payments, underpinned by a patient registration system. **(Recommendation 3, page 39)**

The Committee recommends that the Welsh Government and Local Health Boards prioritise taking proactive action to address issues of cooperation and joint working between community pharmacists and GPs, both in rural and urban areas. We believe that better leadership from within the professions in this context is vital to securing the stronger relationships between key health professionals which are needed for the successful integration of community pharmacy services and the delivery of the Government's ambitions for primary care in Wales. **(Recommendation 6, page 78)**

# 1. Introduction

1. The Health and Social Care Committee agreed on 13 July 2011 to undertake an inquiry into the contribution of community pharmacy to health services in Wales. The purpose of this inquiry was to examine how effective the 2005 Community Pharmacy contract has been in developing the contribution of community pharmacy to health and wellbeing services in Wales.

2. Our report draws a number of key conclusions in relation to the role community pharmacy can play in Welsh health services. Most notably, we do not feel that the contribution of community pharmacy has been fully realised to date. Furthermore, the Committee believes that there is further scope for community pharmacy to be utilised to help meet the health needs of the Welsh population.

3. During the course of this inquiry a number of announcements relating to the provision of community pharmacy services have been made by the Minister for Health and Social Services.[1] Where possible, these announcements have been taken into account during the course of the Committee's deliberations.

### Terms of reference

4. The inquiry's terms of reference were:

To examine the effectiveness of the Community Pharmacy contract in enhancing the contribution of community pharmacy to health and wellbeing services, including:

- 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;
- the scale and adequacy of 'advanced' services provided by community pharmacies;

[1] Announcements include the introduction of a discharge medicines review service (31 October 2012), the launch of a consultation on pharmacy regulations in Wales (1 February 2012) and the establishment of a national minor ailments scheme in Wales (7 March 2012)

- the scope for further provision of services by community pharmacies in addition to the dispensing of NHS medicines and appliances, including the potential for minor ailments schemes;
- 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;
- progress on work currently underway to develop community pharmacy services.

**Method of inquiry**

5. The Committee launched a call for written evidence on 1 August 2011. We received 44 responses from individuals and organisations. We began taking oral evidence on 28 September 2011 and held 10 evidence sessions over the course of 7 Committee meetings. Our evidence gathering drew to a close with oral evidence from the Minister for Health and Social Services, Lesley Griffiths AM, on 11 January 2012.

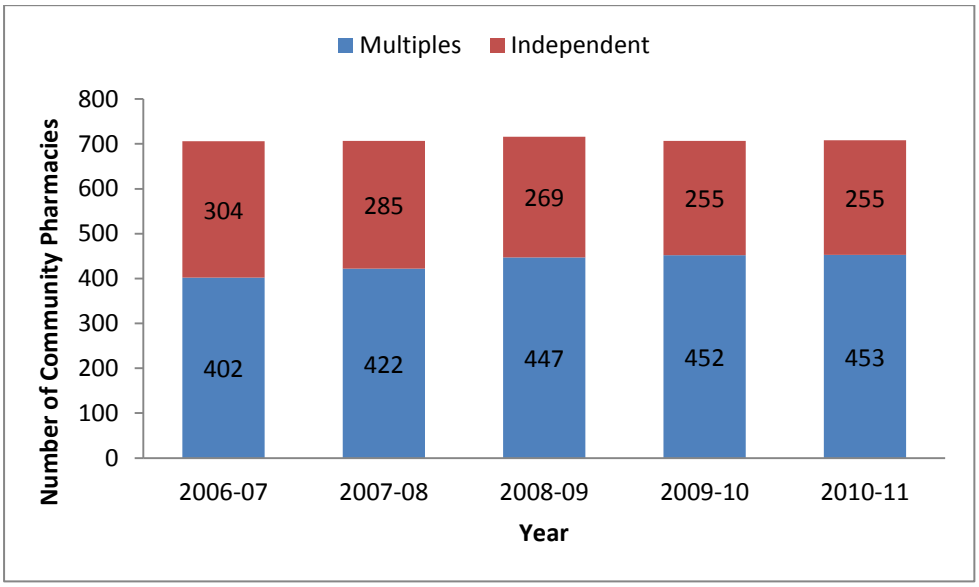
6. We would like to thank all those who responded to this inquiry for taking the time to inform our considerations via written or oral evidence. A list of those who gave oral evidence is provided in Annex B to this report; a list of all written submissions is provided in Annex C.

# 2. Background

7. Community pharmacies are often patients' first point of contact with healthcare professionals and services. Regardless of demography or geography, community pharmacies operate in almost all communities in Wales and are one of a limited number of providers of publicly-funded services with a remaining presence on the high street. It is currently estimated that, on an average day, the network of community pharmacies across Wales will deal with more than 50,000 individual cases.[2]

### The community pharmacy network in Wales

8. The community pharmacy network in Wales comprises 710 community pharmacies.[3] Since 2003, there has been little change to the number of community pharmacies in Wales. Figures for 2011show that 64% of community pharmacies in Wales (453 of 708) were run by multiples, meaning that 6 or more branches were held nationwide by a parent company.




9. Due to the geography of Wales, fifteen community pharmacies are supported by the Essential Small Pharmacies Scheme (ESPS). The ESPS aims to ensure adequate provision of pharmaceutical services for individuals in rural areas who would otherwise have difficulties

[2] National Assembly for Wales, Health and Social Care Committee, *Consultation Response CP24 – Community Pharmacy Wales* para 1.5 [accessed 20 April 2012]
[3] Welsh Government Consultation Document *Proposals to reform and modernise the NHS (Pharmaceutical Services) Regulations 1992* February 2012, para 28 [accessed 20 April 2012]

accessing a community pharmacy.[4] In addition, in some parts of Wales, doctors are authorised to provide pharmaceutical services.[5]

## Services provided by community pharmacies

10. Services provided by community pharmacies are outlined in the NHS Community Pharmacy Contractual Framework ("the contract"). The current contract was introduced in 2005 and consists of three levels of services: essential services, advanced services and enhanced services. Whilst pharmacy owners (contractors) must provide essential services, they can choose whether they wish to provide advanced and enhanced services.

11. The contractual framework is explored in more detail in chapter 4.

### *Essential services*

12. All community pharmacies in England and Wales must deliver key functions, referred to as *essential services*. Essential services include:

- dispensing of medicines;
- repeat dispensing;
- the safe disposal of unused medicines or medication waste;
- the promotion of healthy lifestyles;
- sign-posting to other health professionals;
- support for self-care; and
- clinical governance, ensuring that the quality of advice provided to patients is high, patients' views on services are obtained and their complaints are heard.[6]

[4] National Assembly for Wales, Health and Social Care Committee, *HSC(4)-01-12 Paper 3 – Evidence from the Minister for Health and Social Services*, para (ii), 11 January 2012 [accessed 20 April 2012]
[5] Welsh Government Consultation Document *Proposals to reform and modernise the NHS (Pharmaceutical Services) Regulations 1992* February 2012, para 24 [accessed 20 April 2012]
[6] National Assembly for Wales, Health and Social Care Committee, *Consultation Response CP5 – Public Health Wales* p3 and *Consultation Response CP6 – Royal Pharmaceutical Society* section 3.1 [all accessed 20 April 2012]

*Advanced and enhanced services*

13. Additional services – referred to as *advanced services* and *enhanced services* – can also be provided via the community pharmacy network. Services of this kind range from medicines use reviews – where pharmacists support patients on multiple medications to take their medicines as intended and to identify any problems the patient may have in doing so[7] – to smoking cessation services, where pharmacies will provide one to one support and advice to people who want to give up smoking[8].

14. The key characteristics of advanced and enhanced services are summarised in Table 1 below:

**Table 1: Key characteristics of advanced and enhanced services under the CPCF**

| SERVICE | Commissioner | Delivery | Current examples |
|---|---|---|---|
| **Advanced services** | Local Health Boards, under direction from the Welsh Government | All community pharmacies can choose to provide advanced services, subject to meeting the necessary accreditation standards and delivery criteria.<br><br>There is no requirement for pharmacies to offer advanced services. | Medicines use reviews (MURs)<br><br>Discharge medicines reviews (DMRs) |
| **Enhanced services** | Commissioned locally by the Local Health Board to reflect the needs of the local population.<br><br>Can be locally or nationally developed | Community pharmacies commissioned by the relevant Local Health Boards to deliver the service.<br><br>Local Health Board determines the specification for local enhanced services and negotiates fees for delivery.<br><br>Welsh Government determines specifications and fees for national enhanced services. There is no requirement for pharmacies to offer enhanced services. | Smoking cessation services<br><br>Minor ailment services<br><br>Needle and syringe programmes<br><br>Supervised consumption of methadone<br><br>Emergency Hormonal Contraception Service |

[7] Pharmaceutical Services Negotiating Committee, *MUR* [accessed 20 April 2012]
[8] Ibid, *Stop Smoking service specification*, September 2005 [accessed 20 April 2012]

# 3. The national direction for community pharmacy

## Introduction

15. In March 2005, the then Minister for Health and Social Services Dr Brian Gibbons AM claimed that:

> "The new [community pharmacy] contract will enable community pharmacists to contribute to NHS provision for patients, to provide a more rewarding and stimulating working environment for the profession, and to reduce the burden of work on many other members of the primary healthcare team. The new contract framework is flexible, and better reflects the extended range of services that local health boards will want to commission on behalf of their local communities…By bringing these provisions into effect, we will be better placed to challenge health inequalities across Wales, as well as improving the standards of healthcare for people."[9]

16. It was anticipated that the 2005 contractual arrangements would provide a step change in the role of community pharmacists, developing the profession beyond its traditional dispensing role to providing overarching pharmaceutical care for patients via new additional services.[10] The contribution community pharmacy could make to the wider health agenda was given greater recognition, and the opportunity was put in place to expand the type of services provided by the network.

17. Despite these high hopes, evidence provided to this inquiry indicates that, although some progress has been made in the seven years since the new contract was introduced, significant limitations to the effective utilisation of the contract remain. Where progress has been made, it has been patchy and inconsistent. More worryingly, little if any progress has been made in relation to certain aspects of the 2005 vision for community pharmacy.

18. Nevertheless, there is a broad consensus that community pharmacy has the potential to help meet more of the health needs of the Welsh population, but that the driving factor for future progress

[9] National Assembly for Wales, Plenary, *RoP [page 81]*, 15 March 2005 [accessed 20 April 2012]
[10] National Assembly for Wales, Health and Social Care Committee, *Consultation Response CP6 – Royal Pharmaceutical Society*, section 3 [accessed 20 April 2012]

will be a clearer national direction for the service in Wales. This chapter explores these issues.

### Potential contribution of community pharmacy

19. The potential for community pharmacy to play a role beyond the traditional dispensing of medicines was acknowledged in almost all evidence submitted to this inquiry. According to witnesses, the strengths of community pharmacy-based health services include:

- the network's **accessibility**, due to the its high street presence and geographical spread;[11]
- its **ability to serve hard to reach groups**, for example young men, rural populations, deprived populations and those who do not attend a GP practice[12]; and
- the fact that it is a **relatively anonymous service** and thus, for certain needs and conditions, an arguably less intimidating way of accessing health care[13].

20. Areas identified by witnesses where community pharmacy can contribute to wider health services include:

- **cost-savings** for the NHS;[14]
- **reducing pressures on other areas of the NHS**, for example GP services, A&E and bed space in secondary care;[15] and
- supporting the **transfer of care** from the secondary to the primary and community sectors[16].

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[11] National Assembly for Wales, Health and Social Care Committee, *Consultation Responses CP13 – Mind Cymru; CP 19 – the Princess Royal Trust for Carers; CP21 National Pharmacy Association; and CP41 Diabetes UK* [all accessed 20 April 2012]
[12] Ibid *RoP [para 7-12]*, 28 September 2012; *Consultation Response CP8 – Company Chemists Association*; *Consultation Response CP18 – ABPI* [all accessed 20 April 2012]
[13] Ibid *RoP [para 83-84]* 16 November 2012; *Consultation Response CP41 – Diabetes UK* [accessed 20 April 2012]
[14] Ibid *Consultation Response CP24 – Community Pharmacy Wales* and *RoP [para 134]* 11 January 2012 [all accessed 20 April 2012]
[15] Ibid *RoP [para 133–135]*, 11 January 2012; *RoP [para 145]*, 28 September 2011; *RoP [para 33]*, 24 November 2011 [all accessed 20 April 2012]
[16] Ibid, *RoP [para 246]*, 2 November 2011 and *RoP [para 47]*, 28 September [all accessed 20 April 2012]

*Accessibility*

21. The accessibility of the community pharmacy network is clear. As noted by the National Pharmacy Association:

> "Located where people work, shop and live, [community pharmacies] provide convenient advice and support to the people of Wales right at the heart of their communities. To the public, it is perhaps the most accessible face of the NHS."[17]

22. This argument was not made by pharmacists alone. The Princess Royal Trust for Carers noted that community pharmacists are "a frontline provider [of services], readily available, and easily accessible".[18] Diabetes UK and Mind Cymru agreed, stating that the Wales-wide network means that community pharmacy is easily accessible and available to people[19] and, for many, is the most accessible health interface in their community[20]. According to the Minister for Health and Social Services:

> "Community pharmacies are the accessible beacons of the NHS located in the centre of towns and cities across Wales."[21]

23. Some respondents to the Committee's written consultation also advocated a role for community pharmacies in providing advice and support with pharmaceutical needs to groups with specific requirements such as carers[22], refugees and asylum seekers[23], Black and Minority Ethnic communities[24], Lesbian, Gay, Bisexual and Transgender communities[25] and those with particular conditions such as hearing loss[26], Parkinson's Disease[27] or those with mental health

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[17] National Assembly for Wales, Health and Social Care Committee, *Consultation Response CP21- National Pharmacy Association*, para 2.1 [accessed 20 April 2012]
[18] Ibid *Consultation Response CP19 - The Princess Royal Trust for Carers* [accessed 20 April 2012]
[19] Ibid *Consultation Response CP13 - Mind Cymru* [accessed 20 April 2012]
[20] Ibid *Consultation Response CP41- Diabetes UK* [accessed 20 April 2012]
[21] Ibid *HSC(4)-01-12 Paper 3 - Evidence from the Minister for Health and Social Services*, para 5.3, 11 January 2012 [accessed 20 April 2012]
[22] Ibid *Consultation Response CP19 - The Princess Royal Trust for Carers* [accessed 20 April 2012]
[23] Ibid *Consultation Response CP31 - Welsh Refugee Council* [accessed 20 April 2012]
[24] Ibid *Consultation Response CP37 - Welsh Food Alliance*, para 52-54 [accessed 20 April 2012]
[25] Ibid *Consultation Response CP1- National Union of Students Wales* [accessed 20 April 2012]
[26] Ibid *Consultation Response CP35 - Action on Hearing Loss Cymru* [accessed 20 April 2012]
[27] Ibid *Consultation Response CP22 - Parkinson's UK* [accessed 20 April 2012]

problems[28]. They argued that, in this context, community pharmacies can increase access to health services and have the potential to address health inequalities.

24. Claims made by Community Pharmacy Wales (CPW) that the network is open seven days a week, 365 days per year and operates outside the hours of 9.00am to 5.00pm[29] were, however, queried by the Committee and other witnesses. Responding to CPW's claim, Catherine O'Sullivan, Chief Officer of the Aneurin Bevan Community Health Council, told the Committee:

> "I have not known many pharmacies in Gwent to be open 24/7…there may be a pharmacy open on a rota for an hour on a Sunday, but that still means that you have to travel a considerable distance to access that pharmacy."[30]

25. The Committee recognises that the presence of the community pharmacy network across Welsh high streets means that it is a highly accessible interface for health services in Wales. There was a clear consensus in the evidence that this makes it a potentially very useful conduit for the delivery of health services in Wales.

