Personal submission to the Health and Social Care Committee, September 2011.

1. ***the effectiveness of the Community Pharmacy contract in enhancing the contribution of community pharmacy to health and wellbeing services;***

There are two issues here, whether the Community Pharmacy contract facilitates and promotes the contribution of Community Pharmacy to health and wellbeing services and whether LHBs use Community Pharmacy to its best effect.

The Contractual framework's main focus is on the dispensing of medicines and remuneration is directly linked to the volumes of prescriptions dispensed. While the contractual framework does contain some additional "quality" elements within the essential services (such as contributing to public health campaigns and ad-hoc health advice), the contribution of pharmacy to enhance the health and wellbeing services are dependent mainly on the enhanced and advanced services of the contract.

Community Pharmacy is not included in LHB Health and Wellbeing Strategies and until such a time as it is formally incorporated into these, will continue to be an afterthought for most LHBs in the provision of health and social care services in Wales. The other main barriers to enhancing the quality of patient care are:

- volume based remuneration (payment per prescription),
- training and support for pharmacists and staff,
- integration with General Practice and Hospitals in order to ensure patients can be looked after across all health interfaces, and
- enabling LHBs to manage poorly performing contractors (no effective sanctions are written into the Regulations).

The challenge for community pharmacy is to prove that it doesn't just increase access to services, but can maintain or improve the quality of those services for an equivalent cost to the NHS. While access is one of pharmacy's biggest benefits (both in terms of geographical location and opening times), increasing access may or may not improve health outcomes for patients. The problem is that until recently the LHBs have not measured (or in the case of the MUR and AUR Advanced Services, cannot measure) patient outcomes for the enhanced services they have commissioned. It is ironic that LHBs will site a lack of evidence for community pharmacy services as a reason for not commissioning them, while themselves largely failing to contribute to any evidence base.

The Committee should give thought to either:

- ensuring that Community Pharmacy is fully included in both Health and Wellbeing Strategies and Primary Care Estate Strategies, and / or:
- providing ring-fenced funding for Community Pharmacy Enhanced Services.

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

Statistical data from WAG indicates that uptake of "novel" community pharmacy services following the introduction of the new pharmacy contractual framework in 2005 was low, with most "enhanced" services being those already commissioned pre-2005 (advice to care homes, methadone supervision and needle exchange). The WAG statistical releases need interpreting with caution as

the data was of low quality: health boards reported non-NHS services and also MURs (an advanced service) as being "enhanced services". Statistical releases for 2009-10 give a more accurate picture.

Various factors impact on the extension of pharmacy services. A major positive force has been the LHB Primary Care Pharmacists, arguing locally for the expansion of Community Pharmacy. On the opposite side, the lack of ring-fenced funding for enhanced services and the exclusion from LHB Health and Wellbeing Strategies and Primary Care Estates Strategies continues to result in the marginalisation of community pharmacy as a frontline healthcare provider as well as a lack of investment in services and premises.

From a Contractor's point of view, there may be reluctance to join up to an enhanced service for many reasons. These may include:

- a lack of any guarantee that the service may continue beyond the financial year (impacting on staffing levels),
- Services that may only be delivered by Pharmacists, not support staff (as would happen in a GP surgery). This can be problematic, especially if a Pharmacy relies on locum cover. In addition, where a Pharmacy has only one pharmacist, the dispensing process usually has to stop if the pharmacist is in a confidential consultation.
- Training, administration and audit requirements (important, but often overly bureaucratic).
- Inadequate funding.

Year	2005-06	2006-07	2007-08	2008-09	2009-10
Area					
Wales	825	1,420	1,678	1,906	1,611
North Wales Region	177	438	479	568	386
Mid and West Wales Region	274	554	725	850	632
South East Wales Region	374	428	474	522	593

Table 1. *Data from StatsWales website (2009/10 figures combined from current LHB structures exclude non-NHS services and MURs explaining the apparent reduction from the previous year). The figures are the sum of enhanced services per pharmacy per region.*

The Committee should be aware of the recent move towards National Enhanced Services, with Emergency Contraception being commissioned earlier this year. This approach is to be commended as it removes the postcode lottery of service provision, streamlines the adminstration and, through the "NECAF" online claims system developed by the Prescribing Services Unit of the Shared Services Partnership, allows national scrutiny of activity.

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

Contractors may opt-in to provide advanced services (Medicines Use Reviews (MURs) and the newer Appliance Use reviews (AURs)). There are a number of issues with MURs, uptake being just one. The Medicine Use Review has little in the way of evidence to prove that it improves patient outcomes, is paperwork heavy for Pharmacists and also for the GPs to whom the reports may be sent. The reputation of the service suffered in the early days as patients on single medicines (like

contraceptive pills) were targeted: GPs rightly questioned the value of such an intervention. Pharmacists also struggle to keep the service as a "concordance review" (does the patient use the medicine to optimize its effects) and not turn it into a clinical review (should the GP have prescribed this or something else?). While some patients will have benefitted, and many appear to like the service, there is still a lack of evidence proving this to be an effective intervention for the NHS. The Committee's attention is drawn to NICE CG76 and the 2008 Pharmacy in England White paper for further information.

