Pecyn dogfennau cyhoeddus

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:
Ystafell Bwyllgora 3 - Y Senedd

Dyddiad:
Dydd Iau, 24 Tachwedd 2011

Amser:
09:30

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

I gael rhagor o wybodaeth, cysylltwch a:

Llinos Dafydd
Clerc y Pwyllgor
029 2089 8403
HSCCommittee@wales.gov.uk

Agenda

1. Cyflwyniad, ymddiheuriadau a dirprwyon

2. Ymchwiliad i'r cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru - Tystiolaeth gan Fferyllfeydd Cymunedol yr Alban a Chymdeithas Fferyllol Frenhinol yr Alban (09.30 - 10.30) (Tudalennau 1 - 16)

HSC(4)-12-11 papur 1- Fferyllfeydd Cymunedol yr Alban

Elspeth Weir, Pennaeth Polisi a Datblygu, Fferyllfeydd Cymunedol yr Alban
Malcolm Clubb, Uwch Fferyllydd Polisi a Datblygu, Fferyllfeydd Cymunedol yr Alban

HSC(4)-12-11 papur 2 - Y Gymdeithas Fferyllol Frenhinol

Alex MacKinnon, Cyfarwyddwr yr Alban, y Gymdeithas Fferyllol Frenhinol

3. Deiseb ar y Ddarpariaeth o Doiledau Cyhoeddus yng Nghymru - Ystyried dull y Pwyllgor Iechyd a Gofal Cyndeithasol o weithredu (10.30 - 10.35) (Tudalennau 17 - 20)

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4. Papurau i'w nodi (Tudalennau 21 - 22)

Cofnodion y cyfarfod a gynhaliwyd ar 10 Tachwedd
HSC(4)-10-11 cofnodion

4a. Ymchwiliad i'r cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru – Tystiolaeth ychwanegol gan Fferylliaeth Gymunedol Cymru (Tudalennau 23 – 31)
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5. Cynnig o dan Reol Sefydlon 17.24(vi) i benderfynu gwahardd y cyhoedd o'r cyfarfod ar gyfer eitem 6 (10.35)

6. Ymchwiliad i'r cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru – Trafodaeth breifat am y materion sy'n codi (10.35 – 11.00)

Health and Social Care Committee

HSC(4)-12-11 paper 1

Inquiry into the Contribution of Community Pharmacy to Health Services in Wales – Evidence from Community Pharmacy Scotland

Who are we?

Community Pharmacy Scotland is the organisation which represents community pharmacy contractor owners in almost every aspect of their working lives, and is the voice of these vital healthcare professionals as they deliver pharmaceutical care to the people of Scotland.

NHS Pharmaceutical Services Regulations 2009 state that Scottish Ministers must consult with a body representative of the general body of pharmacy contractors. Community Pharmacy Scotland is recognised as that body by Scottish Ministers. We currently represent the owners of 1234 pharmacies in Scotland. We negotiate on their behalf with the Scottish Government on all matters of terms of service and contractors' NHS service activity including remuneration and reimbursement for the provision of NHS pharmaceutical services.

Historical Background

The NHS in Scotland is operated under the NHS Scotland Act, first introduced in 1948. This recognises that NHS Boards must ensure adequate provision of pharmaceutical services. It also covers the arrangements for other independent contractors. Pharmacy contractors in Scotland since the inception of the NHS have negotiated with the civil service in Scotland directly. Post devolution the responsibility for Health moved from the Secretary of State to the Health Minister elected at Holyrood.

The first act of the new government was to produce *Our National Health: a plan for action, a plan for change.* This plan set out a new direction for health policy and delivery in Scotland. It was followed by the publication of *The Right Medicine: A strategy for Pharmaceutical Care in Scotland*. The Right Medicine was an agenda for the modernisation of pharmacy services.

The Right Medicine stated that the Government would work with the profession to develop a new system of remuneration which provides incentives to deliver a quality patient focused service. A set of principles was agreed in January 2003 to underpin the development of a new contract.