*'Hard to reach' groups*

26. During the course of our inquiry it was also claimed that, as well as being easily accessible to the general population, community pharmacies have the ability to serve 'hard to reach'[31] groups. Community Pharmacy Wales argued that pharmacies can reach those in rural communities who struggle to access services in their localities (supported in the most remote areas by the Essential Small Pharmacies Scheme) and those not engaged with GP services, either through not being registered or by being unable to access those services during normal opening hours. They also noted that the highest concentration

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[28] National Assembly for Wales, Health and Social Care Committee, *Consultation Response CP13 – Mind Cymru* [accessed 20 April 2012]
[29] Ibid *Consultation Response CP24 – Community Pharmacy Wales* para 2.4 [accessed 20 April 2012]
[30] Ibid *RoP [para 78]*, 10 November 2011[accessed 20 April 2012]
[31] 'Hard to reach' could include the homeless, travellers, asylum seekers, refugees, people with disabilities, rural populations and deprived populations. Other hard to reach groups could include those who are able to access services but rarely engage with them due to their attitudes towards health. Men traditionally fall into this second category.

of community pharmacies in Wales is in the most disadvantaged communities.[32]

27. This trend was confirmed by a recent Public Health Wales report, *Distribution of community pharmacies and deprivation in Wales*, which illustrated the positive correlation between the number of pharmacies in a locality and its relative level of deprivation.[33] The report concluded that:

> "Locating appropriate services within community pharmacies could provide an opportunity to reduce inequalities and support increased access to services for those living in more deprived areas."[34]

28. The Committee's inquiry did highlight the fact that empirical evidence to support the claim that community pharmacy serves hard to reach groups in Wales is sparse; further research is needed to provide a firm evidence base for this claim. Although community pharmacies are more likely to be found in areas of greatest need, evidence suggested that the availability of a service cannot be equated, simply, with greater use. It is the Committee's understanding that, even though pharmacies are to be found in disadvantaged areas, people may not be making best use of the services they provide.[35]

29. In addition to the network's accessibility and potential to serve those who are traditionally hardest to reach, evidence suggested that the relative anonymity of the community pharmacy service means it is an arguably less intimidating way of accessing health care. Melanie Gadd of the Family Planning Association told the Committee:

> "The thing about going into a pharmacy is that you could be going in there for any reason. This takes a lot of the stigma away."[36]

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[32] National Assembly for Wales, Health and Social Care Committee, *HSC(4)-01-12 paper 8 – Additional evidence from Community Pharmacy Wales*, 11 January 2012 [accessed 20 April 2012]
[33] Public Health Wales *Distribution of community pharmacies and deprivation in Wales* 18 January 2012 [accessed 20 April 2012]
[34] Ibid p8 [accessed 20 April 2012]
[35] National Assembly for Wales, Health and Social Care Committee, *RoP [para 28-30]*, 12 October 2011 [accessed 20 April 2012]
[36] Ibid *RoP [para 97]* 16 November 2011[accessed 20 April 2012]

30. Jason Harding from Diabetes UK Cymru agreed, noting that community pharmacy provides "…the opportunity to provide easy access to non-threatening and non-authority health professionals."[37]

*Cost and time savings*

31. According to Community Pharmacy Wales, the introduction of community pharmacy minor ailment services, post discharge medicines services, medicines management services and medicines waste services could save £95 million pounds for the NHS in Wales annually.[38] CPW's manifesto for the 2011 National Assembly election *Good Health – Community Pharmacy: The Best Medicine for Health Lives in Wales* sets out where it believes the savings could be made:

**Table 2: Possible cost savings for the NHS in Wales via the introduction of community pharmacy services, as claimed by Community Pharmacy Wales**

| *Community pharmacy service* | *Potential saving per year* | *Reasoning* |
|---|---|---|
| Medicines Management | £10 million | CPW claim that between 30% – 50% of patients fail to take their medicines correctly or are otherwise non-compliant with their prescribed medicines regime.<br><br>They note that this often results in unnecessary hospital admissions and other interventions, costing the NHS in Wales almost £10 million a year. |
| Minor Ailments | £30 million | CPW cite research by the Bow Group – *Delivering Enhanced Pharmacy Services in a Modern NHS* – to support this assertion.<br><br>The Bow Group claim that significant savings could potentially be made if patients were seen by their pharmacist for minor ailments instead of their GP.[39] This is based on a 2008 publication by the Personal Social Services Research Unit (PSSRU) which noted that an average GP consultation costs £32 for the NHS[40], whilst the same consultation in a pharmacy would cost an average £17.75[41]. |

[37] National Assembly for Wales, Health and Social Care Committee, *RoP [para 84]* 16 November 2011[accessed 20 April 2012]
[38] Ibid *Consultation Response CP24 – Community Pharmacy Wales* p23 [accessed 20 April 2012]
[39] The Bow Group, *Enhanced Pharmacy Services in a Modern NHS* ,16 September 2010 [accessed 20 April 2012]
[40] Personal Social Services Research Unit (PSSRU) *Unit Costs of Health and Social Care 2008* p109, 23 December 2008 [accessed 20 April 2012]
[41] Ibid p98

| | | |
|---|---|---|
| Hospital Discharge Specialists | £5 million | According to CPW 25% of discharge letters never reach a patient's GP and 38% of hospital readmissions are related to medications (61% of which are preventable). They claim that a discharge medicines reconciliation service could save the NHS more than £5m a year in avoidable and unnecessary secondary care services. |
| Medicines Waste | £50 million | CPW claim that wasted medicines cost the Welsh NHS £50m per year and that a targeted medicines waste service based in community pharmacies could save this sum. |

*Source: Community Pharmacy Wales 2011 Manifesto, page 5*

32. Aneurin Bevan Health Board's written evidence noted a saving of £50,000 to its budget in 2010-2011 due to its waste reduction scheme. Addressing the question of what cost savings an expansion of community pharmacy services could offer, the Board argued that:

> "Waste reduction is key to improving efficiencies within the health service and medicines are no different to other areas of health. With £50 million estimated of wasted medicines each year a concerted effort needs to be made to reduce this wastage."[42]

33. As noted by Public Health Wales, however, although the transfer of services from general practice to community pharmacy can reduce GP workload in terms of the number of minor ailment consultations they undertake, there is little evidence that overall GP workload decreases – GPs merely accept different types of consultation in the freed up time.[43] However, the Committee's inquiry does suggest that a shift in workload of this kind frees GPs' time to do other things which can save money in other parts of the health system (for example, by allowing GPs more time to concentrate on looking after more frail and elderly people in the community, thus avoiding unnecessary admissions to secondary care).

[42] National Assembly for Wales, Health and Social Care Committee, *Consultation Response 20 – Aneurin Bevan Health Board* [accessed 20 April 2012]
[43] Ibid *Consultation Response 5 – Public Health Wales* pp 12-13 [accessed 20 April 2012]

**Proposition 1: The Committee believes that further independent analysis of the possible cost-savings associated with an expanded community pharmacy ought to be commissioned by the Welsh Government. This would ensure a more robust basis upon which to build any future work to develop community pharmacy on the grounds of cost-savings.**

34. According to Community Pharmacy Wales, however, the expansion of community pharmacy is not about cost savings alone:

> "It is not just about saving money; it is about releasing resources…Some people who have minor ailments, such as head lice or whatever, really do not need to see a doctor; they would be better off coming to a pharmacy."[44]

35. Giving evidence on 11 January 2012, the Minister for Health and Social Services, Lesley Griffiths AM, told the Committee that a community pharmacy minor ailments scheme *alone* had the potential to free up to 40% of general practitioner appointments. She noted that, although those GP appointments would be taken up by other people, "they will hopefully need them more".[45] Professor Roger Walker, the Welsh Government's Chief Pharmaceutical Officer, reiterated this claim noting that, in the case of a minor ailments scheme, the general literature suggests that 38% of work could be shifted from GPs to community pharmacy.[46]

36. Although doctors' representatives attending Committee on 2 November agreed that potential cost savings could be made by expanding community pharmacy services, they argued that "the evidence is a bit anecdotal".[47]They did acknowledge, however:

> "If pharmacists can advise on minor illnesses, it will free up time for other patients with more complex needs. That is a very good use of pharmacy time…pharmacists looking at minor ailments is absolutely a way that you can free up GP services

[44] National Assembly for Wales, Health and Social Care Committee, *RoP [para 145]*, 28 September 2011 [accessed 20 April 2012]
[45] Ibid *RoP [para 135]*, 11 Jan 2012 [accessed 20 April 2012]
[46] Ibid *RoP [para 133]*, 11 Jan 2012 [accessed 20 April 2012]
[47] Ibid *RoP [para 63]*, 2 November 2011 [accessed 20 April 2012]

for more complex care, and make the health service more accessible for patients as well."[48]

37. In addition to the claim that expanding community pharmacy services could improve access to GP services, evidence submitted to the inquiry suggested that it also has the potential to reduce pressures on A&E and secondary care beds, and to support the transfer of care from the secondary to the primary and community sectors. Chris Martin, Chair of Hywel Dda Health Board, told the Committee that better use of pharmacy within primary care could "stop those patients who are frequent flyers from going into hospital all the time."[49]

**Key conclusion 1: The Committee is convinced that there is more community pharmacy can do to contribute to health services in Wales.**

**Key conclusion 2: The Committee endorses the proposition that community pharmacies have a reach into communities across Wales that other services can find difficult to penetrate. This, in our view, is a key strength of the network.**

### Policy intentions of the Welsh Government

38. As quoted at the beginning of this chapter, the Welsh Government hailed the potential contribution of community pharmacy to Welsh health services when the new contract was introduced in 2005, and has continued to favour its development since that time. Despite this, a strong theme flowing through this inquiry has been the need for a greater sense of national direction in the development of community pharmacy services in Wales.

39. Evidence has suggested that, where left to local health board commissioning, the development of additional community pharmacy services has been patchy and inconsistent at best, and absent at worst. Witnesses claimed that this inconsistent commissioning of services has led to a lack of uniformity of provision across Wales; this in turn, they argued, has frustrated public awareness of additional pharmacy services and caused a degree of confusion for people about where to access the treatments they may need. Where services have been

[48] National Assembly for Wales, Health and Social Care Committee, *RoP [para 61]*, 2 November 2011 [accessed 20 April 2012]
[49] Ibid *RoP [para 246]*, 2 November 2011 [accessed 20 April 2012]

commissioned on a national basis, however, evidence has suggested that they have been more successfully embedded and understood by the public. These issues are explored in this section, and in further detail in chapter 5.

*Local Health Board commissioning*

40. The commissioning of enhanced community pharmacy services has been a matter left largely to Local Health Boards in Wales. According to Community Pharmacy Wales, however:

> "…the commissioning of enhanced services by the Welsh Health Boards has been extremely disappointing. The anticipated transformation of community pharmacies into high street health care centres has at best been slow and piecemeal and, at worst, been non-existent."[50]

41. Alliance Boots stated that:

> "…there is a lack of consistency across the country due to different commissioning by health boards and variations in service specifications. Services are patchy and despite being national priorities, not everyone in Wales can access them."[51]

42. Giving evidence to the Committee on 2 November, representatives from three of Wales's seven Local Health Boards – Hywel Dda, Betsi Cadwaladr and Cwm Taf – acknowledged that opportunities have been missed by local health boards to commission additional services from community pharmacy.[52] Reasons given by health boards for the lack of uptake include the lack of an evidence base of which services could be commissioned to achieve the best impact[53] and an alleged overlap between the community pharmacy and General Medical Services contracts (explored in more detail in the next chapter)[54]. The most prevalent reason given by boards for the relatively

[50] National Assembly for Wales, Health and Social Care Committee, *Consultation Response CP24 – Community Pharmacy Wales* p17 [accessed 20 April 2012]
[51] Ibid *Consultation Response CP30 – Alliance Boots* p2 [accessed 20 April 2012]
[52] Ibid *RoP [para 224]*, 2 November 2011 [accessed 20 April 2012]
[53] Ibid *RoP [para 226]*, 2 November 2011 [accessed 20 April 2012]
[54] Ibid *Consultation Response CP15 – Betsi Cadwaladr University Health Board* [accessed 20 April 2012]

poor uptake of opportunities, however, was a lack of funding streams to support the development of community pharmacy services.[55]

43. Public Health Wales also acknowledged that the lack of long-term funding streams for community pharmacy services has been a challenge both for health boards and community pharmacy contractors and that repeated pilots and short-term funding have been a source of frustration.[56] According to Community Pharmacy Wales:

> "…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…This contrasts with GP services, the funding for which is ring fenced."[57]

44. The Royal Pharmaceutical Society agreed that the financial backing of secured funding streams for new services is needed to increase commissioning activity by local health boards, but went on to argue that there is a lack of expertise amongst those planning services at that level.[58] They argued that:

> "…pharmaceutical care requires a more prominent role at executive and strategic levels within each Health Board. This should increase opportunities for the inclusion of pharmaceutical care in the planning and development of new models of care to ensure the full potential of pharmacy is realised."[59]

45. When asked whether there is a need to raise the profile of pharmaceutical care at the executive level, Chris Martin, Chair of Hywel Dda Health Board agreed that, although there is access within the

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[55] National Assembly for Wales, Health and Social Care Committee, *Consultation Response CP3 – Abertawe Bro Morgannwg University Health Board* and *Consultation Response CP20– Aneurin Bevan Health Board* [all accessed 20 April 2012]
[56] Ibid *Consultation Response 5 – Public Health Wales* p6 [accessed 20 April 2012]
[57] Ibid *HSC(4)-01-12 paper 8 – Additional evidence from Community Pharmacy Wales*, 11 January 2012 [accessed 20 April 2012]
[58] Ibid *Consultation Response CP6 – Royal Pharmaceutical Society* section 5.1.2 [accessed 20 April 2012]
[59] Ibid

organisations to pharmaceutical expertise, this may not be high enough within the hierarchy.[60]

46. It is of concern to the Committee that, despite the claims of an alleged lack of expertise at executive level within LHBs, the Minister for Health and Social Services continues to emphasise that the provision of services remain a matter for local health boards to deliver where they think they are needed.[61] This concern is exacerbated by the fact that, although the Government's investment to support the development of community pharmacy services increased by 51% between 2005 and 2011-12 (from £96 million to £145 million, excluding funding for the costs of medicines prescribed)[62], local health boards continue to claim that sufficient funding mechanisms are not in place to develop services.

**Proposition 2: The apparent divergence between the Welsh Government's view of its investment in the provision of community pharmacy services on the one hand, and the views of local health boards which are responsible for service commissioning on the other, is of concern to the Committee. Work should be undertaken by the Minister's department and LHB representatives as a matter of priority to address this.**

*Public information and awareness*

47. A frequent observation made by witnesses during the course of this inquiry was that variable provision across Wales has led to a lack of public understanding of the availability of additional community pharmacy services. When asked about the level of knowledge and understanding by the general public of the services provided by community pharmacies Catherine O' Sullivan, Chief Office of Aneurin Bevan Community Health Council, said:

> "I think that there is confusion…so many pharmacists offer so many different levels of service. One will offer emergency contraception and a needle-syringe programme, while others will not. It is down to their personal choice as to which service

[60] National Assembly for Wales, Health and Social Care Committee, *RoP [para 204]*, 2 November 2011 [accessed 20 April 2012]
[61] Ibid *RoP [para 192]*, 11 January 2012 [accessed 20 April 2012]
[62] Ibid *HSC(4)-01-12 Paper 3 – Evidence from the Minister for Health and Social Services*, introduction, 11 January 2012 [accessed 20 April 2012]

> they would like to offer in that locality. Some services are focused on local need, but it is down to the pharmacists as to what services they will offer. There is no consistency; there is a great variation between pharmacies."[63]

48. In addition to the influence of the variability of service provision on public awareness of community pharmacy services, Abertawe Bro Morgannwg University Health Board[64], Conwy County Borough Council[65] and Age Cymru[66] argued that further work to raise the profile of the services offered by community pharmacies is needed to improve public awareness of their availability.

49. When asked about the alleged lack of public information about – and awareness of – community pharmacy services, the Minister for Health and Social Services acknowledged in Committee that:

> "…there has been a fragmented giving of information about what is available from community pharmacies. We have developed the all-Wales pharmacy database, which is able to capture information regarding all of the available services. We must now work with stakeholders, such as local health boards, to ensure that they give out that information to the local population, so that they are aware of what the pharmacy can provide and how it can sometimes be a first port of call for minor ailments, for instance."[67]

| **Table 3: The All Wales Pharmacy Database** |
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| The All Wales Pharmacy Database was launched in November 2011 by the NHS Wales Shared Services Partnership. The purpose of this database is to collate information on services provided by each community pharmacy in Wales and to act as a single central source of accurate information on community pharmacy services. The database will also provide a feed to NHS Direct to update public facing information.[68] Community pharmacists will be asked to verify the information held on the database on an annual basis for auditing purposes. |

[63] National Assembly for Wales, Health and Social Care Committee, *RoP [para 32]*, 10 November 2011 [accessed 20 April 2012]
[64] Ibid *Consultation Response CP3 – Abertawe Bro Morgannwg University Health Board* p1 [accessed 20 April 2012]
[65] Ibid *Consultation Response CP16 – Conwy County Borough Council* p2 [accessed 20 April 2012]
[66] Ibid *Consultation Response CP29 – Age Cymru* p4 [accessed 20 April 2012]
[67] Ibid *RoP [para 84]*, 11 January 2012 [accessed 20 April 2012]
[68] Ibid *HSC(4)-01-12 Paper 3 – Evidence from the Minister for Health and Social Services*, para 2.5, 11 January 2012 [accessed 20 April 2012]

50. The Chief Pharmaceutical Adviser reiterated the Minister's comments, noting that:

> "…on signposting and the clarity of services offered through community pharmacy, I am conscious that we have to do more. We have to work with LHBs to do more in that area."[69]

**Proposition 3: The Committee welcomes the establishment of the All Wales Pharmacy Database.**

51. The Committee was struck during the course of this inquiry that more information about different types of services available at any individual community pharmacy is needed for the general public. It is our view that clarity of communication is needed – led by the Welsh Government – to ensure clearer understanding of which services are available within any given community pharmacy.