2009-10	Number MURs Paid
Wales	107,998
Betsi Cadwaladr ULHB	19,771
Powys Teaching LHB	3,184
Hywel Dda LHB	16,058
ABM ULHB	24,633
Cwm Taf LHB	8,720
Aneurin Bevan LHB	16,798
Cardiff & Vale ULHB	18,834

Table 2. MUR uptake 2009/10. *With 707 pharmacies in Wales able to each offer 400 MURs per year, this represents just over 38% uptake nationally. In this period 613 (86.7%) of pharmacies had self-accredited to provide the service (data from StatsWales).*

The service is a confidential one between patient and pharmacist, with the GP only being informed if the patient agrees. The data cannot be shared with LHBs and thus there is no quality control over the service. Some LHBs have attempted to rectify this through training and / or enhanced services on top of the MUR to encourage certain quality markers to be included and therefore measured.

A suitably redesigned electronic MUR (capable of being imported directly onto GP computer systems and being open to scrutiny by LHBs) could solve some of the problems associated with MURs.

Nationally, the money to fund MURs came from reducing the dispensing fee (with an expectation that pharmacists would do more to keep the same level of income), but it has resulted in additional work pressures that some contractors have been unwilling to support with additional staffing. The Drug Tariff sets out minimum staffing levels for the dispensing process, but consideration should be given to including provision of enhanced and advanced services within the staffing level requirements to ensure that essential services and enhanced and advanced services can all be delivered safely and with minimum disruption to patients.

The Committee should consider:

- Changing the MUR to make it open to LHB scrutiny and enable standards to be raised,
- Moving the MUR and its funding into the Essential Service element of the contract, with minimum service levels rather than a maximum, and
- Ensuring the MUR and AUR and the new hospital discharge service generate evidence of benefit for patients.

4. 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;

Minor ailments schemes exist within the NHS in England, but uptake is patchy. One key reason for this is that while it is believed that such schemes may reduce the number of GP consultations for these conditions, those "savings" can never be realized: other patients take up the spare appointments. In Wales we have an emphasis on patient self-care. If this is taken to mean keeping a stock of medicines in house for those "minor emergencies" such as diarrhoea, then a minor ailments scheme may stop patients purchasing self-care medicines as they would access them free from the NHS. Some existing schemes indicate that there are lower per-transaction costs involved with pharmacy minor ailments schemes (as 32 paracetamol are supplied instead of 100 being prescribed) – but there is little evidence that GPs prescribe fewer medicines as a result.

For a minor ailments scheme to work and be able to show cost and patient benefit to the NHS a similar system to the one that exists in Scotland should be pursued: patients have to register for the service and any supplies should be notified back to the patient's GP.

Other services that could be developed ought to include those where provision is currently lacking but would significantly improve the health of Welsh residents – for example 'flu or pneumococcal vaccination of high risk patients, Cognitive Behavioural Therapy for non-medical treatment of depression, treating or preventing benzodiazepine addiction, Level 3 smoking cessation, healthy living and weight management services.

All of these services, if delivered well and to large numbers of patients, need either an increase in pharmacists OR for pharmacy support staff to be able to deliver them. They also need significant investment, not just in paying for the services but also in the training and set up costs for the LHBs. In addition, Pharmacists will need to access parts of the GP held patient's medical records in order to ensure a safe service.

The Committee should give thought to the following:

- How can the NHS shift the focus from dispensing to "clinical" services when almost all the funding is linked to dispensing?
- Can Community Pharmacists manage patients' pharmaceutical care, including ensuring any diagnostic tests are carried out, and could this be the basis of outcome-related funding?
- How this shift can be managed – if a Welsh Pharmacy Contract is envisaged, will the Welsh Government be given the resources it currently lacks to create and implement it?
- Whether Community Pharmacy represents an opportunity for the NHS to address the health needs of patients being "missed" by the current providers.
- Creating opportunities, or encouraging careers for, clinical pharmacists within the Community setting.

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

The current strength of community pharmacy is also one of its major barriers to redesign and refocus. Dispensing of medicines is the core business for most pharmacies and provides the major income stream. Dispensing in pharmacies is highly regulated to ensure patient safety is maintained, for example:

- Dispensing errors are a criminal offence,
- Pharmacy support staff must be qualified to carry out their assigned jobs,
- Pharmacists must carry out a clinical check on each prescription,
- Standard operating procedures must be in place for each aspect of pharmacy work,

- There are minimum staffing levels covering the dispensing process, linked to practice payments.