SG/Community Pharmacy Scotland Agreed Principles for new Community Pharmacy Contract

The new contract should:

- provide services that deliver pharmaceutical care in an efficient and effective way and in line with the proposals set out in *The Right Medicine*;
- support a rational network of pharmacies/pharmacists that provides equitable and convenient access for patients in terms of location and opening times;
- ensure that the provision of quality pharmaceutical care services, including the traditional dispensing function, is properly resourced;
- provide services in a way that ensures patients have better access to a full range of pharmaceutical care services;
- ensure that developments in pharmacy tie in with the priorities for healthcare in Scotland (e.g. Public Health, Chronic Disease Management);
- deliver a quality service throughout Scotland;
- provide opportunities for continuing professional development and the development of new skills for all staff within community pharmacy;
- provide opportunities to recruit, retain and motivate all staff within community pharmacy;
- encourage and support better partnerships between individual community pharmacies and with other members of the wider health and community care team, including pharmacists working out-with community pharmacy;
- ensure that patients throughout NHS Scotland benefit from the introduction of any new services, following due consultation and evaluation, which are resourced accordingly;
- ensure that pharmaceutical services are provided from premises fit for the purpose;
- ensure that a suitable infrastructure is in place including the provision of IT resource;
- ensure minimum financial turbulence for contractors who have demonstrated their commitment to NHS Scotland through their financial investment; and
- incorporate a 'high trust/low bureaucracy' approach.

Following the agreement of principles meetings were arranged between the two parties to agree further development. These meetings have two agenda sets – strategic and technical.

Our evidence on the questions posed follows.

1) **Funding of the Community Pharmacy Contract**

Funding for the provision of pharmaceutical services was traditionally made on the basis of a cost-plus contract. The cost of the service was established through surveys and an agreed level of profit calculated. This funding was known as the **global sum**.

The cost-plus arrangements were abolished many years ago and the global sum was subsequently updated through negotiation. When the new contracts were introduced, in 2005 in England & Wales and 2006 in Scotland, a new element was an agreement on the amount of reimbursement income which contractors would be allowed to keep. This was the **retained purchase profit element**.

The overall funding envelope for the provision of the core services therefore consists of: **Global Sum** + **Retained Purchase Profit**

Since 2006 the global sum has been updated through negotiation and the retained purchase profit arrangements have been modified to introduce an agreement that where the profits earned exceed a guaranteed amount then that surplus will be shared between pharmacy contractors and NHS Boards. The intention behind these new arrangements is to provide an incentive for contractors to purchase well.

A cost survey was held in to inform negotiations on the funding of the service and quarterly spot checks are held to confirm the level of purchase profit existing in the market place.

Funding for the provision of a number of services, the additional services, is negotiated between the pharmacy contractors and the NHS Boards. The NHS Boards have an allocation from central funds for these services but can chose to supplement that payment from other “funding pots”.

Distribution of the Financial Envelope

Prior to the introduction of the revised contractual arrangements in 2006 detailed discussions took place on the make up of the financial envelope, including the transfer of money (£30m) from reimbursement into remuneration when the Category M pricing arrangements were introduced, the way the money should be allocated to each of the new services, and the actual method of distribution for each of the service areas. For obvious

reasons both pharmacy contractors and the NHS Boards were keen to see that this transfer of money worked accurately. A full series of booklets is available on the Community Pharmacy Scotland to outline funding since 2006 for further perusal.

Method of Distribution

A. Remuneration

Minor Ailment Service (MAS)

Funding for this service is made on a **banded capitation basis**. Information on the number of patient registrations per pharmacy is held centrally and payment is made on the number of registrations on the system at the end of the month. Reimbursement is also made for any product supplied. No fees are paid.

Public Health Service (PHS)

Funding for this service was initially made as a **fixed amount** per pharmacy. As the new patient -centred PHS services were introduced the fixed payment element has been reduced and **payment per intervention** has been introduced.

Acute and Chronic Medication Service (AMS/CMS)

A unique feature of the Scottish contract was the decision taken in 2004 to move away from the payment of individual fees and allowances and to enter into a **transitional payment system.** The idea then was to provide stability over a period of time while the new services were introduced. For each contractor where sufficient information was available a fixed monthly payment was introduced. In subsequent years the monthly payment was adjusted to reflect growth within the system and negotiations on the overall sums available. In October 2011 the first steps have been taken to move away from the fixed payments and start to allocate money for the provision of the Chronic Medication Service. It has always been the stated intention that payment for CMS will be made on a **capitation basis**, weighted as appropriate.

Miscellaneous

A number of other fixed payments are also made, e.g. for participating in the Urgent Supply arrangements, for the provision of flu vaccines on stock orders, and towards IT requirements.

A. Reimbursement

The arrangements for the pricing of products supplied are set out in the Drug Tariff. The amount of profit within the system is modulated through the application of both generic and proprietary discount clew back rates.