**Recommendation 1: The Committee recommends that the Welsh Government improves the communication mechanisms it uses to inform the general public about the services available at any individual community pharmacy. To this end, we recommend that the Welsh Government makes it an obligation for all community pharmacies to place a prominent notice in their premises identifying the range of services available in that pharmacy.**

*Strategic national direction*

52. According to the Royal Pharmaceutical Society:

> "Since the introduction of the [community pharmacy contractual framework] there has been no corresponding strategic vision for pharmaceutical care and pharmacy services in Wales…there appears to be a significant gap between national policy intent and local interpretation and implementation across Wales."[70]

53. The National Pharmacy Association argued that:

> "…putting a [contractual] framework in place has little value unless it is accompanied by a clear vision and delivery

[69] National Assembly for Wales, Health and Social Care Committee, *RoP [para 172]*, 11 January 2012 [accessed 20 April 2012]
[70] Ibid *Consultation Response CP6 – Royal Pharmaceutical Society* [accessed 20 April 2012]

> plan…the Welsh Government has adopted a 'hands-off' approach leaving the health boards to introduce community pharmacy services without any strategic direction…The absence of a coherent and shared vision and delivery plan for community pharmacy is a key factor in the underutilisation of the network."[71]

54. The pharmacy profession was not alone in calling for a national strategy for services in Wales. Nursing colleagues argued that stronger national direction is key to designing policies and services.[72] The Royal College of Nursing told the Committee that:

> "There needs to be clearer national direction to try to get some kind of consistency…If it is left to individual committees and individual areas, you will get that kind of inconsistency in approach."[73]

55. Local Health Board representatives also called for a clearer national direction from the Welsh Government for the development of community pharmacy services. Chris Martin, Chair of Hywel Dda Health Board referred to the recommendation of the Strategic Delivery Group which evolved from the Task and Finish Group established by the then Minister for Health and Social Services, Edwina Hart, to review pharmaceutical services in Wales in 2009. This Group suggested that national enhanced services, common to all, that are standardised and could be delivered consistently across Wales rather than the current position, should be explored.[74]

| **Table 4: Pharmacy Strategic Delivery Group** |
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| In 2009 the then Minister for Health and Social Services, Edwina Hart AM, established a Task and Finish Group to consider the development of pharmaceutical services in Wales. Its terms of reference were:<br><br>"...to review the provision of pharmacy services in Wales and bring final recommendations aimed at improving efficiency, effectiveness and value for money of pharmacy services in Wales while maintaining a focus on improving patient outcomes."<br><br>The group made a number of recommendations in its 'emerging themes' document, |

[71] National Assembly for Wales, Health and Social Care Committee, *Consultation Response CP21 – National Pharmacy Association*, paras 3.2, 4.1 and conclusion [accessed 20 April 2012]
[72] Ibid *RoP [para 63]* 16 November 2011 [accessed 20 April 2012]
[73] Ibid *RoP [para 45]* 16 November 2011 [accessed 20 April 2012]
[74] Ibid *RoP [para 219]*, 2 November 2011 [accessed 20 April 2012]

published in September 2009. The Strategic Delivery Group evolved from the Task and Finish Group and was responsible for implementing its recommendations. The groups were chaired by Chris Martin, Chair of Hywel Dda Health Board.

In October 2011 the Group was dissolved by the Minister for Health and Social Services, Lesley Griffiths AM. In a letter to members of the Group she noted:

> "The Group has now fulfilled its role and it is time to pass the baton to others."

56. Evidence provided from Scottish community pharmacy representatives noted that, although the Scottish model has the same distinction between 'core' and 'additional' services as Wales, more services are provided as 'core', national services there (see Table 5).[75] This approach has been developed in Scotland to provide consistent provision in relation to the key health services identified by the Government as priorities.[76]

**Table 5: Community Pharmacy services in Scotland**

Scotland has its own Community Pharmacy Contract. Its contract operates differently from the contract in Wales in that it is commissioned nationally and not locally.

Pharmacy contractors in Scotland are expected to provide all four 'core' community pharmacy services in the contract framework. The four core services in Scotland are:

- chronic medication service;
- minor ailments service;
- public health service (which includes smoking cessation and emergency hormonal contraception); and
- acute mediation service.

Pharmacy contractors will also provide locally negotiated (additional) services in agreement with their local health board. Such services include needle exchange schemes and the dispensing and supervision of consumption for methadone prescriptions.

57. Giving evidence to the Committee on 11 January 2012, the Minister for Health and Social Services cited the example of the only nationally commissioned enhanced service in Wales – emergency hormonal contraception – as an exemplar. She stated that:

> "We had a single national specification for emergency hormonal contraception, and I would like to see that for other enhanced services."[77]

[75] National Assembly for Wales, Health and Social Care Committee, *RoP [para 60]*, 24 November [accessed 20 April 2012]
[76] Ibid *RoP [para 60]*, 24 November [accessed 20 April 2012]
[77] Ibid *RoP [para 173]*, 11 January 2012 [accessed 20 April 2012]

58. The Committee agrees with the Royal Pharmaceutical Society's comments that the overall vision for community pharmacy services has not been achieved to date.[78] The original intentions for the development of community pharmacy services have been repeated in many policy statements but, to a large degree, these have not been translated into delivery on the ground.[79]

## Conclusions and recommendations

59. This inquiry has illustrated that the contribution of community pharmacy to wider health services under the 2005 Community Pharmacy Contractual Framework has yet to be fully realised. As outlined in this chapter, however, the Committee endorses the proposition that there is further scope for community pharmacy to help meet the health needs of the Welsh population.

60. We agree with witnesses that the broader policy intentions of the Welsh Government for community pharmacy have not been fully implemented at the local level by local health boards. Evidence received suggests that provision appears to be patchy at best. In Scotland, on the other hand, a clear national direction for community pharmacy – driven by the Scottish Government – has been key to the development of community pharmacy services.

**Recommendation 2: The Committee recommends that the Welsh Government provides a clear national lead for the future development of community pharmacy services to ensure that the necessary policies and structures are in place to secure its delivery. This should include nationally agreed priorities for the service and a centrally driven direction for its development.**

[78] National Assembly for Wales, Health and Social Care Committee, *RoP [para 39]*, 28 September 2011 [accessed 20 April 2012]
[79] Ibid *RoP [para 39]*, 28 September 2011 [accessed 20 April 2012]

# 4. The community pharmacy contractual framework

## Introduction

61. Despite the devolution of health services to Wales, the current NHS Community Pharmacy Contractual Framework (CPCF) was developed on an England and Wales basis and introduced in April 2005. Its aim was to widen the range of services provided by community pharmacists beyond the essential services traditionally provided by them, and to enable more extensive use of pharmacists' skills on a wider range of health and wellbeing services.

62. Evidence provided to the Committee in relation to the contractual framework varied. Whilst certain stakeholders argued that the *contract itself* is becoming a barrier to enhancing the contribution of pharmacy to health and wellbeing services (due to its negotiation at an England and Wales level and a lack of consolidated regulation to underpin it in Wales), others argued that the heart of the issue lies in a general *failure to take the opportunities* offered by the contract.

63. Although there was inconclusive evidence regarding whether a Wales-only contract is necessary, it was widely acknowledged that recent developments in England are likely to change the context within which the contract develops in the future.

64. Concerns were also raised in relation to the synergy of the pharmacy contract with others in primary care, and the way in which the contract provides for the remuneration of community pharmacies. This chapter explores these issues in more detail.

## England and Wales contract

*Negotiating arrangements*

65. As an England and Wales contract, the overall value of the CPCF is negotiated annually between Whitehall's Department of Health and the Pharmaceutical Services Negotiating Committee (PSNC). PSNC is the body that represents pharmacy contractors in England and liaises with the Department of Health and representatives of the NHS in England to

negotiate the contractual terms for the provision of NHS community pharmacy services.[80]

66. In relation to Wales, PSNC is expected to work with its sister body, Community Pharmacy Wales, which represents community pharmacy contractors in Wales.[81] According to the PSNC:

> "At present most of the English national pharmacy contract negotiated by PSNC is adopted by the Welsh Government, but where Welsh contractual arrangements differ from those in England, Community Pharmacy Wales negotiates on behalf of its contractors."[82]

67. Despite this arrangement being in place, Community Pharmacy Wales noted in its evidence that it is only a constituent member of the PSNC. As such, it is not represented on the negotiating committee. Furthermore, the Committee was told that neither Community Pharmacy Wales nor Welsh Government officials attend contract negotiations.[83]

**Proposition 4: Whilst contractual negotiations remain at and England and Wales level, the Welsh Government should consider making representations to the Department of Health to ensure that Welsh Government officials are present at the negotiating table to ensure that Welsh interests are considered in all contractual discussions.**

*Welsh regulations*

68. In addition to an alleged lack of input at negotiating stages, the pharmacy sector raised concerns about the absence of a consolidated set of regulations to underpin Welsh aspects of the contract.[84]

69. The Royal Pharmaceutical Society, for example, called for "a simpler, more streamlined, more transparent" set of regulations in

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[80] Pharmaceutical Services Negotiating Committee *About PSNC* [accessed 20 April 2012]
[81] Ibid
[82] Ibid
[83] National Assembly for Wales, Health and Social Care Committee, *Consultation Response CP24 – Community Pharmacy Wales* section 1.4 [accessed 20 April 2012]
[84] Ibid

Wales.[85] The Committee agrees that clarification of the regulations would be helpful.

70. Giving evidence to the Committee on 11 January 2012, the Minister for Health and Social Services, Lesley Griffiths AM, stated her intention to consult on the regulations.[86] This consultation was launched on 1 February 2012 and was closed on 27 April 2012. The consultation seeks to address challenges identified in relation to the interpretation of the regulations and the need to create a simplified and consolidated set of clear regulations.

*Diverging policy between England and Wales*

71. According to Community Pharmacy Wales, increasing divergence in policy making between Wales and England means that:

> "…the existing contractual arrangements in Wales are in danger of becoming a major barrier to enhancing the contribution of community pharmacy to health and wellbeing services."[87]

72. Written evidence submitted by the ABPI in Wales also questioned what it referred to as "the validity of the England / Wales Pharmacy Contract", suggesting that the current arrangement may be hampering the implementation of expanded service delivery by community pharmacists.[88]

73. Representatives from Local Health Boards in Wales argued that consideration ought to be given to scoping what capacity and resource would be necessary to develop a new Welsh contract for community pharmacy.[89] Mr Chris Martin, Chair of Hywel Dda Health Board and former chair of the Task and Finish Group on Community Pharmacy stated that:

> "…there is now a feeling among the LHBs, because we have different health policies and because there is a divergence in

[85] National Assembly for Wales, Health and Social Care Committee, *RoP [para 103]*, 28 September 2011 [accessed 20 April 2012]
[86] Ibid *RoP [para 96]*, 11 January 2012 [accessed 20 April 2012]
[87] Ibid *Consultation Response CP24 – Community Pharmacy Wales* section 4.1 [accessed 20 April 2012]
[88] Ibid *Consultation Response CP18 – ABPI* [accessed 20 April 2012]
[89] Ibid *RoP [para 198]*, 2 November 2011 [accessed 20 April 2012]

> health policy across the UK, that we should be looking at a community pharmacy contract just for Wales."[90]

74. Representatives from the Royal Pharmaceutical Society expressed the view, however, that the contract itself has not been the main problem; rather, in their opinion, the opportunities offered by the contract have not been sufficiently exploited to date.[91] As such, they did not argue that a Welsh-only contract would necessarily improve the provision of community pharmacy services in Wales.

75. Evidence submitted to the inquiry also questioned the capacity and resources held at Welsh Government and Local Health Board levels to be able to formulate and deliver a separate Welsh contractual framework.[92] Representatives of Community Pharmacy Wales referred to an "understaffed" department and noted that they "detect[ed] capacity issues" in relation to handling contractual issues.[93]

76. During the oral evidence session with the Minister for Health and Social Services Lesley Griffiths AM stated clearly that she has no plans to develop a Wales-only contractual framework.[94] This was largely due to the fact that a separate contract would, in her view, necessitate a separate pricing and funding structure for pharmacy in Wales, which would not be appropriate in the current economic climate.[95] She did note, however, that she would keep the current arrangement under close scrutiny.

77. The Chief Pharmaceutical Officer, Professor Roger Walker, also added that:

> "[Government officials] have had discussions without our counterparts in the UK Department of Health, and they have reassured us that we can still move forward on a joint England-Wales basis…Our counterparts have reassured us that the

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[90] National Assembly for Wales, Health and Social Care Committee, *RoP [para 230]*, 2 November 2011 [accessed 20 April 2012]
[91] Ibid *RoP [para 97]*, 28 September 2011 [accessed 20 April 2012]
[92] Ibid *Consultation Response CP17 –Stefan Fec* p4 and *Consultation Response CP24 – Community Pharmacy Wales* section 4.1 [all accessed 20 April 2012]
[93] Ibid *RoP [para 1577]*, 28 September 2011 [accessed 20 April 2012] 157
[94] Ibid *RoP [para 140]*, 11 January 2012 [accessed 20 April 2012]
[95] Ibid

contract will be fit for our purposes and will allow us flexibility in Wales."[96]

78. It remains unclear to the Committee whether frustrations relating to the development of community pharmacy policy in Wales are attributable to the detail of the contract and its associated regulations, or to a lack of implementation of the opportunities afforded by the current contract. A clear, evidence-based case for a Wales-only contract was not made during the course of this inquiry, however numerous suggestions were made that work needed to be done to monitor the implications of any further divergence between relevant policy in England and Wales. It is the Committee's view that, in order to monitor these developments adequately, sufficient resource must be allocated to this task within the Minister's department.

**Proposition 5: The Committee welcomes the Minister's assurance that she will keep the contractual arrangements currently in place in Wales under close scrutiny. We believe that active monitoring should take place of the extent to which policy divergence between the nations points in the direction of a Wales-only contract. We also believe that there is an on-going need for the Welsh Government to ensure that the necessary capacity is developed – and sufficient resources provided – within the relevant department to undertake this scrutiny effectively.**

### Synergy with other primary care contracts

79. Evidence received by the Committee suggested strongly that there is a lack of synergy between the Community Pharmacy Contractual Framework (CPCF) and other primary care contracts, particularly the General Medical Services (GP) contract.[97]This lack of synergy, it is claimed, has hindered efforts to broaden the contribution of community pharmacy to health care services.

80. The written evidence from the Royal Pharmaceutical Society noted that:

> "…the original intention of fusing the primary care contracts to provide a holistic care opportunity in the community is

[96] National Assembly for Wales, Health and Social Care Committee, *RoP [para 142],* 11 January 2012 [accessed 20 April 2012]
[97] Ibid *Consultation Response CP6 – Royal Pharmaceutical Society* section 5.1.1 [accessed 20 April 2012]

> currently being missed...the opportunity for joint services planning and service development is not being taken."[98]

81. The British Medical Association, the Royal College of General Practitioners and Betsi Cadwaladr University Health Board all referred to possible fragmentation and duplication of services due to a lack of synergy across primary care contracts (this is explored in more detail in chapter 7).[99] Betsi Cadwaladr Universisty Health Board stated that:

> "Barriers to commissioning medicines management type services include overlap between GMS and Pharmacy services i.e. GMS is funded to provide the service but, because GMS money is ring-fenced, moving resources to fund a pharmacy scheme is difficult."[100]

82. It is difficult to establish whether concerns relating to the synergy of primary care contracts are purely contractual in nature, particularly given the inter-professional tensions between GPs and pharmacists cited frequently during this inquiry. This is explored in more detail in chapter 7 which considers issues relating to joint working between the professions.