Pharmacies could increase their dispensing business in a number of ways, for example if they were able to dispense hospital in-patient prescriptions (a faster service than most hospitals offer), or if there were a change in the Regulations that enable GPs to dispense in rural areas. Both options may have consequences, in the case of GPs this is a potential destabilising of some rural practices (but should they really rely on dispensing income to remain profitable?).

	Pharmacy	**Dispensing GP**
Signed Contract?	No (Contractual framework).	Yes (nGMS and Pharm Regs)
Clinical governance	Yes	Partly
Staff training	Mandatory	Voluntary
Staffing levels	Defined in Drug Tariff	Only in Dispensing Services Quality Scheme (voluntary additional service with extra payments).
Funding	90p dispensing fee, plus allowances (totals approx £2.63 per item) plus purchasing profit (minus clawback).	Sliding scale of fees (by GP, not practice) between 209.7p and 187.4p, plus purchasing profit (minus clawback). No allowances but IT, premises and staff pensions covered by NHS.
Dispensing overseen by / clinical check	Pharmacist must check. Prescriptions may not be given out unless pharmacist present.	Dispensing lead but no clinical check. Prescriptions may be given out if no GP on site.
Decision support software (interactions)	Universally used as part of Patient Medication Record (PMR)	Partially used, PMR usually additional module of prescribing system.
Dispensing support software	Not usually used (trained staff and final check)	Becoming more common (barcode readers check accuracy)
Additional services	In contractual framework, may need to be commissioned	Not applicable (covered in nGMS contract)
Standards and Regulation	General Pharmaceutical Council and LHB.	LHB possibly (but no framework). No professional regulator although some issues covered by GMC guidance.

Table 3: comparison of Community Pharmacy and Dispensing GP contractual arrangements.

Increasing the overall amount of dispensing may not be in the interests of the NHS. Wales has the highest number of prescriptions issued per capita of all the UK nations. The WHO believe that up to 50% of all medicines for chronic conditions are used incorrectly, so there is the potential that we in Wales are wasting a massive amount of money on medicines that are either ineffective because they

are underused, or causing harm because they are over used, or may not have been needed in the first place. Some Community Pharmacists may argue that this is the problem of the prescribers, but I disagree: for Community Pharmacists to be taken seriously as members of a multidisciplinary health team they must show they can reduce the amount of unnecessary medicines being dispensed and also improve compliance for those necessary medicines. The tools are available through MURs and also a little used Waste Reduction Scheme piloted in some LHBs: but until the remuneration issues are resolved, *reducing the number of medicines dispensed is sadly not in the interests of community pharmacy nor of the wholesalers who own many of the "multiple" pharmacy chains.*

The Committee should consider whether dispensing through GPs and Pharmacies are of an equivalent standard and represent good value for money for the NHS. A level playing field in terms of remuneration and Regulation is needed to ensure patients benefit from high standards of service.

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

The former Minister for Health, Edwina Hart, created a Task and Finish group to review Community Pharmacy, chaired by Chris Martin (Chair of Hywel Dda Health Board). While this has effectively ceased to operate now, out of their review has come the following positives:

- National Enhanced Service for Emergency Contraception and others planned for substance misuse and smoking cessation.
- National Electronic Claims and Audit Form (NECAF) developed by Prescribing Services (NHS Wales Shared Service Partnership),
- Annual Operating Framework targets for Community Pharmacies, including increasing the amount of Repeat Dispensing.
- Pressure to develop and improve Hospital Pharmacy computer systems leading to electronic discharge summaries capable of being printed and sent to Community Pharmacies. This is now being taken forward as a new national service whereby pharmacists will ensure any changes made to patients' medicines in hospital are actioned by the GP, thus avoiding medication errors.
- Development of an all Wales Pharmacy database.

Credit needs go to Dave Hopkins and Neil Jenkins of Prescribing Services for developing the NECAF system and to NWIS and the BSC for developing the Pharmacy database.

Apart from the financial issues and a lack of inclusion in LHB Health and Wellbeing Strategies, NHS service development is hampered by a number of issues. Firstly within the Civil Service, there are insufficient resources within the Pharmacy and Prescribing Branch to manage any significant development of the Pharmacy Contract. The Chief Pharmaceutical Officer (Professor Roger Walker) is similarly under-resourced. Secondly, LHBs are still sorting out their structures following the NHS reorganisation, creating further barriers for the development of Pharmacy and Medicines Management within the NHS (despite considerable cost savings and safety improvements achieved by NHS pharmacists).

Stefan Fec, MRPharmS
Primrose Pharmacy
Talgarth
Powys
LD3 8AW