2) Arrangements for Sharing Information

An electronic infrastructure has been created to allow transmission of prescription information from GPs to CPs. More detailed information may be accessed at Scottish Health on the Web Community Pharmacy.

Currently two services support the sharing of information electronically. The first is the Acute Medication Service (see annex A for further information). This shares GP prescription information using barcode technology to support ongoing remuneration and reimbursement.

The use of barcodes on prescriptions also supports improvements in patient safety. Downloading the electronic message directly minimises the risk of transcription error from a handwritten or non e-enabled prescription. The barcode also prevents the dispensing of an out of date prescription previously this relied on human intervention and this could be missed.

The second core service which shares information electronically with GPs is the Chronic Medication Service (see Annex A for further information).Two sorts of information are shared. Firstly, dates of dispensing for CMS serial prescriptions will be automatically sent to GPs for information. Secondly once CMS is fully established it will also be possible for CPs to provide end of treatment reports to GPs. The information shared will support GPs to ensure appropriate monitoring and feedback on patients is shared to support the release of a further serial prescription or QOF (quality and outcomes framework) review.

In terms of access to information community pharmacists are currently very restricted in terms of what they can see. CPS continues to lobby for access to the electronic record information. We believe the following information would be useful for pharmacy contractors:

- **Cholesterol results**

Cholesterol results for patients who are taking cholesterol lowering medicines (statins) if the patient is not reaching target levels and previously was, the intervention of a pharmacist could support improved adherence along with lifestyle advice without requiring increased doses (and therefore cost) of medicines.

- **Warfarin blood results**

Warfarin requires careful monitoring and patients must achieve a certain target level (INR). This level is maintained in a dose response relationship and it would be helpful for pharmacists to have sight of an e-copy of the required dose and current level. Patients are currently expected to provide their Warfarin Book but routinely forget to bring it.

- **Chemotherapy prescribing by secondary care**

Community Pharmacy currently has no visibility on prescribing in secondary care. This would be helpful in this instance if a patient presented feeling unwell in the unscheduled care period. There is a risk if a patient does not inform the pharmacist they are undertaking chemotherapy that infection which is more severe in immunocompromised patients is not escalated appropriately.

3) **Integration into Wider Health Services**

The focus within NHS Scotland is to use Community Pharmacies where appropriate to make services accessible to patients and to reduce pressures on other parts of NHS Scotland. Examples of how this is being achieved are:

- The Minor Ailment service – 790,059 patients were registered at the end of March 2011 and 1.7m items were prescribed.
- The Public Health Service – NRT and EHC – Over 80% of EHC consultations in Scotland are now delivered through the community pharmacy network and in the past two years a reduction has been seen in the abortion rate and in the birth rate.
- Provision of services in the GP out of hours' period – NHS24 uses community pharmacy as a major line of referral.
- CPUS Service – where a patient who is receiving treatment for a chronic condition has been unable to access the GP practice that patient will be able to receive a full cycle of his/her medication from a pharmacy through the “urgent supply” arrangements. The pharmacist has the facility to write a prescription for a full cycle and the service is underpinned by a national PGD hosted by NHS 24.

4) **Key Drivers of an Enhanced Role**

The key drivers behind an enhanced role for community pharmacy are:

1. Deliver Pharmaceutical Care for Patients in Scotland to ensure they get the most from their medicines.

2. Efficient use of monies for Prescribing Budgets through reduction of waste

3. The availability of access to a healthcare professional

4. The need to make best use of all health professionals

5. The challenges posed by the forthcoming demographic changes. We need to ensure ongoing review and reshaping of care provided to prevent unnecessary admissions to hospital.

5) What pharmaceutical care services do we provide?

Pharmacy contractors in Scotland are expected to provide all four core pharmacy services in the contract framework. The four core services (detailed description in Annex A) are:

- Chronic Medication Service
- Minor Ailment Service
- Public Health Service
- Acute Medication 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.

6) How was the contract developed?

The contract evolved through a series of discussions between us and the Scottish Government. The key components of these discussions focussed around:

- Who was the contract for?
- What did we want it to do?
- What services would be provided?
- How would we get paid?
- What infrastructure would be required?

The objectives of the service redesign were to ensure:

- Ready access to the Community Pharmacy network for supply and care
- Deliver Quality services for patients, users and carers
- An Improvement in the public's health
- Position the pharmacy profession as key provider of Healthcare.

It must be recognised that the development of the contract would not have been possible without the underpinning of the ePharmacy programme. Every pharmacy has been provided with an N3 connection.