**Proposition 6: Providing evidence to the Committee on 11 January, the Minister for Health and Social Services emphasised repeatedly the need for a "seamless primary care team".[101] The Committee suggests that the Minister considers the extent to which current primary care contractual arrangements hinder the delivery of this aim, as suggested by the evidence we received.**

### Remuneration arrangements

83. The remuneration of community pharmacies for additional services has, to date, been primarily volume based. Evidence submitted to the inquiry suggested that this could create an incentive to treat large numbers of patients with the least complex needs. It was suggested, therefore, that different arrangements may be needed for

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[98] National Assembly for Wales, Health and Social Care Committee, *Consultation Response CP6 – Royal Pharmaceutical Society* section 5.1.1 [accessed 20 April 2012]
[99] Ibid *Consultation Response CP32 – BMA Cymru Wales* p3; *Consultation Response CP10 – Royal College of GPs* p1; *Consultation Response CP15 – Betsi Cadwaladr University Health Board* p1 [all accessed 20 April 2012]
[100] Ibid *Consultation Response CP15 – Betsi Cadwaladr University Health Board* p1 [accessed 20 April 2012]
[101] Ibid *RoP [para 95, 153 and 168]*, 11 January 2012 [accessed 20 April 2012]

the further development of services in line with the Government's stated intention to develop services measured on the basis of quality and outcomes as opposed to volume alone.

84. Giving oral evidence, Mr Chris Martin of Hywel Dda Health Board stated that a volume-based contract makes it difficult to manage the added-value services for which the contract allows. All five health boards that responded to this inquiry noted that a system of remuneration based on the quality of outcomes - as opposed to dispensing volume - would be preferable.[102]

85. This view was not unique to service planners and providers. When listing what it views as missed opportunities in relation to the community pharmacy contract, the Royal Pharmaceutical Society questioned an alleged "focus on volume rather than quality" for additional services.[103]

86. The Committee explored remuneration arrangements for community pharmacy services by seeking written and oral evidence from pharmacy representatives in Scotland. In recent years, Scotland has introduced banded capitation payments, for example for its minor ailments schemes, which are made based on the number of patients registered for this service at a pharmacy.

87. Evidence provided by the Royal Pharmaceutical Society in Scotland and Community Pharmacy Scotland suggested that the movement towards service-based, as opposed to volume-based, remuneration has helped provide consistent funding to allow community pharmacy to invest in and develop new services. Transition funding has also been provided to community pharmacies to allow them to develop new services such as the Chronic Medication Scheme, moving to a banded and weighted capitation system when schemes are established.

88. The Committee accepts the view that remuneration arrangements for additional community pharmacy services require further exploration and consideration. The Scottish example provides a prime opportunity for the Welsh Government to work with Scottish

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[102] National Assembly for Wales, Health and Social Care Committee, *Consultation Response CP15 – Betsi Cadwaladr University Health Board*; *Consultation Response CP34 – Hywel Dda Health Board*; *Consultation Response CP20 - Aneurin Bevan Health Board*; and *Consultation Response CP39 – Cwm Taf Health Board* [all accessed 20 April 2012]

[103] Ibid *Consultation Response CP6 – Royal Pharmaceutical Society* [accessed 20 April 2012]

colleagues to understand the implications of any changes and to establish the steps which would need to be taken to deliver appropriate and effective reform.

89. The Committee welcomes the Minister's recent letter confirming that one of the options being explored for the new minor ailments scheme proposed for Wales is payment on a capitation basis, underpinned by a patient registration system, and that this would not have any significant implications for the contractual framework.[104]

**Conclusions and recommendations**

90. It is clear to the Committee from the evidence it has taken that the community pharmacy contractual framework is key to the future of pharmacy services in Wales. As the foundation upon which all services are provided, its future development is central to the achievement of Government ambitions for the profession.

91. As illustrated in this chapter, witnesses to the inquiry, particularly those representing the community pharmacy sector, have been critical of the arrangements in the contractual framework. Limited Welsh representation at the negotiating table, as noted by the sector, is of concern to the Committee, as is the apparent lack of synergy between the community pharmacy and GP contracts. Work needs to be done by the Welsh Government to address the concerns highlighted, particularly to ensure that the contracts are utilised strategically to secure integrated primary care services and to ensure that the Welsh voice is clearly heard in all contractual negotiations.

92. Calls for a Wales-only contract were made by a number of witnesses, however it remains unclear to the Committee whether a Wales-only contract is the solution to the challenges identified in this report. The Committee acknowledges, however, that recent developments in England are likely to change the context within which the contract develops in the future, and that this ought to be monitored closely.

93. The Committee would note, however, that the evidence suggested that the implementation of the contract (or lack thereof) has been as significant a problem, if not more so, than its nature as an England

[104] National Assembly for Wales, Health and Social Care Committee, *HSC(4)-06-12 paper 7 – Additional information from the Minister for Health and Social Services* [accessed 20 April 2012]

and Wales agreement. There was an overwhelming consensus amongst witnesses that opportunities afforded by the current contract have been far from exhausted.

94. We believe that better efforts should have been – and could still be – made by the Welsh Government, Local Health Boards and the profession itself to take fuller advantage of the current contractual framework. It is our view that to introduce a new Wales-only contract without addressing the implementation weaknesses of its predecessor would be imprudent and ill-advised.

**Recommendation 3: The Committee recommends that the Welsh Government should take the opportunity afforded by the recently announced national minor ailments scheme to consider changes to the way in which community pharmacies are remunerated, including a transition to capitation-based payments, underpinned by a patient registration system.**

# 5. Community pharmacy additional services

## Introduction

95. The current contractual framework for community pharmacists allows them to offer additional services – referred to as *advanced services* and *enhanced services* – in addition to the *essential services* required by the contract. Whilst community pharmacy must provide essential services, they can choose whether they wish to provide advanced and enhanced services subject to meeting certain criteria.

96. However, evidence to this inquiry has suggested strongly that opportunities to commission and deliver enhanced and advanced services have not been exploited consistently or sufficiently. Furthermore, where commissioning of services has taken place, criticism has been made of the relative absence of an evidence base for that activity. The capacity of the profession itself to deliver adequate advanced and enhanced services was also probed, as was the appropriateness of the training and accreditation system for community pharmacists in Wales. These issues are considered in more detail in this chapter.

## Advanced services

97. Advanced services are national schemes for which accreditation is required before the service can be provided. They are commissioned by Local Health Boards under direction from the Welsh Government and can be delivered by any pharmacy choosing to do so subject to both the pharmacist and the pharmacy premises meeting certain criteria.

98. The first advanced services introduced in Wales were the Medicines Use Review and prescription intervention services. The purpose of these services is to allow community pharmacists to help patients understand more about their medicines, identify problems that patients may have in taking their medicines, and identify those patients who may be at most risk of making less effective use of their medicines.[105]

[105] National Assembly for Wales, Health and Social Care Committee, *Consultation Response CP6 – Royal Pharmaceutical Society* section 3.2 [accessed 20 April 2012]

99. More recently, the Discharge Medicines Review has also been introduced as an advanced service in Wales. This service will provide support to individuals following discharge from a care setting into the community (for example, when a patient is discharged from hospital to home) by improving transfer of medicines information and allowing community pharmacists to consider the hospital discharge prescription alongside any other medication they may be prescribed.[106]

*Medicines Use Reviews*

100. The main advanced service offered by community pharmacy is Medicines Use Review (MUR) which supports patients on multiple medications. Pharmacies offering this service must have a consultation area and staff that have undertaken relevant training. In 2010-11, 88% of community pharmacies were accredited to provide this service.[107]

101. Under the current specification, each pharmacy is entitled to deliver up to 400 MURs per year.[108] According to Public Health Wales, just under half the permitted number of MURs were delivered in 2010/11 (46%) in Wales and this varied between local authority areas from 27% to 60%.[109]

102. Witnesses to the inquiry expressed concerns around the use of Medicines Use Reviews (MURs) on a number of fronts, not least the lack of data available to assess their success, the lack of acceptance by GPs of the service, the inflexibility built in to the service specification and the absence of clear criteria about which patients should be targeted for the most successful outcomes.

103. According to Public Health Wales:

> "Data detailing the MUR…is not available for evaluation. It has therefore been very difficult to assess whether MURs are clinically and cost-effective, or how MUR services could be developed to increase the health gain for patients from them."[110]

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[106] Welsh Government News Release *New pharmacy service to benefit patients* 31 October 2011
[107] National Assembly for Wales, Health and Social Care Committee, *Consultation Response CP5 – Public Health Wales* p9 [accessed 20 April 2012]
[108] Ibid
[109] Ibid
[110] Ibid

104. Aneurin Bevan Local Health Board agreed, noting that there is little evidence of "real outcomes" from MURs and that there is a lack of scrutiny of health boards in terms of assessing quality of outcomes.[111] The Community Chemists' Association's written evidence also suggested that more evidence is needed on MURs to ensure that the best service is delivered to patients.[112]

105. The extent to which GPs are willing to accept the MUR service and work with community pharmacy to deliver the best outcomes for patients was also questioned. According to Abertawe Bro Morgannwg University Health Board:

> "The MUR service was not well received by GPs as, despite local explanation, seemingly no national piloting and evaluation had demonstrated its potential value."[113]

106. The lack of GP acceptance was illustrated by the Royal College of General Practitioners' written evidence which stated:

> "The use of computerised reminders for prescription review by the GP mean that there is often little added value in Pharmacist led medication review for the many patients having regular treatment for a straightforward long term condition."[114]

107. The alleged inflexibility of the MUR service was also cited by those contributing to the inquiry. Public Health Wales's written evidence noted that:

> "A maximum of one MUR per year is permitted per patient and patients must attend the pharmacy. House bound patients who have limited opportunities to discuss their medication with a health professional may benefit from MURs but are unable to access them. Additionally, to establish adherence it may be desirable for the pharmacist to follow-up a patient, for example

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[111] National Assembly for Wales, Health and Social Care Committee, *Consultation Response CP20 - Aneurin Bevan Health* p3 [accessed 20 April 2012]
[112] Ibid *Consultation Response CP8 – Company Chemists' Association* p3 [accessed 20 April 2012]
[113] Ibid *Consultation Response CP3 – Abertawe Bro Morgannwg University Health Board* p2 [accessed 20 April 2012]
[114] Ibid *Consultation Response CP10 – Royal College of GPs* p1 [accessed 20 April 2012]

> at weekly intervals for the first month when a complex medication regimen or high risk medicine has been initiated."[115]

108. Cwm Taf Health Board's written evidence stated that:

> "The target of 400 MURs per contracted pharmacy is inflexible. Many small pharmacies do not have the capacity to undertake all 400 MURs. Some pharmacies have the capacity to do more than 400 MURs but are unable to do so as they are constrained by current regulations."[116]

109. Betsi Cadwaladr University Health Board also noted that they are aware that practice varies between community pharmacies with some focusing on quality and others on quantity:

> "The independent contractors and smaller multiples seem to have been less concerned with quantity of MURs completed and to have focused more on the quality of the MUR being undertaken. In contrast, it appears that the larger multiples have developed a target driven culture to increase MUR uptake, while being less focused on the quality of the reviews undertaken."[117]

110. A more targeted approach to the use of MURs was another area referred to by local health boards, GPs, Public Health Wales and the profession itself. Abertawe Bro Morgannwg University Health Board noted that they would welcome the ability to specify target groups in line with NHS and health board priorities to help provide consistent messages to the public.[118] Betsi Cadwaladr University Health Board argued for the targeting of MURs on the basis of improving return on MUR spend. The BMA's written evidence argued that MURs ought to be targeted appropriately "to ensure good value for money".[119]

111. In November 2011, the Welsh Government introduced a more targeted approach to MURs. The Minister's written evidence stated:

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[115] National Assembly for Wales, Health and Social Care Committee, *Consultation Response CP5 – Public Health Wales* p10 [accessed 20 April 2012]
[116] Ibid *Consultation Response CP39 – Cwm Taf Health Board* p2 [accessed 20 April 2012]
[117] Ibid *Consultation Response CP15 – Betsi Cadwaladr University Health Board* p2 [accessed 20 April 2012]
[118] Ibid *Consultation Response CP3 – Abertawe Bro Morgannwg University Health Board* p2 [accessed 20 April 2012]
[119] Ibid *Consultation Response CP32 – BMA Cymru Wales* p2 [accessed 20 April 2012]

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;
- patients identified as being at risk of wasting their medicines.

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.[120]

**Proposition 7: The Committee welcomes the introduction of a more targeted approach to MURs. However, we strongly suggest that the Minister consider introducing a more rigorous evaluation of the effectiveness, value for money and impact of the newly targeted MURs on NHS services.**

### Enhanced services

112. The aim of the opportunity afforded by the 2005 contract to commission enhanced services was to widen the range of services available from the community pharmacy. According to the Welsh Government's written submission to the inquiry:

> "The opportunity to provide enhanced services was intended to enable local health boards to introduce services based upon an assessment of local healthcare need, and utilise community pharmacy when identified as the most appropriate provider."[121]

113. Community pharmacies are commissioned to deliver enhanced services by the relevant Local Health Board. Where enhanced services

[120] National Assembly for Wales, Health and Social Care Committee, *HSC(4)-01-12 Paper 3 – Evidence from the Minister for Health and Social Services*, para 3.5-3.6, 11 January 2012 [accessed 20 April 2012]
[121] Ibid para 2.1

are locally developed, the Local Health Board determines the specification for the service and negotiates fees for delivery. Where enhanced services are developed on a national level, the specification and fee is set by the Welsh Government. Whether developed nationally or locally, there is no requirement for pharmacies to offer enhanced services.

*Local enhanced services*

114. According to the Welsh Government, needle exchange, supervised administration of substitute medication for opiate addiction and smoking cessation are the enhanced services most commonly provided by community pharmacies.[122] Other enhanced services include care home services, palliative care services, head lice management service and disease-specific medicines management services.

115. Examples of successful, locally-commissioned enhanced services were given during the course of the inquiry and are summarised in Table 6 below:

**Table 6: Examples of locally-commissioned enhanced services[123]**

| **SERVICE: Minor Ailments Scheme** | **LOCALITY: Torfaen** |
|---|---|
| The minor ailment service was introduced in Torfaen in 2006. People can visit their local pharmacy for advice and treatment free of change. According to Community Pharmacy Wales, during 2009/10, 752 people received a minor ailment consultation in one Cwmbran pharmacy, releasing an estimated 125 hours of local GP time and saving a sum of £10,800 for the LHB.[124]<br><br>Aneurin Bevan Health Board noted that "the scheme is supported by patients, GPs and pharmacists and has the ability to improve access for patients to GP consultations if used effectively. There is scope to spread this to areas with high access demand."[125] It is understood that the scheme is currently under review. | |
| **SERVICE: Primary care local enhanced service for patients with diabetes** | **LOCALITY: Llanidloes** |
| Community pharmacist support was commissioned in Llanidloes to support practice based diabetes clinics. | |

[122] National Assembly for Wales, Health and Social Care Committee, *HSC(4)-01-12 Paper 3 – Evidence from the Minister for Health and Social Services*, para 2.2, 11 January 2012 [accessed 20 April 2012]
[123] Examples provided by National Assembly for Wales, Health and Social Care Committee, *Consultation Response CP6 – Royal Pharmaceutical Society* and *Consultation Response CP24 – Community Pharmacy Wales* [accessed 20 April 2012]
[124] National Assembly for Wales, Health and Social Care Committee, *Consultation Response CP24 – Community Pharmacy Wales*, p15 [accessed 20 April 2012]
[125] Ibid *Consultation Response CP20 - Aneurin Bevan Health* p5 [accessed 20 April 2012]

| | |
|---|---|
| In this model of care, the GP practice identified patients whose diabetes control was sub-optimal. Patients were then invited to attend a monthly clinic in which the pharmacist saw each patient immediately prior to their appointment with the GP. During their consultation with the pharmacist the patient's medicines were reviewed and the pharmacist assessed how the patient was taking their medicines and what they knew about them. Information and advice was then provided, the pharmacist could also suggest possible changes to treatment, after discussion with the patient.<br><br>According to Community Pharmacy Wales and the Royal Pharmaceutical Society, evaluations of this service model highlighted that many patients were not regularly taking their medicines even though they were collecting them regularly and almost three quarters of patients did not know the purpose of at least one of their medicines. It was also shown that noncompliance with medication regimens was an issue for many patients but this was resolved through discussions between the pharmacist and the patients ensuring a patient willingness to restart their medicines and take them as prescribed. | |
| **SERVICE: Prevention and management of coronary heart disease** | **LOCALITY: Pembrokeshire** |
| The Pembrokeshire Coronary Heart Health project have utilised the skills of four community pharmacies to offer opportunistic lifestyle-based risk assessment for patients identified as likely to have significant risk factors for the development of CHD in the near future.<br><br>The pharmacist's role concentrated on identifying those people who do not access their GP, thus increasing coverage of the population. Referrals to healthy eating advisors can also be made from the pharmacies. Audit of the first 40 people to participate in the scheme showed that half had a CHD risk over 15%, one in ten of these having a CHD risk over 30%, one in four had already been diagnosed with a heart condition, and half had a family history of heart disease. | |
| **SERVICE: Patient education in COPD and other chronic conditions** | **LOCALITY: Torfaen** |
| Pharmacists have delivered educational sessions on medication at Structured Education Course Groups facilitated by the Long Term Conditions Specialist Nurses. These sessions have included Chronic obstructive pulmonary disease (COPD), diabetes, the cardiac exercise group and the stroke rehabilitation group. They allowed for two way discussions about patients' disease management and provided appropriate advice to help improve health literacy. They also provided an opportunity for broader discussions about the use of the CPCF, the costs of medicines, and the use of branded and generic medicines. | |
| **SERVICE: Level 3 Smoking Cessation Service** | **LOCALITY: North Wales (excl. Flintshire)** |
| Level 3 services have continued to be available across most of North Wales, with only the former Flintshire LHB failing to commission the service. The Level 3 service – which entails being able to provide a full range of interventions, from advice to nicotine replacement therapy and appropriate medicines – in North Wales has generated quit rates of around 46%, which are amongst the highest achieved in comparative schemes elsewhere. | |

116. According to the Royal Pharmaceutical Society, the examples given illustrate the best use of the enhanced service provision to support local initiatives to meet the unmet health needs of local populations. This, they argued, enables LHBs to deliver on their aim of

ensuring health improvement within their local populations.[126] Both RPS and Community Pharmacy Wales noted, however, that these approaches are not embedded within community pharmacy service provision and, as such, they lack the secure funding necessary to make them sustainable services.[127]

117. The lack of funding for locally commissioned enhanced services - and the associated lack of sustainability for such services – was also highlighted by health boards and Public Health Wales. Aneurin Bevan Health Board – one of the most active commissioners of enhanced services – stated that the lack of a ring-fenced or allocated budget for the development of enhanced services hampers progress with developing services.[128] This was echoed by Abertawe Bro Morgannwg University Health Board whose written evidence noted that the development of enhanced services has been limited due to financial constraints. It cited the examples of its minor ailments scheme and prescription intervention scheme, both of which have been decommissioned as they proved to be "financially unsustainable".[129] Public Health Wales told the Committee:

> "The lack of long-term funding streams for community pharmacy enhanced services has been a challenge, both for Health Boards, and for community pharmacy contractors for whom repeated pilots and short-term funding have been a source of frustration. The limited income available from enhanced services is also a barrier to further development of the role of community pharmacy. Anecdotally, pharmacists report difficulty in securing sufficient funding to employ additional staff, whilst having little spare capacity to deliver enhanced services within existing resources."[130]

118. This position was supported by Stefan Fec, a community pharmacist from Mid Wales. In written evidence, he listed a lack of any guarantee that the service may continue beyond the financial year

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[126] National Assembly for Wales, Health and Social Care Committee, *Consultation Response CP6 – Royal Pharmaceutical Society* p6 [accessed 20 April 2012]
[127] Ibid *Consultation Response CP6 – Royal Pharmaceutical Society* p6 and *Consultation Response CP24 – Community Pharmacy Wales* p16 [accessed 20 April 2012]
[128] Ibid *Consultation Response CP20 - Aneurin Bevan Health Board* p3 [accessed 20 April 2012]
[129] Ibid *Consultation Response CP3 – Abertawe Bro Morgannwg University Health Board* p2 [accessed 20 April 2012]
[130] Ibid *Consultation Response CP5 – Public Health Wales* p6 [accessed 20 April 2012]

(impacting on staffing levels) and inadequate funding as reasons for the reluctance of pharmacy contractors to join up to an enhanced service.[131]

119. As noted in chapter 3, in addition to the lack of stable funding with which to secure continuity of services, local health boards have not made full use of the opportunities provided by the contract.[132] As such, it is clear to the Committee that provision of enhanced services is patchy and inconsistent at the local level. The Company Chemists' Association's written evidence argues that this inconsistency in provision has the potential to impact on the general public's perception of community pharmacy:

> "Despite some excellent outcomes from pharmacy Enhanced Services in some areas of the country, commissioning of Enhanced Services is patchy and far from universal…The scale of these [enhanced] services has varied within LHB's limiting the number of community pharmacies commissioned as service providers. This practice has led to inconsistency of delivery in areas and has also given a poor reflection on some contractors and the profession if patients are unable to access services they believe are offered locally."[133]

*National enhanced services*

120. Evidence has suggested that, although the provision of locally-commissioned enhanced services has proved to be disparate in nature, where services have been commissioned nationally in Wales, they have been more successful. In April 2011, the Welsh Government introduced the first national enhanced service for the provision of emergency hormonal contraception (EHC). There was a consensus amongst witnesses and those submitting written evidence that this service has proved to be one of the more successful outputs from the current community pharmacy contractual framework.

121. The EHC national enhanced service aims to provide a consistency of access for patients to discrete counselling, information and referral

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[131] National Assembly for Wales, Health and Social Care Committee, *Consultation Response CP17- Stefan Fec* p2 [accessed 20 April 2012]
[132] See Chapter 3, paras 40 – 46 for detailed evidence relating to local health board commissioning of services.
[133] Ibid *Consultation Response CP8 – Company Chemists' Association* p4 [accessed 20 April 2012]

services on a range of sexual health matters together with assessment for Emergency Hormonal Contraception where deemed appropriate by the pharmacist. Whilst not all pharmacies must offer this service, those who are commissioned to do so by the LHB must do so in accordance with a national specification to ensure consistency of provision. Those accredited to deliver the service in one LHB are also able to do so in all others.

122. The EHC national enhanced service was one of four services which the Task and Finish Group on Pharmaceutical Services (see Chapter 3, Table 4) recommended in 2009 should be introduced as national enhanced services. The other three were smoking cessation, minor ailments and substance misuse services. The Group argued that national enhanced services would provide equity of provision across Wales with regard to access and improved standards. [134]

123. Community pharmacy representatives welcomed the development of the EHC service, as did the Family Planning Association, who valued the service highly due to the fact that it draws on the accessibility of community pharmacies, which helps draws young people, and reduces the pressure on family planning services.[135] Professor Roger Walker, Chief Pharmaceutical Officer for the Welsh Government, noted that:

> "The most recent figures show that almost 8000 units [of EHC] were issued through community pharmacy, compared with less than 3000 through GP practices. GP practices are now referring women to pharmacies, because they know that they will have more rapid access…[EHC] is a very personal and confidential issue. It reflects the fact that patients and women have confidence in their community pharmacy. Community pharmacy is now the preferred supplier."[136]

124. Despite the general consensus in favour of adopting a more national approach to enhanced service commissioning – like that seen for the EHC service in Wales – Public Health Wales warned that caution is needed against implementing a national enhanced service specification for services where the needs of local populations differ

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[134] Task and Finish Group on Pharmaceutical Services *Emerging Themes: Improving Pharmaceutical Services in Wales* September 2009 [accessed 20 April 2012]
[135] National Assembly for Wales, Health and Social Care Committee, *Consultation Response CP42 – Family Planning Association* [accessed 20 April 2012]
[136] Ibid *RoP [para 172],* 11 January 2012 [accessed 20 April 2012]

considerably and the priorities of Health Boards vary.[137] Alliance Boots, on the other hand, argued:

> "There is undue emphasis on finding local solutions to what are clear national priorities for healthcare and public health, such as heart disease, COPD, smoking, sexual health and flu vaccinations. National frameworks and tariffs would allow the consistent delivery of quality services across the country and better collaboration with other healthcare professionals in primary care, while still allowing local commissioners the freedom to choose the range of services, the volume of provision and delivery locations that meet their local requirements."[138]

*Minor ailment schemes*

125. Giving evidence to the Committee the Minister stated her desire to see more enhanced services developed on a national basis.[139] In March 2012, the Minister announced her intention to introduce a national enhanced minor ailments service.[140]

126. Information published by the Welsh Government notes that the national minor ailments service will be delivered in a staged manner so that evaluation of each stage can take place. The Committee welcomes this staged approach as conflicting evidence was received during the course of our inquiry about the relative success of minor ailment schemes.

127. Whilst Community Pharmacy Wales argued that minor ailment schemes can reduce pressure on secondary care services[141], doctors representatives were concerned that such schemes may require diagnostic skills with which community pharmacists are not equipped.[142] This concern was also voiced by Aneurin Bevan Community Health Council who argued that, if visited regularly by a patient,

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[137] National Assembly for Wales, Health and Social Care Committee, *Consultation Response CP5 – Public Health Wales* p8 [accessed 20 April 2012]
[138] Ibid *Consultation Response CP30 – Alliance Boots* para 3.1[accessed 20 April 2012]
[139] Ibid *RoP [para 173]*, 11 January 2012 [accessed 20 April 2012]
[140] Welsh Government, Lesley Griffiths (Minister for Health and Social Services) *Establishment of a National Minor Ailments Scheme in Wales*, Cabinet Written Statement, 7 March 2012 [accessed 20 April 2012]
[141] National Assembly for Wales, Health and Social Care Committee, *Consultation Response CP24 – Community Pharmacy Wales* p22 [accessed 20 April 2012]
[142] Ibid *RoP [para 48]*, 2 November 2011 [accessed 20 April 2012]

> "[pharmacists] will need significant diagnostic training to support that level of minor ailment assessment."[143]

128. Evidence on the cost-effectiveness of increasing the use of pharmacy consultations, including minor ailment schemes, was also inconsistent. Whilst Community Pharmacy Wales claimed that £30 million could be saved through patients visiting a pharmacy rather than the GP for minor ailment treatment[144], Alliance Boots stated in their written evidence than a national scheme could release £57 million from savings on GP appointments.[145] Public Health Wales evidence suggested, however, that the benefits for NHS services are not always clear cut in the case of minor ailment schemes:

> "There is evidence that the transfer of minor ailments from general practice to community pharmacy does reduce GP workload in terms of the number of minor ailment consultations however there is little evidence that overall GP workload decreases as GPs accept different types of consultation in the freed up time."[146]

129. Furthermore, Public Health Wales also argued:

> "Advising on minor ailments is recognised as a core function of community pharmacy under the essential service support for self-care. Within the essential service patients requiring medication would need to purchase an over-the-counter medicine. Minor ailments schemes permit provision of medication at NHS expense."

130. This was reiterated by Aneurin Bevan Community Health Council who suggested that patients have misused the scheme in their area to obtain over the counter drugs on free prescription, sometimes bypassing a consultation with a pharmacist.[147]

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[143] National Assembly for Wales, Health and Social Care Committee, *RoP [para 60]*, 10 November 2011 [accessed 20 April 2012]
[144] Ibid *Consultation Response CP24 – Community Pharmacy Wales* section 2.7 [accessed 20 April 2012]
[145] Ibid *Consultation Response CP30 – Alliance Boots* p1[accessed 20 April 2012]
[146] Ibid *Consultation Response CP5 – Public Health Wales* p12-13 [accessed 20 April 2012]
[147] Ibid *RoP [para 56]*, 10 November 2011 [accessed 20 April 2012]

131. The Committee heard that the Scottish national minor ailments scheme operates on the basis of patient registration.[148] The Committee welcomes the fact that the Minister's proposals for a national minor ailments scheme in Wales are underpinned by a system of patient registration. It is the Committee's view that this is necessary to ensure that pharmacists and GPs have access to the necessary information to make correct decisions about patient care and to monitor that the system is being used appropriately by the public. The Committee also welcomes the announcement that pharmacists, where appropriate, will supply medication from an agreed list to seek to ensure that NHS resources are not abused by this free service, as feared by some witnesses.

### Data and evaluation

132. Evidence submitted to the inquiry suggested that a lack of evaluation evidence on enhanced and advanced services has hindered service planning and the development of community pharmacy as a provider of health care services.

133. Public Health Wales's written evidence calls on local health boards to commission enhanced services on the basis of a robust assessment of local need. This, they argue, should include an identification of the local need, an assessment of existing service provision, and assessment of the clinical and cost effectiveness evidence for the proposed service, and engagement with professionals and patients to determine the acceptability of the proposed service.[149] The purpose of a more strategic, evidence-based approach to commissioning enhanced services would be to address criticisms of patchy and inconsistent provision of enhanced services, and to ensure that community pharmacy is embedded in local health services.

134. The Royal Pharmaceutical Society's evidence supported this proposition, noting that:

[148] National Assembly for Wales, Health and Social Care Committee, *RoP [24 November]* [accessed 20 April 2012]
[149] Ibid *Consultation Response CP5 – Public Health Wales* p6 [accessed 20 April 2012]

> "Pharmaceutical needs assessments should be used to develop enhanced services and support service developments across Wales."[150]

### Community pharmacy capacity

135. During the course of the inquiry some issues emerged around the capacity of the community pharmacy to meet the challenge of providing a wider range of services. Chapter 6 of this report refers to the variable level of uptake for the contracted diabetes awareness campaign, despite that campaign having the so-called 'golden triangle' of funding, third-sector support and national coordination.

136. Concerns around staffing capacity, for example the availability of accredited staff to provide specific services – particularly in relation to community pharmacies provided by multiples or located in supermarkets – were raised.[151] Public Health Wales told the Committee:

> "…pharmacies sometimes suffer from the fact that, if there is not a regular pharmacist in an establishment, there may be a locum on duty who does not have the appropriate accredited training to support an enhanced service. So, a member of the public may be disappointed because, on a particular day, that service may not be available to them."[152]

137. The FPA told the Committee:

> "…there were initial issues with rolling out the EHC programme, because the contract was with the pharmacist not the building or the location. So, someone might go to a location because they thought that they could get EHC, but it might be that particular pharmacist's day off and there might be a locum who did not have the contract to deliver it."[153]

138. The extent to which limited opening hours in some areas limits the availability of services was also raised[154] as was the provision and

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[150] National Assembly for Wales, Health and Social Care Committee, *Consultation Response CP6 – Royal Pharmaceutical Society* section 8 [accessed 20 April 2012]
[151] Ibid *RoP [para 74-79]* 10 November 2011 and *RoP [para 117]* 16 November 2011 [accessed 20 April 2012]
[152] Ibid *RoP [para 14]* 12 October 2011 [accessed 20 April 2012]
[153] Ibid *RoP [para 117]* 16 November 2011 [accessed 20 April 2012]
[154] Ibid *RoP [para 170]* 28 September 2011 [accessed 20 April 2012]

quality of private consulting rooms[155]. The Chief Pharmaceutical Officer stated in oral evidence, however, that 92% of community pharmacies now have private consulting areas, of which 83% are registered with LHBs.[156]

139. Figures provided by Local Health Board on uptake of opportunities to offer enhanced and advanced services also showed variable participation by the community pharmacy sector. Betsi Cadwaladr University Health Board noted that no pharmacy had applied to provide the advanced Appliance Use Review service, attributing this to a lack of knowledge and confidence to provide the service.[157] Cwm Taf Health Board's uptake figures for enhanced services were as follows:

**Table 7: Uptake of enhanced community pharmacy services in Cwm Taf Health Board[158]**

| *Enhanced Service* | *Uptake (%)* |
|---|---|
| Substance misuse / supervised consumption | 91% |
| Emergency hormonal contraception | 53% |
| Home medication administration scheme (Medication Administration Record charts) | 47% |
| Smoking cessation (levels 2 & 3) | 38% |
| Needle exchange | 27% |
| Waste reduction scheme | 25% |
| Out of hours pharmacy rota | 9% |

140. The community pharmacy sector attributes this variable uptake, however, to lack of long-term funding assurances that are needed to allow them to make the necessary investment in staff and premises often needed to deliver services. They also refer to the accreditation requirements for many services as "complex and way over what is

[155] National Assembly for Wales, Health and Social Care Committee, *RoP [para 52-53]* 10 November 2011 [accessed 20 April 2012]
[156] Ibid *RoP [para 185]* 11 January 2012 [accessed 20 April 2012]
[157] Ibid *Consultation Response CP15 – Betsi Cadwaladr University Health Board* p2 [accessed 20 April 2012]
[158] Ibid *Consultation Response CP39 – Cwm Taf Health Board* pp1-2 [accessed 20 April 2012]

reasonably required to provide the service, which is not always guaranteed".[159] Accreditation requirements are considered in the next section.

*Training and accreditation*

141. Accreditation to provide additional community pharmacy services is given to individual community pharmacists, not businesses, and concerns were expressed about unnecessary duplication where pharmacists have been required to undertake further accreditation when working in a different health board area.