Money has also been provided for other infrastructure requirements such as the training of staff, for premises improvements, for the availability of Pharmacy Champions and Pharmacy IM& T facilitators.

Training material for the new services has been made available by NHS National Education Scotland.

7) Strengths and Weaknesses of the Scottish Pharmacy contract

Strengths – The first recognisable strength of the contract is close collaboration between the Scottish Government and Pharmacy contractors to realise a joint aim. The second strength was a vision was clearly laid out for all to see at the beginning of the process. A further strength was the Scottish Government and CPS being bold enough to ensure ongoing contractor financial stability during the development of the contract including novel ways of funding such as capitation and a move away from what was seen to be a perverse incentive.

The use of pilots prior to full service rollout was also useful as these highlighted potential issues in service delivery. There was also recognition of the need to build capacity in IT, staff and premises which has resulted in a improved pharmacy network better able to deliver the new services

Weaknesses – The introduction of GP QOF has resulted in inexorable increases in prescription volume. Whilst this has improved the management of long term conditions the pace of dispensing and supply required in pharmacy to service this reduces time available for new services. Community Pharmacy Scotland is aware this needs to be tackled to support ongoing service delivery.

The fact that IT system suppliers are required to deliver different solutions for other home nations has slowed development at times. We now have operational underpinning for all services as required but system upgrades are required to improve service delivery and these are only now coming on stream.

The protracted roll out of CMS has resulted in GPs being less engaged than would be desirable. Hopefully this will improve in time as co-delivery of care ramps up.

A further weakness for the Scottish contract was the effect of the implementation of Category M changes agreed in England and Wales. Due to

this steps were undertaken this financial year to distance ourselves from the link to Category M.

8) Translation across to Wales

In terms of service development which could be transferred across to Wales we see potential for adopting elements of MAS and CMS. The software packages have already been developed for contractors and it would be worth exploring to see how they could be integrated into the existing pharmacy systems. It would of course also be necessary to look at the NHS IT systems, particularly in terms of setting up registration systems, and we do not know whether this is something NHS Wales has already looked at.

Elspeth Weir
Head of Policy and Development
Community Pharmacy Scotland

Annex A

Core Services Description

The Minor Ailment Service

This service was introduced in 2006 and evolved out of successful pilot schemes run in 2 Health Board areas.

Initially patients who were exempt from prescription charges could register with the community pharmacy of their choice and use that pharmacy as the first port of call for the consultation and treatment of common illnesses. The pharmacist advises treats or refers the patient according to their needs. The service is underpinned by an electronic infrastructure. A module has been developed within the pharmacy PMR which allows:

- registration information to flow to and from a central registration store maintained by a support division within NHS Scotland
- the pharmacist to generate a prescription form for signature by the patient

Payment for the service is made on a banded capitation basis and through reimbursement for any item provided. No fees per item are paid.

The pharmacist can provide any P or GSL item that is not blacklisted, dressings and appliances from Part 2 of the Drug Tariff, selected appliances from Part 3 such as bug busting kits and any prescription only medicines agreed suitable and underpinned by a Patient Group Directive (PGD).

Pharmacists are expected to prescribe in line with local and national formularies. A separate budget line has been created for MAS prescribing costs.

A recent research paper concluded that the banded capitation payment system was one of the strengths of the service.

The current position is that the service remains available only to those patients who were previously exempt from prescription charges. CPS has proposed that all patients should be allowed to register for the service but that the contents of the formulary should become more restricted.

Public Health Service

This service was first introduced in 2006 and has been developed over the succeeding years.

Initially the service specification covered the promotion of self care, the display of public health posters and leaflets and the provision of opportunistic interventions for advice and support on self care, health protection and health improvement. Subsequently new initiatives saw the delivery of a smoking cessation support service and a sexual health service. Initially the sexual health service covered both the provision of Emergency Hormonal Contraception and HC and a Chlamydia testing service but the chlamydia element has now been withdrawn.

Contractors are required to return information to the NHS board in the form of a minimum dataset for the smoking cessation service. The Boards are charged with meeting HEAT targets for smoking cessation.

Payment for the service is made through a combination of a fixed rate payment plus a fee per intervention for the patient centred services.

eAMS – Electronic Transmission of Prescriptions

In essence this element of the contract covers the traditional dispensing and supply role. An electronic infrastructure has been developed to support electronic transmission of prescription information (ETP)

The overall aim of ETP is to enable the electronic generation, transmission, dispensing and
processing of prescriptions.