142. Accreditation requirements were referred to as burdensome by Public Health Wales in written evidence. When probed on this in Committee, Nuala Brennan, Consultant in Pharmaceutical Public Health, told the Committee:

> "No pharmacist will ever argue against the requirement to undertake any accreditation that ensures their competence in delivering the clinical elements of a service—we would not argue with that…In services such as enhanced services, where pharmacists are able to provide prescription-only medicine…they have to undertake accreditation in order to deliver the medicine under what is called a patient group direction. The actual interpretation of the patient group direction is often the same in terms of the process, regardless of what the medicine is, yet pharmacists are required to attend another training course in order to operate another patient group direction …You would not make those demands of a medical professional; you would not require a GP to go through what is largely a process-driven accreditation rather than a clinically driven one."[160]

143. Public Health Wales also referred in oral evidence to the need to gain accreditation from Health Board to Health Board for very similar services.[161] Both Public Health Wales and the Royal Pharmaceutical Society noted, however, that work has been done to improve the harmonisation of accreditation and training for pharmacists for

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[159] National Assembly for Wales, Health and Social Care Committee, *HSC(4)-01-12 paper 8 – Additional evidence from Community Pharmacy Wales*, p5 11 January 2012 [accessed 20 April 2012]
[160] Ibid *RoP [para 159-60]* 12 October 2011 [accessed 20 April 2012]
[161] Ibid *RoP [para 64]* 12 October 2011 [accessed 20 April 2012]

enhanced services to provide one training and accreditation for all of Wales in relation to a specific service.[162] This has also been done in relation to the national enhanced EHC service.

**Proposition 8: The Committee notes that progress has been made in relation to streamlining the training and accreditation system for community pharmacists. We urge the Welsh Government to work with the Welsh Centre for Pharmacy Professional Education to ensure that the standardisation of training and accreditation is fully implemented.**

### Conclusions and recommendations

144. Evidence to this inquiry has suggested strongly that opportunities to commission and deliver enhanced and advanced services have not been exploited sufficiently. Where services have been commissioned, this has been done in a piecemeal fashion which has frustrated the development of the role of community pharmacy in primary care.

145. It is the Committee's view that the evidence submitted to this inquiry strongly favours the development of national enhanced services where an appropriate, evidenced case can be made for them. Although locally commissioned enhanced services remain suitable in some circumstances to meet the specific needs of local populations, where needs are common across Wales (for example in relation to smoking cessation, substance misuse, minor ailments and chronic conditions), the Welsh Government should develop services as national enhanced services akin to the current provision for emergency hormonal contraception.

**Recommendation 4: The Committee recommends that the Welsh Government promotes further enhanced services with a national specification for community pharmacy, including a national Chronic Conditions Service, and follows the incremental model proposed for the introduction of the National Minor Ailments Scheme to ensure robust monitoring, evaluation and improvement of services. The Committee recommends that where there are clearly *national* health conditions, the service should be *nationally* specified, but that some continuing scope should be allowed for the volume and location of such services to be determined locally.**

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[162] National Assembly for Wales, Health and Social Care Committee, *RoP [para 127]* 28 September 2011 [accessed 20 April 2012]

# 6. Public health

## Introduction

146. Public health is one of the essential services provided by community pharmacies under the Community Pharmacy Contractual Framework. Evidence suggests that there is scope to develop further the public health contribution of community pharmacy. Where activity has been undertaken to date via the community pharmacy network, evidence suggests that it has been successful. Despite this, concerns have been raised about the variable levels of community pharmacy participation across Wales and the manner in which campaigns are planned and rolled out. This chapter explores these issues.

## Contractual requirements

147. As part of the Community Pharmacy Contractual Framework, community pharmacies are expected to provide opportunistic advice on lifestyle and public health issues to patients receiving prescriptions. Pharmacies are also expected to participate pro-actively in national or local campaigns to promote public health messages to general pharmacy visitors during specific targeted campaign periods.[163]

148. According to the service specification, the purpose of this essential service is to increase patient and public knowledge and understanding of important healthy lifestyle and public health messages so that they are empowered to take actions which should improve their health; and to target the 'hard to reach' sectors of the population who are not frequently exposed to health promotion activities in other parts of the health or social care sector.[164]

149. Interventions take place either as a link with the dispensing of prescriptions or as part of a wider campaign. In the case of prescription-linked interventions, pharmacists and their staff are expected to give opportunistic advice, as appropriate, on specified healthy living/public health topics to people presenting prescriptions with diabetes, those at risk of coronary heart disease, especially with high blood pressure, those who smoke and those who are overweight. The advice will normally be given verbally but supported by the provision of written material such as leaflets, and referral to another

[163] NHS Wales *Essential Service Specifications* [accessed 20 April 2012]
[164] Ibid

source of advice or assistance. Pharmacists are expected to keep a record of the advice given on the patient's pharmacy record for auditing purposes and for any future follow up with the patient.

150. In the case of campaign-based interventions, pharmacists and their staff are expected, as part of the contractual framework, to pro-actively take part in – and contribute to – national or local campaigns for patients and general pharmacy visitors during the campaign period. Advice given as part of the campaign may be supplemented by provision of written information and in-store displays. As part of the contract, the pharmacy should provide this service to its Local Health Board for up to 6 campaigns per year. The pharmacy should record the number of people who receive advice if requested to do so by the Local Health Board. The Local Health Board is charged with the responsibility for determining the topics of the campaigns and is expected to provide any appropriate support, for example briefing packs and patient literature to support campaign messages.

**Delivery of campaigns via community pharmacies**

151. Historically, health promotion campaigns have been determined by Local Health Boards in line with locally identified priorities. Examples include Carers' Week in Powys Teaching Health Board.

152. Prior to the project Powys Carers Service noted that no referrals from pharmacies had been made; since its roll out, 1 direct referral, 3 self-referrals and an estimated 18 self-referrals from the leaflet drop have been received. [165]

153. According to Powys Carers Service:

> "Working closer with pharmacies has already been a positive experience for us…the contractual obligation on pharmacies to participate in defined public health campaigns has allowed projects such as ours to gain 'traction' and support. Before the new contract we may have possible received support from some, but not all, pharmacies."[166]

154. In 2011, for the first time, the Chief Pharmacists of Wales's seven health boards agreed to support a national public health campaign.

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[165] NHS Wales *Essential Service Specifications* [accessed 20 April 2012]
[166] National Assembly for Wales, Health and Social Care Committee, *Consultation Response CP25 – Powys Carers Service* p2 [accessed 20 April 2012]

The campaign focussed on diabetes risk and was designed by Diabetes UK and Community Pharmacy Wales. The campaign was facilitated by Public Health Wales's Pharmaceutical Public Health Team and took place over a period of two weeks during June 2011.[167]

155. The campaign's key objectives were to identify people at high risk of developing or having diabetes, refer them to their GP practice for further investigation and to provide the public with information and advice relating to healthy lifestyle. Results were recorded for 17,507 people with 1478 (8.44%) categorised as being at high risk.[168] High risk individuals were referred to their GP practice for further investigation.[169]

156. According to Community Pharmacy Wales, the results of the diabetes campaign demonstrated the success that can be achieved by using community pharmacy for public health purposes. They argued that success was due to the Wales-wide nature of the campaign, and advocated the adoption of this national model for future public health campaigns:

> "…public health campaigns would be far more effective if they were generally run as national campaigns across Wales at the same time. All seven Welsh Health Boards agreed to run a national Diabetes Awareness Campaign organised jointly by CPW and Diabetes UK Cymru over the same two week period in June 2011. The results of the campaign demonstrate that exceptional added value to the existing arrangements was realised and proved to be highly successful…CPW would hope to see more of the 6 annual campaigns being run on an all Wales basis in future."[170]

157. Public Health Wales's evidence to the Committee noted that:

> "The public health essential service permits co-ordination of health improvement campaigns across a local area or even all Wales. This can have additional benefits in terms of getting the message across as local and national media report the

[167] Public Health Wales *Community Pharmacy Diabetes Risk Health Promotion Campaign* August 2011 [accessed 20 April 2012]
[168] A 'high risk' individual is defined as a person with a one in three risk of developing diabetes in the next 10 years.
[169] Public Health Wales *Community Pharmacy Diabetes Risk Health Promotion Campaign* August 2011 [accessed 20 April 2012]
[170] Ibid

initiative. The recent diabetes campaign through community pharmacy…is a good example of how this element of the can contract can be developed to improve population health."[171]

**Barriers to delivery**

158. There seemed to be a consensus amongst those submitting evidence to the inquiry, however, that better use could be made of this element of the contractual framework. The British Lung Foundation told the Committee:

> "The health protection and promotion role of pharmacies could be developed further."[172]

159. Aneurin Bevan Health Board agreed with this view, arguing that:

> "Public health messages are included in the contract, but these could be optimised and better coordinated across Wales."[173]

160. The suggestion that improvements could be made by planning Wales-wide public health campaigns, as opposed to more local campaigns, arose frequently when discussing this element of the contract. According to Alliance Boots:

> "The Welsh Government is committed to concerted national action on key public health issues…but this is being undermined by variable and inconsistent local approach across Wales."[174]

161. Community Pharmacy Wales called on the Welsh Government to ensure that at least half of the 6 annual public health campaigns should be Wales wide.[175] CPW based this recommendation on the development of the core public health service in Scotland, delivered by all community pharmacies:

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[171] National Assembly for Wales, Health and Social Care Committee, *Consultation Response CP5 – Public Health Wales* p4 [accessed 20 April 2012]
[172] Ibid *Consultation Response CP4 – British Lung Foundation* p2 [accessed 20 April 2012]
[173] Ibid *Consultation Response CP20 – Aneurin Bevan Health Board* p2 [accessed 20 April 2012]
[174] Ibid *Consultation Response CP30 – Alliance Boots* section 4.3 [accessed 20 April 2012]
[175] Ibid *Consultation Response CP24 – Community Pharmacy Wales* p26 [accessed 20 April 2012]

> "The national Public Health Service in Scotland is also part of the core contract and so plays a completely different role in the national health vision and policy of Scotland than to the public health contracts which are part of the core contract in Wales. **Characteristically the Scottish approach to public health is proactive and campaigning**, whereas the Welsh approach is passive and often little more than a few posters and leaflets. Evaluation of Welsh public health exercises tends to be on the basis of numbers of posters and leaflets produced and distributed rather than clinical assessment of impact on the national health."[176]
>
> (Original emphasis)

162. Giving evidence to the Committee on 16 November 2011, Jason Harding from Diabetes UK Cymru told the Committee that the Wales-wide diabetes awareness campaign would not have happened had they, as an organisation, not pushed for it. He referred in particular to financing and resourcing, stating that:

> "The charity did all of the project management and produced and paid for all of the materials."[177]

163. The Committee was also concerned to learn about the variable levels of participation in this campaign by community pharmacies across Wales. Public Health Wales's evaluation of the campaign noted that only 75% of community pharmacies responded with an evaluation of their work.[178] This suggested that, at best, 1 in 4 community pharmacies participated in the scheme but failed to report their results and, at worst, 1 in 4 did not participate at all.

164. When asked about this variable level of campaign participation and reporting by community pharmacies, Jason Harding of Diabetes UK Cymru told the Committee:

> "This initiative was delivered via the community pharmacy contract, so every pharmacy should have taken the information and delivered on that initiative…75 per cent of pharmacies

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[176] National Assembly for Wales, Health and Social Care Committee, *HSC(4)-12-11 paper 4 – Additional evidence from Community Pharmacy Wales*, 24 November 2011 [accessed 20 April 2012]
[177] Ibid *RoP [para 111]* 16 November 2011 [accessed 20 April 2012]
[178] Public Health Wales *Community Pharmacy Diabetes Risk Health Promotion Campaign* August 2011 [accessed 20 April 2012]

responded with an evaluation of their work within the initiative. One can imagine that some did the work, but did not respond. The information was provided to the pharmacies and communication occurred via the local health boards and the chief pharmacists. So, if some pharmacies did not take part, I do not know why that was the case. Those pharmacies should have followed their obligations, because they are obliged and paid to do that."[179]

165. The Committee agrees that national coordination is an area which needs further consideration to ensure that the potential role of community pharmacy in public health awareness campaigns is achieved. Nevertheless, it strikes the Committee that further work is also needed with the profession itself to ensure that pharmacists take up the opportunities afforded by the contract. While the diabetes campaign was an undoubted success in many ways, concerns remain that, even with the so-called 'golden triangle' of available finance, third sector involvement, and national coordination in place for this campaign, reporting levels by community pharmacies fell to as low as 45% in some LHB areas.[180]

166. The Committee was also interested to note Diabetes UK Cymru's suggestion that, given the amount of work involved in this campaign, a long-term programme would represent a better use of resources. Jason Harding told the Committee that:

> "…putting a lot of effort into peaks of activity for public awareness is not a very good use of resource or of the information gained from the work conducted…to have an opportunity for some type of screening of chronic conditions continuously throughout the year, if that were possible, would be a more appropriate response to the nature of the situation that is currently seen in public health in Wales"[181]

167. The Committee agrees with the Minister that we have yet to realise the full potential impact of community pharmacy involvement

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[179] National Assembly for Wales, Health and Social Care Committee, *RoP [para 95]* 16 November 2011 [accessed 20 April 2012]
[180] 40% in Ceredigion and 45% in Pembrokeshire - Public Health Wales *Community Pharmacy Diabetes Risk Health Promotion Campaign* p6, August 2011 [accessed 20 April 2012]
[181] Ibid – para 130

in the public health agenda.[182] The Welsh Government should take heed of the lessons learned from the diabetes awareness campaign before the next round of public health campaigns[183] take place. The willingness of third sector organisations to assist with these campaigns – as noted by Public Health Wales[184] and illustrated by third sector responses to our inquiry – should be embraced by the Government. The Committee welcomes the fact that notice has been taken of the need to develop campaigns on a national basis to maximise their impact and that the Welsh Government intends to work on this basis over the year ahead.

**Recommendation 5: The Committee recommends that the consistent participation of community pharmacies across Wales is secured for the next round of public health campaigns, whether national or local. Close monitoring of community pharmacy's participation is required by Local Health Boards to ensure that those failing to deliver on their contractual obligations are called to account for their non-compliance.**

### Flu vaccinations

168. Evidence to the inquiry highlighted the benefits of, and obstacles to, developing a community pharmacy based flu vaccination service to further deliver the Welsh Government's objectives for public health. Whilst many argued that the accessibility of the community pharmacy network meant it would be in an ideal position to provide flu vaccinations, doctors' representatives expressed reservations about this proposition.

*Target groups*

169. In Wales (and the UK more widely) the flu vaccination is routinely offered free to people considered to be more at risk of developing complications from contracting flu, including those 65 years of age or over, pregnant women, those with a serious medical condition (such as chronic asthma, chronic heart disease, diabetes or those with a

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[182] National Assembly for Wales, Health and Social Care Committee, *HSC(4)-01-12 Paper 3 – Evidence from the Minister for Health and Social Services*, para 4.12, 11 January 2012 [accessed 20 April 2012]
[183] The Minister's written evidence noted that these will target cardiovascular disease, respiratory disease and the expert patient programme.
[184] National Assembly for Wales, Health and Social Care Committee, *Consultation Response CP5 – Public Health Wales* p15 [accessed 20 April 2012]

weakened immune system), residents of residential or long-stay care facilities, carers and frontline health or social care workers.[185]

170. From 2002 – 2010, the Welsh Government target immunisation uptake rate was 70% for people aged 65 years or over. For the 2010/11 season the national uptake target was raised by the Welsh Government to the World Health Organisation target of 75% uptake in recommended groups.[186]

171. According to figures circulated to Local Health Boards in February 2012 by the Chief Pharmaceutical Officer, uptake figures for flu vaccinations in Wales are not meeting the target of 75% uptake in recommended groups:

**Table 8: Flu vaccination uptake in Wales**

| *Year* | *Uptake amongst those aged 65+* | *Uptake amongst under 65s in clinical risk groups* | *Uptake amongst health workers* |
|---|---|---|---|
| 2010 – 2011 | 65.7% | 48.5% | Figure not given |
| 2011 – 2012 (figures to date) | 67% | 49.9% | 30% |

*Source: Letter from Chief Pharmaceutical Officer to LHBs, 24 February 2012*

### *Role of community pharmacy*

172. According to the community pharmacy sector, the accessibility and convenience of the community pharmacy network – as well as the experience of community pharmacists administering the vaccination as a private service – makes it an ideal distribution point for the flu vaccination.[187] The Royal Pharmaceutical Society told the Committee:

> "Not everyone with a chronic condition is 80 years old and based at home; there are people in their 40s and 50s with asthma who work every day, and who appreciate the convenience of getting the service through a pharmacy."[188]

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[185] Public Health Wales *Influenza immunisation* [accessed 20 April 2012]
[186] Ibid
[187] National Assembly for Wales. Health and Social Care Committee *Consultation Response CP30 – Alliance Boots*; *Consultation Response CP17 – Stefan Fec*; *Consultation Response CP21 – National Pharmacy Association*; *Consultation Response CP29 – Age Cymru*; and *RoP [para 71]* 24 November 2011 [accessed 20 April 2012]
[188] Ibid *RoP [para 82]* 28 September 2011[accessed 20 April 2012]

173. Although Community Pharmacy Wales noted that the pharmacy sector would not have the capacity to be the sole provider of flu vaccinations for the NHS, it argued that the sector could help to serve those target groups who are currently being missed:

> "This is not about pharmacies taking over the service, because I do not think that pharmacies have the capacity to cope with it. It is, rather, a case of mopping up shortfall in those people who are not taking up free flu vaccinations on the NHS... every month, these people are in the pharmacy collecting their repeat prescription. While they are there, they could take the opportunity to have a flu vaccination."[189]

174. Reservations were expressed, however, by both doctors' representatives and Aneurin Bevan Community Health Council about introducing a community pharmacy-based flu vaccination service without sufficient mechanisms for the exchange of information between both professions. Catherine O'Sullivan, Chief Officer of Aneurin Bevan Community Council said:

> "Unless pharmacists have access to patient records, the convoluted system of notifying the GP that someone has been vaccinated with a flu jab will create another stream of paperwork and there is the potential for errors."[190]

175. This was reiterated to Dr David Bailey, Chair of the General Practitioners Committee for the BMA in Wales who stated that:

> "Our principal problem with having a pharmacist administer flu jabs is that you would not have a clear clinical record…There are a number of people with regard to whom you have to be careful to have a continuous clinical record. At the moment, there is no real means to provide that seamlessly between general practitioners and pharmacists."[191]

176. Although the Minister for Health and Social Services' written evidence argued that the location, accessibility, training and expertise of a community pharmacist make it an ideal location for the delivery of

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[189] National Assembly for Wales, Health and Social Care Committee, *RoP [para 174]* 28 September 2011 [accessed 20 April 2012]
[190] Ibid *RoP [para 66]* 10 November 2011 [accessed 20 April 2012]
[191] Ibid *RoP [para 50]* 2 November 2011 [accessed 20 April 2012]

the flu vaccination[192], attempts to run community pharmacy vaccination schemes failed in 2011/12.[193] The Minister told the Committee:

> "It is…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."[194]

177. The Minister proceeded to emphasise that community pharmacies will be used in 2012/13 to deliver flu vaccinations alongside GP services, and that all LHBs will be encouraged to engage with community pharmacies earlier this year to avoid last year's difficulties.[195]

178. The Committee believes that the community pharmacy network has the potential to play a valuable role in ensuring targets are met for the delivery of flu vaccination to target groups. Evidence does not suggest that the service should be delivered in its entirety via community pharmacists, but that the network could be positively utilised to reach those target groups currently being missed. We note the concerns raised by some witnesses about the need to improve information exchange between GPs and community pharmacists – this issue is addressed in more detail in chapter 7 of this report.

**Proposition 9: The Committee welcomes the Welsh Government's proposal to encourage all local health boards to consider community pharmacy as a provider of flu vaccinations in winter 2012/13. It is our view that this will be an important development in achieving the target rate for immunisation of recommended groups who may struggle to access their GP surgery but who, because of their condition, are frequent visitors to their community pharmacy.**

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[192] National Assembly for Wales, Health and Social Care Committee, *HSC(4)-01-12 Paper 3 – Evidence from the Minister for Health and Social Services*, para 4.14, 11 January 2012 [accessed 20 April 2012]
[193] Ibid *Consultation Response CP24 – Community Pharmacy Wales* pp 20-21 [accessed 20 April 2012]
[194] Ibid *HSC(4)-01-12 Paper 3 – Evidence from the Minister for Health and Social Services*, para 4.14, 11 January 2012 [accessed 20 April 2012]
[195] Ibid *RoP [para 145]* 11 January 2012 [accessed 20 April 2012]

# 7. Links with other health services

## Introduction

179. The Minister for Health and Social Services emphasised the importance of all health professionals working as a "seamless primary care team" when she gave evidence to the Committee on 11 January 2012.[196] Evidence submitted to this inquiry suggests, however, that significant work is still needed to achieve this ambition.

180. Disagreement between the community pharmacy sector and doctors' representatives about the extent to which community pharmacy should be offering services historically provided by GPs (for example prescribing, minor ailments, medication reviews and diagnostic services) were highlighted throughout the inquiry. The need for improved cooperation and joint working between community pharmacy and GPs was acknowledged by both professions, although action on this front appears to be at the earliest of stages and requires further facilitation by local health boards, professional bodies and the Welsh Government.

181. Information exchange, facilitated by an improved ICT infrastructure, was suggested as an avenue by which better links and cooperation could be developed between primary care professionals. There remains disagreement, however, about the extent to which community pharmacists should have access to patient information. These issues are explored in more detail in this chapter.

## Cooperation between community pharmacy and GPs

182. One of the most striking elements of the evidence gathered as part of this inquiry is that significant professional tensions exist between community pharmacists and general practitioners about their respective roles in the delivery of primary care services. Although no significant problems were reported between community pharmacists and GPs on the ground, written and oral evidence suggested that significant work is needed at the level of the respective professional bodies, local health boards and Welsh Government to achieve the 'seamless' primary care team to which the Minister aspires.

[196] National Assembly for Wales, Health and Social Care Committee, *RoP [para 95, 153 and 168]* 11 January 2012 [accessed 20 April 2012]

*Duplication and fragmentation of services?*

183. Evidence from the community pharmacy sector and doctors' representatives highlights disagreement about the extent to which community pharmacy should be offering services historically provided by GPs. This includes services such as prescribing, minor ailments, medication reviews, flu vaccinations and diagnostic reviews.

184. The Royal Pharmaceutical Society's vision for pharmaceutical care in Wales, for example, envisages community pharmacists as "an integrated part of clinical teams in and across the NHS"[197]. However, in their written evidence, the British Medical Association and the Royal College of General Practitioners emphasised what they saw as the "holistic" role of GP practices provided by an integrated primary care team:

> "GPs have a unique role in managing their patients in a holistic way….There is a danger that increasing use of pharmacists and other non-medical professionals leads to a fragmentation of care, to the ultimate detriment of the patient and resulting in increased eventual cost to the NHS."[198]

185. The Committee was disappointed, however, by the lack of information provided by the BMA and the Royal College of General Practitioners in their written evidence to support the claims of fragmentation and duplication, and the relatively protectionist stance taken by them. When probed further on these matters during oral evidence on 2 November, both organisations were more willing to acknowledge the potential contribution of community pharmacy, subject to certain caveats. Dr David Myers, Chair of the Royal College of General Practitioners in Wales, acknowledged that:

> "There have been traditional professional barriers between the professions over the years, but the approach from both GPs and pharmacists now is that we are both in primary care together and that we can collaborate."[199]

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[197] National Assembly for Wales, Health and Social Care Committee, *Consultation Response CP6 – Royal Pharmaceutical Society* section 7 [accessed 20 April 2012]
[198] Ibid *Consultation Response CP10 – Royal College of GPs* p1 [accessed 20 April 2012]
[199] Ibid *RoP [para 36]* 2 November 2011 [accessed 20 April 2012]

186. Dr David Bailey, Chair of the General Practice Committee, BMA Cymru Wales, told the Committee:

> "I have absolutely no problem with using enhanced services to improve the services from community pharmacies…There are reservations, clearly, but if they can be overcome, we would commend that mechanism of delivery services."[200]

187. The reservations Dr Bailey referred to include the need to address issues relating to information sharing (discussed in more detail in the next section of this report) and the need to acknowledge that diagnostic work is the limit to community pharmacy involvement in healthcare:

> "What I would be concerned about is where the pharmacist would have to use diagnostic skills that he is not trained for….Where you can identify things for which you can provide a service through community pharmacy without the need for diagnostic skills, then I think that that is perfectly reasonable and it should come down to patient choice."[201]

188. The Minister of the Health and Social Service's written evidence to the Committee noted that:

> "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 pharmacy is considered in this context and not in isolation."[202]

189. The Committee agrees with the comment made by the British Lung Foundation that:

> "Pharmacy must be fully integrated into the patient pathway…Too often pharmacy is not sufficiently integrated with other services, resulting in poorer overall service for

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[200] National Assembly for Wales, Health and Social Care Committee, *RoP [para 71]* 2 November 2011 [accessed 20 April 2012]
[201] Ibid *RoP [para 48]* 2 November 2011 [accessed 20 April 2012]
[202] Ibid *HSC(4)-01-12 Paper 3 – Evidence from the Minister for Health and Social Services*, para 4.4, 11 January 2012 [accessed 20 April 2012]

patients and a missed opportunity for more effective use of resources."[203]

**Proposition 10: It is the Committee's view that a clearer role for community pharmacy on the health care pathway is needed vis-à-vis other service providers. Although patient choice and preferences may mean that similar services are accessed in both community pharmacies and GP surgeries, a clearer national direction is needed to ensure effective use of resources and better public understanding of where to access the service needed.**

*Facilitation of joint working and cooperation*

190. Aneurin Bevan Health Board's written evidence provides a précis of the evidence received relating to joint working and cooperation between community pharmacists and GPs:

> "Pharmacists need to work more cohesively with their GPs and develop better working relationships."[204]

191. Witnesses representing the community pharmacy sector acknowledged that sufficient collaborative working has not occurred to date between GPs and community pharmacists.[205] Mair Davies, Chair of the Royal Pharmaceutical Society's Pharmacy Board Wales, argued that Local Health Boards need to play a bigger role in facilitating joint working between the two professions. She told the Committee that, in the specific case of a lack of development to the repeat dispensing aspect of the contract,

> "…it is the same problem over and over again, in that collaborative working between GPs and community pharmacists has just not been happening and there is no facilitation by the LHB to make it work."[206]

192. According to Paul Gimson, Director for Wales for the Royal Pharmaceutical Society, where successful collaboration has occurred it has been attributable to:

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[203] National Assembly for Wales, Health and Social Care Committee, *Consultation Response CP4 – British Lung Foundation* p1 [accessed 20 April 2012]
[204] Ibid *Consultation Response CP20 – Aneurin Bevan Health Board* p2 [accessed 20 April 2012]
[205] Ibid *RoP [para 113]* 28 September 2011 [accessed 20 April 2012]
[206] Ibid

> "…a combination of local enthusiasm, where the GP or pharmacist has been keen to take this forward, supported by facilitation from the health board."[207]

193. Initial attempts have been made to improve cooperation and joint working between the two professions in the form of a joint statement between the Royal Pharmaceutical Society and the Royal College of General Practitioners. The Committee welcomes the joint statement - *Breaking down the barriers: how community pharmacists and GPs can work together to improve patient care* – which was issued in August 2011.[208]

194. We remain concerned, however, that the implementation of the joint-statement's content was still at discussion stage with no firm action plan at the time oral evidence was given to the Committee.[209]

195. Evidence to the inquiry highlighted that issues relating to inter-professional cooperation within primary care are not unique to Wales. Even in Scotland, which has otherwise made considerable progress in developing community pharmacy services, relations between GPs and community pharmacy are not universally positive. Alex MacKinnon, Director for Scotland for the Royal Pharmaceutical Society told the Committee:

> "…there is more engagement to do, more talking to do with the GPs, more work to do from the Government, and more negotiating from the professional body. We all have a role here in ensuring that GPs understand what this pharmacy service is about, and that it is not about duplication, but about pharmacists' role in pharmaceutical care and medicine safety and ensuring that patients get the full benefit of their medicine."[210]

196. Although the synergy of the primary care contracts is covered in chapter 4, its relevance to the issue of inter-professional cooperation and joint-working is clear. As noted by Mair Davies, Chair of the Royal

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[207] National Assembly for Wales, Health and Social Care Committee, *RoP [para 116]* 28 September 2011 [accessed 20 April 2012]
[208] RPS and RCGPs *Joint Statement: Breaking down the barriers – how community pharmacists and GPs can work together to improve patient care* August 2011 [accessed 20 April 2012]
[209] National Assembly for Wales, Health and Social Care Committee, *RoP [para 36]* 2 November 2011[accessed 20 April 2012]
[210] Ibid *RoP [para 83]* 24 November 2011 [accessed 20 April 2012]

Pharmaceutical Society's Pharmacy Board Wales, work is needed on the contracts to achieve better cooperation between the professions:

> "They need to consider the contracts, the expertise and who should do what role. At the moment, they seem to be in competition rather than working for the benefit of the patient…We do not want pharmacists saying one thing and GPs saying another. They really need to be singing from the same hymn sheet, and the patient should be in the middle."[211]

197. Giving evidence to the Committee on 11 January 2012, the Minister acknowledged that professional differences constitute a barrier to the development of community pharmacy services and emphasised the importance of "ensuring that everyone works as a seamless primary care team."[212]

**Proposition 11: It is the Committee's view that failure to address inter-professional tensions will significantly restrict the Welsh Government's ability to deliver its ambition to treat Welsh people in their communities, via the primary health care team, in the future. There is a role for the Welsh Government and Local Health Boards in sponsoring the necessary discussions, but the responsibility remains firmly in the hands of the professions themselves, and the bodies which represent them collectively. It is a responsibility which needs to be addressed both more positively and with a greater sense of urgency.**

*Rural issues*

198. Evidence to the inquiry suggested that there are particular tensions between services provided by community pharmacies and dispensing rural GP practices. The Dispensing Doctors Association expressed concerns that the development of community pharmacy services may undermine the viability of dispensing practices where they depend on dispensing income to subsidise general medical services.[213]

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[211] National Assembly for Wales, Health and Social Care Committee, *RoP [para 72]* 28 September 2011 [accessed 20 April 2012]
[212] Ibid *RoP [para 95]* 11 January 2012 [accessed 20 April 2012]
[213] Ibid *Consultation Response CP11 – Dispensing Doctors Association* [accessed 20 April 2012]

199. Written evidence submitted by Tal y Bont Surgery and Llanfairpwll Health Centre, both on Ynys Môn, noted that they would have to reduce services and lose staff if they lost their dispensing income.[214] During oral evidence, Dr Philip White, a Negotiator on behalf of the General Practice Committee Wales for the BMA and a dispensing doctor in North Wales, explained that his practice's dispensing income is used to subsidise a full partner in practice.[215]

200. In oral evidence on 11 January 2012, the Minister for Health and Social Services stated:

> "…everybody should be working as part of the same team. Dispensing doctors were introduced to ensure the availability of dispensing services in the areas where a community pharmacy is perhaps unlikely to provide them, or where a community pharmacy is unlikely to open because of the volume of prescriptions that it would be dispensing. GPs need to realise that their dispensing fees are not meant or designed to support their medical services; they are an addition. We are therefore looking at the matter very carefully, but we have no plans to abolish the role of dispensing doctors."[216]

201. The Minister reiterated the Government's commitment to a vibrant rural community with access to good quality health services, noting that rural communities benefit from "a sustainable, reliable and effective community pharmacy network".[217] The Committee welcomes her acknowledgement, however, of the need to build new services based on a clear understanding of pharmaceutical need. We also welcome the further work being undertaken by the Welsh Government and Public Health Wales to better understand the pharmaceutical needs of those living in rural communities.[218]

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[214] National Assembly for Wales, Health and Social Care *Committee Consultation Response CP7 – Tal y Bont Surgery* and *Consultation Response CP14 – Llanfairpwll Health Centre* [all accessed 20 April 2012]
[215] Ibid *RoP [para 31]* 2 November 2011 [accessed 20 April 2012]
[216] Ibid *RoP [para 153]* 11 January 2012 [accessed 20 April 2012]
[217] Ibid *HSC(4)-01-12 Paper 3 – Evidence from the Minister for Health and Social Services*, para 4.9, 11 January 2012 [accessed 20 April 2012]
[218] Ibid *Consultation Response CP5 – Public Health Wales* p15 [accessed 20 April 2012]

## ICT and patient records

202. ICT featured heavily during the course of this inquiry as an area in need of further development in the context of community pharmacy services. Evidence suggested that developments in information and communication technologies are needed to improve the exchange of information between pharmacists and other health services, especially GPs, in order for pharmacy to fulfil its full potential as a member of the primary care team.

203. According to the Royal Pharmaceutical Society, a lack of appropriate IT has proven to be a barrier to the development of community pharmacy services, particularly as community pharmacists cannot access vital patient information.[219] There was disagreement, however, amongst witnesses about the extent to which community pharmacists should have access to patient information. These issues are explored in more detail in this section.