ETP allows a GP to produce a bar-coded paper prescription and an associated electronic message. This message is an electronic version of all the details that are printed on the prescription form. The message is sent by the GP system to the ePharmacy Message Store (ePMS) where it sits until the patient presents the prescription in a pharmacy.

Pharmacists or their staff are able to retrieve the message by scanning the bar code on the prescription form. The pharmacy PMR (Patient Medication Record) system can then use most of the information in the message to process the prescription, whilst still allowing referral to the paper form where necessary. Once the prescription is dispensed, contractors send an electronic claim message to the message store. This claim is later retrieved by Practitioner Services Division (PSD) at NHS National Service Scotland (NHS NSS). This electronic claim information is used where possible and supported by a set of pricing business rules for remuneration, reimbursement and

information gathering purposes. This forms the basis of the 'ePay' element of the ePharmacy Programme.

ETP has initially covered all acute and repeat GP prescriptions. ETP will also be extended to cover serial dispensing, other prescribers and Out of Hours prescriptions.

The electronic transfer of prescriptions was initially piloted in NHS Ayrshire & Arran, where in excess of one million ETP prescriptions were successfully issued by a number of GP practices prior to National Role Out.

CMS – Pharmaceutical Care Support for Long Term Conditions

Chronic Medication Service (CMS) provides an ideal opportunity to:

- build on and strengthen existing good pharmacy practice
- encourage joint working between GPs and community pharmacists
- further improve patient care

The purpose of CMS is to further develop the contribution of community pharmacists in the management of individual patients with long-term conditions by improving their understanding of their medicines and working in partnership with them and other healthcare practitioners to maximise the clinical outcomes from their therapy.

By applying a systematic approach pharmacists will help patients manage their long-term conditions in order to:

- identify and prioritise risk
- minimise adverse drug reactions
- address existing and prevent potential problems with medicines
- provide structured follow-up with referral interventions where necessary.

CMS is underpinned by a generic framework for pharmaceutical care planning based on the Clinical Resource and Audit Group (CRAG) Framework document, *Clinical Pharmacy Practice in Primary Care*. It is described in more detail in *Establishing Effective Therapeutic Partnerships*, the CMS Advisory Group report commissioned by the Chief Pharmaceutical Officer and produced under the chairmanship of Professor Lewis Ritchie.

CMS outline

CMS is a service which requires patients to opt in before participation. There are three specific stages in the Community Pharmacy CMS process each of which is underpinned by the ePharmacy Programme.

- **Stage 1** involves the **registration** of patients for CMS.
- **Stage 2** introduces a generic framework for **pharmaceutical care planning.**
- **Stage 3** establishes **the shared care** element which allows a patient's general practitioner (GP) to produce a **serial prescription** for up to 48 weeks (generally 24 or 48 weeks) and which is dispensed at appropriate time intervals determined by the patient's GP.

This stage will be supported by disease specific protocols for a number of pertinent disease conditions which outline common potential pharmaceutical care issues, referral criteria and reporting requirements.

Current tools being developed support safe use of Methotrexate, Lithium and initiation of new medicines. It is anticipated other high risk medicines such as Warfarin will also be supported.

Health and Social Care Committee

HSC(4)-12-11 paper 2

Inquiry into the contribution of community pharmacy to health services in Wales – Evidence from the Royal Pharmaceutical Society Scotland

Royal Pharmaceutical Society
Holyrood Park House
106 Holyrood Road
Edinburgh
EH8 8AS

Thank you for the opportunity to input into our inquiry. The Royal Pharmaceutical Society (RPS) is the professional body for pharmacists in Scotland, Wales and England. We are the only body that represents all sectors of pharmacy.

The RPS promotes and protects the health and well-being of the public through the professional leadership and development of the pharmacy profession. This includes the advancement of science, practice, education and knowledge in pharmacy. In addition, it promotes the profession's policies and views to a range of external stakeholders in a number of different forums.
Many of the questions are related to payment and contractual matters. Community Pharmacy Scotland is the organisation which represents pharmacy contractors in Scotland and therefore is best placed to answer these questions.

1. **The arrangements for sharing patient information between GPs and pharmacists**

- Most prescription information now transfers electronically between GP surgeries and community pharmacy. When the Chronic Medication Service (CMS) is fully operational an electronic facility to send messages back to the GP from the Patient Care Record will exist in the pharmacy. Currently there is no formal system to share any other patient information.