*Exchange of information*

204. Giving evidence to the Committee on 2 November 2011, the Royal College of General Practitioners noted that:

> "…there are a huge number of areas around enhanced services that we as a college feel that would be excellent for pharmacists to help us with, but we need good IT…There is important information that might be in a GP record that they cannot access, so we would like to see an improvement in that."[220]

205. The Royal Pharmaceutical Society echoed this view, arguing further that:

> "It is also about the ability of the pharmacist to share the information that they have, because, often, the most accurate record of what a patient has taken is held in a pharmacy, because that is where they pick it up."[221]

206. According to the Royal College of Nursing, more work needs to be done to improve the informatics structure to support the work that all

[219] National Assembly for Wales, Health and Social Care Committee, *Consultation Response CP6 – Royal Pharmaceutical Society* section 5.2.2 [accessed 20 April 2012]
[220] Ibid *RoP [para 54]* 2 November 2011 [accessed 20 April 2012]
[221] Ibid *RoP [para 76]* 28 September 2011 [accessed 20 April 2012]

health professionals, not only community pharmacy, would do in the community.[222] They argued that this is particularly important in the context of ensuring patient safety:

> "In a model where community pharmacy and general practice are linked for a wider team approach, you need connecting information systems, because you want to know that everybody has the same information about a patient so that anything that is important to know about that patient is considered. That is on the grounds of safety; you do not want to miss out that valuable bit of information that makes a decision important."[223]

207. There was broad agreement from across the professions, therefore, that further ICT development to encourage the exchange of information is needed to facilitate further development of community pharmacy enhanced and advanced services. It was also suggested that such systems could improve data collection on community pharmacy activities for use in evaluating and planning services.

208. In oral evidence the Royal Pharmaceutical Society Scotland underlined the importance of ICT:

> "One of the key successes in this right from the beginning of the first set of pilot schemes has been that the core services have been underpinned by an appropriately nationally developed IT infrastructure, funded by the Scottish Government. That commitment was there right from these early pilot schemes and has continued right the way through all the different core services to the electronic pharmaceutical care review web-based plan that Community Pharmacy Scotland worked with the Government to develop. That must not be underestimated, because it allows us to electronically collect information that could be used very positively in future."[224]

209. Evidence provided by Scottish pharmacy representatives explained that community pharmacies in Scotland are able to communicate information back to GPs when prescriptions are dispensed, and provide them with an 'end of care treatment

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[222] National Assembly for Wales *RoP [para 12]* 16 November 2011 [accessed 20 April 2012]
[223] Ibid *RoP [para 27]* 16 November [accessed 20 April 2012]
[224] Ibid *RoP [para 57]* 24 November 2011 [accessed 20 April 2012]

summary'.[225] The NHS Wales Informatics Service (NWIS) is exploring the use of electronic messaging ('structured clinical messaging') between community pharmacies, GPs and hospitals.[226]

210. In addition to exploring the use of structured clinical messaging, NWIS's written evidence to the Committee also noted that consideration is being given to an electronic Medicines Use Review (MUR) service. The purpose of this service would be to facilitate two-way information flows between community pharmacies and GPs.[227] NWIS also noted that there is scope for the further development of ICT to support greater collaborative working across the primary care sector, including community pharmacies, and access to electronic patient records.[228]

211. Giving evidence to the Committee on 11 January 2012, the Minister for Health and Social Services acknowledged that ICT provision has constituted a barrier to the development of community pharmacy services to date. The Minister noted, however, that informatics is also "a huge lever that would help" develop services.[229]

*Access to patient information*

212. In its written evidence the Royal Pharmaceutical Society argued that lack of access to patient information is preventing the expansion of clinical services provided by community pharmacists and the development of a range of advanced and enhanced services.[230] The pharmacy sector noted that full clinical record sharing would not be required, but a summary record should be made available to ensure patients' pharmaceutical safety.[231]

213. Doctors' representatives expressed the view, however, that patients would not expect pharmacists to have access to their full

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[225] National Assembly for Wales, Health and Social Care Committee, *Consultation Response CP44 – RPS Scotland* p1 [accessed 20 April 2012]
[226] Ibid *Consultation Response CP23 – NWIS* p5 [accessed 20 April 2012]
[227] Ibid
[228] Ibid
[229] Ibid *RoP [para 112]* 11 January 2012 [accessed 20 April 2012]
[230] Ibid *Consultation Response CP6 – Royal Pharmaceutical Society* section 5.2.2 [accessed 20 April 2012]
[231] Ibid *RoP [para 180-181]* 28 September [accessed 20 April 2012]

medical records and that more public consultation would be needed before such a measure was introduced.[232]

214. Aneurin Bevan Community Health Council challenged this assumption, suggesting that patients expect all health professionals to have access to their medical records, including pharmacists. The CHC's Chief Officer, Catherine O'Sullivan, told the Committee:

> "The majority of patients that we would have contact with, and the public, always assume that all health professionals have access to every piece of information about them – information about every health issue they have. They expect the consultant in the hospital to know what the GP knows. They also expect the pharmacist to know it. They do not see the barriers that the professionals see."[233]

215. In relation to the sharing of patient information, Ms O'Sullivan went on to tell the Committee:

> "If you are going to offer continuity of care and support any clinician in establishing a history for a patient, that [sharing of records] needs to happen. We do not want to see information getting into the wrong hands or going in the wrong direction, but surely clinicians who are delivery an NHS service [including pharmacists] should be trusted to maintain a patient's confidentiality."[234]

216. In oral evidence, Dr Gwyn Thomas, Chief Information Officer for the Welsh Government, noted that, although there is no technological reason why pharmacists could not access patient information via the individual healthcare record, there remains a behavioural and social question around the appropriateness of sharing information:

> "That restriction is defined entirely as a boundary of trust between the clinicians and the patients."[235]

217. Dr Thomas proceeded to note that the Welsh Information Governance Board – comprised of representatives from all the clinical professions and community health councils as well as those expert in

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[232] Health and Social Care Committee *RoP [para 43]* 2 November 2011 [accessed 20 April 2012]
[233] Ibid *RoP [para 44]* 10 November 2011 [accessed 20 April 2012]
[234] Ibid *RoP [para 49]* 10 November 2011 [accessed 20 April 2012]
[235] Ibid *RoP [para 115]* 11 January 2012 [accessed 20 April 2012]

relevant legal and ethical issues – is currently addressing issues around information sharing and confidentiality. According to Dr Thomas,

> "We have to shift this debate away from the risks and problems of sharing to the benefit to the patient. That is, to consider the risks of not sharing information as opposed to the risks of sharing."[236]

## Conclusions and recommendations

218. The need for improved cooperation and joint working between community pharmacy and GPs was a clear theme in this inquiry. It is our view that the professions themselves must show better leadership in this context. Nevertheless, we also believe that the full potential of community pharmacy to contribute to health services in Wales will only be realised if the performance of the whole network is levered up to the standard of the best examples provided to us in evidence.

**Key conclusion 3: Significant barriers to realising the full potential of community pharmacy lie both within the profession and between professional groups in the health service. It is our view that work needs to be done within community pharmacy to bring the standard of the whole network up to the standard of the best. We also believe that there is a considerable inter-professional responsibility to resolve some of the issues between professions which were illustrated during our inquiry as barriers to the future development of community pharmacy.**

**Recommendation 6: The Committee recommends that the Welsh Government and Local Health Boards prioritise taking proactive action to address issues of cooperation and joint working between community pharmacists and GPs, both in rural and urban areas. We believe that better leadership from within the professions in this context is vital to securing the stronger relationships between key health professionals which are needed for the successful integration of community pharmacy services and the delivery of the Government's ambitions for primary care in Wales.**

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[236] Health and Social Care Committee *RoP [para 116]* 11 January 2012 [accessed 20 April 2012]

219. The importance of further developing an ICT infrastructure that links community pharmacies with NHS services has been demonstrated to the Committee during the course of this inquiry. The Committee believes that this is not only necessary to deliver an efficient service of the high standard to which we should aspire, but to ensure patient safety. An associated benefit, if implemented correctly, could be an improvement in the collection of data on pharmacy activities that a robust ICT infrastructure could facilitate.

220. It is the Committee's view that the recent announcement to establish a national minor ailments scheme, underpinned by a patient registration system, offers the opportunity to explore the extent to which appropriate and necessary patient information should be shared with community pharmacists to allow them to deliver the best and safest service possible.

221. Evidence submitted to this inquiry illustrates that the problem here is not *technological*. Technological solutions exist, even if they need careful implementation. The key issue is to resolve professional tensions, so that the best way ahead can be properly identified. The technical means of delivering that solution can then be put in place. A consensus must be reached between professionals and with patients on the extent to which community pharmacies and other health professionals should have access to patient information – the national minor ailment scheme provides the opportunity to reach this consensus.

**Recommendation 7: The Committee recommends access by community pharmacists to summary patient records where patients are registered with a community pharmacy.**

## Annex A – Propositions

Listed below are the propositions put forward in the body of this report. These propositions support the Committee's key conclusions and recommendations and, in the Committee's opinion, merit further consideration by the Government.

**Proposition 1:** The Committee believes that further independent analysis of the possible cost-savings associated with an expanded community pharmacy ought to be commissioned by the Welsh Government. This would ensure a more robust basis upon which to build any future work to develop community pharmacy on the grounds of cost-savings. **(Page 21)**

**Proposition 2:** The apparent divergence between the Welsh Government's view of its investment in the provision of community pharmacy services on the one hand, and the views of local health boards which are responsible for service commissioning on the other, is of concern to the Committee. Work should be undertaken by the Minister's department and LHB representatives as a matter of priority to address this. **(Page 25)**

**Proposition 3:** The Committee welcomes the establishment of the All Wales Pharmacy Database. **(Page 27)**

**Proposition 4:** Whilst contractual negotiations remain at and England and Wales level, the Welsh Government should consider making representations to the Department of Health to ensure that Welsh Government officials are present at the negotiating table to ensure that Welsh interests are considered in all contractual discussions. **(Page 32)**

**Proposition 5:** The Committee welcomes the Minister's assurance that she will keep the contractual arrangements currently in place in Wales under close scrutiny. We believe that active monitoring should take place of the extent to which policy divergence between the nations points in the direction of a Wales-only contract. We also believe that there is an on-going need for the Welsh Government to ensure that the necessary capacity is developed – and sufficient resources provided – within the relevant department to undertake this scrutiny effectively. **(Page 35)**

**Proposition 6:** Providing evidence to the Committee on 11 January, the Minister for Health and Social Services emphasised repeatedly the need for a "seamless primary care team".[237] The Committee suggests that the Minister considers the extent to which current primary care contractual arrangements hinder the delivery of this aim, as suggested by the evidence we received. **(Page 36)**

**Proposition 7:** The Committee welcomes the introduction of a more targeted approach to MURs. However, we strongly suggest that the Minister consider introducing a more rigorous evaluation of the effectiveness, value for money and impact of the newly targeted MURs on NHS services. **(Page 44)**

**Proposition 8:** The Committee notes that progress has been made in relation to streamlining the training and accreditation system for community pharmacists. We urge the Welsh Government to work with the Welsh Centre for Pharmacy Professional Education to ensure that the standardisation of training and accreditation is fully implemented. **(Page 56)**

**Proposition 9:** The Committee welcomes the Welsh Government's proposal to encourage all local health boards to consider community pharmacy as a provider of flu vaccinations in winter 2012/13. It is our view that this will be an important development in achieving the target rate for immunisation of recommended groups who may struggle to access their GP surgery but who, because of their condition, are frequent visitors to their community pharmacy. **(Page 66)**

**Proposition 10:** It is the Committee's view that a clearer role for community pharmacy on the health care pathway is needed vis-à-vis other service providers. Although patient choice and preferences may mean that similar services are accessed in both community pharmacies and GP surgeries, a clearer national direction is needed to ensure effective use of resources and better public understanding of where to access the service needed. **(Page 70)**

**Proposition 11:** It is the Committee's view that failure to address inter-professional tensions will significantly restrict the Welsh Government's ability to deliver its ambition to treat Welsh people in their

[237] National Assembly for Wales, Health and Social Care Committee, *RoP [para 95, 153 and 168]*, 11 January 2012 [accessed 20 April 2012]

communities, via the primary health care team, in the future. There is a role for the Welsh Government and Local Health Boards in sponsoring the necessary discussions, but the responsibility remains firmly in the hands of the professions themselves, and the bodies which represent them collectively. It is a responsibility which needs to be addressed both more positively and with a greater sense of urgency. **(Page 72)**

## Annex B – Witnesses

The following witnesses provided oral evidence to the Committee on the dates noted below. Transcripts of all oral evidence sessions can be viewed in full at: http://www.senedd.assemblywales.org/mgIssueHistoryHome.aspx?IId=1309

*8 September 2011*

| | |
|---|---|
| Mair Davies | Royal Pharmaceutical Society |
| Paul Gimson | Royal Pharmaceutical Society |
| Russell Goodway | Community Pharmacy Wales |
| Ian Cowan | Community Pharmacy Wales |
| Chris James | Community Pharmacy Wales |

*12 October 2011*

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| Anne Hinchliffe | Public Health Wales |
| Nuala Brennan | Public Health Wales |

*2 November 2011*

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| Dr David Bailey | BMA Cymru Wales |
| Dr Philip White | BMA Cymru Wales |
| Dr David Baker | The Dispensing Doctors' Association |
| Dr Paul Myers | Royal College of General Practitioners |
| Chris Martin | Hywel Dda Health Board |
| Berwyn Owen | Betsi Cadwaladr University Health Board |
| Bernardine Rees | Cwm Taf Health Board |

*10 November 2011*

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|---|---|
| Catherine O'Sullivan | Chief Officer, Aneurin Bevan Community Health Council |
| Byron Grubb | Chair, Aneurin Bevan Community Health Council |

*16 November 2011*

| | |
|---|---|
| Lisa Turnbull | Royal College of Nursing Wales |
| Sue Thomas | Royal College of Nursing Wales |
| Jason Harding | Diabetes UK Cymru |
| Melanie Gadd | Family Planning Association |

*24 November 2011*

| | |
|---|---|
| Dr Elspeth Weir | Community Pharmacy Scotland |
| Malcolm Clubb | Community Pharmacy Scotland |
| Alex MacKinnon | Royal Pharmaceutical Society Scotland |

*11 January 2012*

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

## Annex C – Written evidence

The following people and organisations provided written evidence to the Committee. All written evidence can be viewed in full at http://www.senedd.assemblywales.org/mgIssueHistoryHome.aspx?IId=1532

| *Organisation* | *Reference* |
|---|---|
| Minister for Health and Social Services | HSC(4)-01-12 Paper 3 |
| NUS Wales | CP 1 |
| ASH Wales | CP 2 |
| Abertawe Bro Morgannwg University Health Board | CP 3 |
| British Lung Foundation | CP 4 |
| Public Health Wales | CP 5 |
| Royal Pharmaceutical Society | CP 6 |
| Dr Ewan Thomas (GP) | CP 7 |
| Company Chemists' Association Ltd | CP 8 |
| Chartered Society of Physiotherapy | CP 9 |
| Royal College of GPs | CP 10 |
| The Dispensing Doctors' Association Ltd | CP 11 |
| Aneurin Bevan Community Health Council | CP 12 |
| Mind Cymru | CP 13 |
| Llanfairpwll Health Centre | CP 14 |
| Betsi Cadwaladr University Health Board | CP 15 |
| CONWY Social Services Department | CP 16 |
| Stefan Fec | CP 17 |
| ABPI Cymru Wales | CP 18 |
| The Princess Royal Trust for Carers | CP 19 |
| Aneurin Bevan Health Board | CP 20 |
| National Pharmacy Association | CP 21 |

| | |
|---|---|
| Parkinson's UK | CP 22 |
| NHS Wales Informatics Service | CP 23 |
| Community Pharmacy Wales | CP 24 |
| Powys Carers Service | CP 25 |
| Medicines Management Programme Board | CP 26 |
| Powys NSF for Older People Monitoring Group | CP 27 |
| Ruth Ridge | CP 28 |
| Age Cymru | CP 29 |
| Alliance Boots | CP 30 |
| Alliance Boots – Scottish model of pharmacy | CP 30a |
| Welsh Refugee Council | CP 31 |
| BMA Cymru Wales | CP 32 |
| Welsh Ambulance Services NHS Trust | CP 33 |
| Hywel Dda Health Board | CP 34 |
| Action on Hearing Loss Cymru | CP 35 |
| Hilda Smith | CP 36 |
| Welsh Food Alliance | CP 37 |
| Dr Christopher John Harris | CP 38 |
| Cwm Taf Health Board | CP 39 |
| RCN Wales | CP 40 |
| Diabetes UK Cymru | CP 41 |
| Family Planning Association | CP 42 |
| Community Pharmacy Scotland | CP 43 |
| Royal Pharmaceutical Society Scotland | CP 44 |