- The Scottish Government, in their recently published e-strategy document, committed to community pharmacist access to the Emergency Care Summary by 2014. Scottish Government policy supports person-centred care, therefore, lobbying continues to secure full access to appropriate sections of patient healthcare records, on patient safety grounds, particularly to allow safer operation of the national Patient Group Direction (PGD) out of hours, for palliative care and to provide further integration between primary and secondary care.

2. **Integration into the wider health services**

   The publication of *The Right Medicine* in 2002 and the introduction of the new *Community Pharmacy Contract* in 2003 was the start of a process of integration of community pharmacy into the NHS which is still in progress. Scottish Government has recognised the expertise, skill and accessibility of having a pharmacist available on the high street and has committed to make better use of pharmacists in the NHS.

   The areas where integration has been most apparent are listed below:

- The National Minor Ailment Service was introduced to encourage the use of pharmacists as a first port of call for minor ailments and to free up GP appointment times where cost was a barrier to accessing medicines. Patients exempt from prescription charges are eligible for this free service. A consultation with the pharmacist is a fundamental requirement thereby harnessing pharmacists' traditional 'over the counter' (OTC) prescribing skills. Registration and capitation- based payments were a first step towards shifting the payment system focus away from volume-based payments and towards pharmaceutical care.

- The introduction of the public health services, allowing access through pharmacies to services such as Emergency Hormonal Contraception and Smoking Cessation, which had previously only been available through either GP or NHS services.

- Integration has occurred in some health board areas, not only with NHS services but also with social care, through council funding for methadone clinics and support for substance misuse clients, with community pharmacists collaborating with Community Psychiatric Services

- NHS 24 works in partnership with community pharmacy to provide out-of-hours services. Patients are referred to community pharmacies for OTC treatments, and community pharmacies now refer directly to out-of-hours GPs, as well as supplying patients with repeat medication when essential supplies have run out. These valuable additions make best use of the available expertise in the community at times when other health professionals are not available, thereby decreasing the number of calls to the emergency NHS 24 helpline and unplanned visits to Accident and Emergency departments.

- CMS will deliver pharmaceutical care to people with long term conditions, encouraging self care, and promoting greater patient understanding of their medicines. This formalises the traditional role of the community pharmacist, giving advice to their patients to aid adherence and optimise use of medicines.

3. Key Drivers

As mentioned above, a series of policy documents have been published; they recognise the expertise, and underuse, of the pharmacy profession as the experts in medicine and the importance of pharmaceutical care in the NHS, with Scottish Government policy promoting person centred care. These include, *The Right Better Health, Better Care 2009, The Road to Recovery 2010, Reshaping Care for Older people 2010* and the *NHS Quality Strategy 2010.* The developing 'Mutual' NHS in Scotland has established a system of collaboration and cooperation rather than one of competition and choice.

The emerging challenges in finance and demographics have resulted in the necessity to revisit the delivery of public services to make best use of the skills and resources available.

The Scottish Government policy to shift the balance of care from secondary to primary and keep patients closer to home where possible, has provided drivers to increase use of the Community Pharmacy network; in the 2011 Election campaign,

making more use of pharmacists was mentioned in each of the Scottish political party manifestos.

4. Strengths and Weaknesses

The Scottish Government made a commitment to e-pharmacy and new services did not start until appropriate electronic system underpinning was in place. The Scottish Government supported this service development with considerable IM&T support monies.

One of the strengths of the Minor Ailment and the Out of Hours services has been the increased public visibility of community pharmacists as prescribers and public health practitioners in line with other healthcare practitioners. There have been considerable advantages to the patient journey with the innovation of the national PGD, increased use of the pharmacist's skills and professional decision making.

Collaboration with National Health Education Scotland (NES) has been a necessary support with core education evenings which ensure that all pharmacists have the opportunity to upskill, where required, to provide the new services.

The piecemeal implementation of new services, without a simultaneous review of workforce planning, has resulted in some pharmacists struggling to manage the workload and feel pressurised with the increasing volume of prescriptions.

Whilst the IT commitment has been welcomed, and provides excellent long term stability, delays have occurred in the implementation of the Chronic Medication Service (CMS).The advantages of collaborative working with CMS have not been marketed well to GPs, who remain relatively disengaged from their local community pharmacists; it is hoped that this situation will improve as the IT challenges are resolved and serial dispensing begins.

Y Pwyllgor Iechyd a Gofal Cymdeithasol

HSC(4)-12-11 papur 3

At: Y Pwyllgor Iechyd a Gofal Cymdeithasol

Oddi wrth: Ysgrifenyddiaeth y Pwyllgor

Dyddiad: Tachwedd 2011

DEISEB AR Y DDARPARIAETH O DOILEDAU CYHOEDDUS YNG NGHYMRU – YSTYRIED DULL Y PWYLLGOR IECHYD A GOFAL CYMDEITHASOL O WEITHREDU

Cefndir

1. Yn ei gyfarfod ar 12 Hydref, cytunodd y Pwyllgor Iechyd a Gofal Cymdeithasol i gynnal sesiwn dystiolaeth lafar ar y ddarpariaeth o doiledau cyhoeddus yng Nghymru. Mae hyn yn dilyn cyfeirio deiseb ar y pwnc hwn o'r Pwyllgor Deisebau (P-03-292) yn ystod mis Gorffennaf 2011.

2. Cytunodd y Pwyllgor i drefnu sesiwn ar ôl toriad y Nadolig i ystyried y materion iechyd cyhoeddus a godwyd yn y ddeiseb, yn benodol goblygiadau iechyd cyhoeddus yr honiad bod diffyg cyfleusterau toiledau cyhoeddus.

3. Er mwyn hysbysu ei waith, awgrymir bod y Pwyllgor yn cynnal ymgynghoriad ysgrifenedig byr, â ffocws, cyn y sesiwn dystiolaeth lafar sydd i'w threfnu ym mis Ionawr 2012. Amlinellir manylion hyn yn y papur hwn.

Diben

4. Gofynnir i'r Pwyllgor ystyried a chytuno ar y canlynol: y cwestiynau a ofynnir fel rhan o'r ymgynghoriad ysgrifenedig; rhestr ddrafft o ymgyngoreion; ac amserlen arfaethedig ar gyfer y gwaith.

Tystiolaeth ysgrifenedig: cwestiynau allweddol

5. Cynigir bod y Pwyllgor yn ceisio barn ysgrifenedig partïon â diddordeb ynghylch y ddarpariaeth o doiledau cyhoeddus yng Nghymru. Awgrymir bod yr ymgynghoriad ysgrifenedig yn:

- canolbwyntio ar oblygiadau iechyd cyhoeddus diffyg honedig yn y ddarpariaeth o doiledau cyhoeddus;
- esbonio'n glir na all y Pwyllgor wneud sylwadau penodol ar ddyletswydd awdurdodau lleol i ddarparu cyfleusterau, gan nad yw hynny'n rhan uniongyrchol o gylch gwaith y Pwyllgor.

6. Atodir rhestr o ymgyngoreion ar gyfer yr ymgynghoriad ysgrifenedig â ffocws yn Atodiad A i'r papur hwn.

7. Dyma gwestiynau yr awgrymir eu gofyn fel rhan o'r ymgynghoriad:

   - Beth yw effeithiau darpariaeth o doiledau cyhoeddus (neu ddiffyg darpariaeth o'r fath) ar iechyd a lles cymdeithasol person?

   - A oes tystiolaeth bod pobl yn methu gadael eu cartrefi oherwydd pryderon ynghylch argaeledd toiledau cyhoeddus? Os oes, beth yw goblygiadau hynny o ran iechyd a lles?

   - A oes cydraddoldeb ledled Cymru – ac yng nghyswllt pob person – o ran y ddarpariaeth o doiledau cyhoeddus?
     - Sut dylai cyfleusterau toiledau cyhoeddus ymateb i anghenion grwpiau gwahanol o bobl (dynion, menywod, pobl anabl, pobl ag anghenion iechyd arbennig, plant)?
     - A oes angen arbennig am well cyfleusterau i grwpiau penodol?

   - Pa effeithiau ehangach gallai darpariaeth annigonol o doiledau cyhoeddus eu cael ar iechyd cyhoeddus a'r gymuned? Er enghraifft, mae gohebiaeth a anfonwyd at y Pwyllgor Deisebau yn awgrymu bod perygl o faeddu strydoedd, gyda chlefydau'n ymledu yn sgil hynny.

Amserlen

8. Awgrymir yr amserlen ganlynol:

25 Tachwedd 2011	Cyflwyno ymgynghoriad ysgrifenedig
23 Rhagfyr 2011	Yr ymgynghoriad ysgrifenedig yn dod i ben
Ionawr 2012	Sesiwn dystiolaeth lafar

Tystiolaeth lafar

9. Tystion a awgrymir ar gyfer y sesiwn dystiolaeth lafar yw:
    - Y Cyng. Louise Hughes (prif ddeisebydd), Age Cymru a Senedd Pobl Hŷn Cymru (yn cefnogi'r ddeiseb);
    - Ymarferwyr iechyd a chynrychiolwyr elusennau'r bledren a'r coluddion; a'r
    - Chris Brereton, Dirprwy Brif Cynghorydd Iechyd yr Amgylchedd, a Dr Sara Hayes fel Dirprwy Brif Swyddog Meddygol (iechyd cyhoeddus) dros dro.

Gweithredu

10. Gwahoddir yr Aelodau i drafod a chytuno ar y dull o weithredu a amlinellir yn y papur hwn, gan gynnwys:
    - y cwestiynau allweddol i'w gofyn fel rhan o'r ymgynghoriad ysgrifenedig byr, â ffocws, cyn y sesiwn dystiolaeth lafar (paragraff 7)
    - yr amserlen arfaethedig (paragraff 8)
    - y tystion a gynigir ar gyfer y sesiwn dystiolaeth lafar ym mis Ionawr (paragraff 9)
    - yr ymgyngoreion a gynigir ar gyfer yr ymgynghoriad ysgrifenedig byr â ffocws (Atodiad A)

ATODIAD A

Rhestr o ymgyngoreion ar gyfer yr ymarferiad ymgynghori ysgrifenedig â ffocws

- Comisiynydd Pobl Hŷn Cymru
- Age Cymru
- Senedd Pobl Hŷn Cymru
- Byrddau Iechyd Lleol
- Iechyd Cyhoeddus Cymru
- Cyfadran Iechyd y Cyhoedd
- Anabledd Cymru
- Mencap Cymru
- Scope Cymru
- Cymdeithas Toiledau Prydain
- Y Rhwydwaith IBS
- Sefydliad y Bledren a'r Coluddyn
- Cymdeithas Genedlaethol Colitis a Chlefyd Crohn
- Y Gymdeithas Cyngor ar Ymataliaeth
- Fforwm Ymataliaeth Cymru Gyfan
- Cymdeithas Gastroenteroleg Prydain
- Sefydliad Joseph Rowntree
- Comisiynydd Plant Cymru
- Plant yng Nghymru

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:	**Ystafell Bwyllgora 1 – Y Senedd**
Dyddiad:	**Dydd Iau, 10 Tachwedd 2011**
Amser:	**10:15 – 11:50**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Gellir gwylio'r cyfarfod ar Senedd TV yn:
http://www.senedd.tv/archiveplayer.jsf?v=cy_200000_10_11_2011&t=0&l=cy

Cofnodion Cryno:

Aelodau'r Cynulliad:	**Mark Drakeford (Cadeirydd)** **Mick Antoniw** **Rebecca Evans** **Vaughan Gething** **William Graham** **Elin Jones** **Lynne Neagle** **Lindsay Whittle** **Kirsty Williams**
Tystion:	**Byron Grubb, Cadeirydd, Cyngor Iechyd Cymunedol Aneurin Bevan** **Catherine O'Sullivan, Prif Swyddog, Cyngor Iechyd Cymunedol Aneurin Bevan**
Staff y Pwyllgor:	**Sarah Beasley (Clerc)** **Llinos Dafydd (Clerc)** **Naomi Stocks (Clerc)** **Catherine Hunt (Dirprwy Glerc)** **Joanest Jackson (Cynghorydd Cyfreithiol)** **Stephen Boyce (Ymchwilydd)** **Victoria Paris (Ymchwilydd)**

1. Cyflwyniad, ymddiheuriadau a dirprwyon

1.1 Cafwyd ymddiheuriadau gan Darren Millar. Nid oedd dirprwy.

2. Y dull o ystyried deddfwriaeth

2.1 Nododd y Pwyllgor y papur a thrafododd ei ddull cyffredinol o ystyried deddfwriaeth.

2.2 Mewn perthynas â'r papur gwyn ar roi organau, cytunodd y Pwyllgor i geisio cynnal dwy sesiwn gydag uwch-swyddogion Llywodraeth Cymru, yn gyntaf ar ddechrau'r broses ymgynghori ac eto ar ôl cau'r ymgynghoriad. Diben y sesiynau hyn fyddai cael y wybodaeth ddiweddaraf am ddatblygiad y papur gwyn, yn hytrach na mynegi barn ar ei gynnwys.

3. Ymchwiliad i gyfraniad fferylliaeth gymunedol i wasanaethau iechyd yn Nghymru – tystiolaeth gan Gyngor Iechyd Cymunedol Aneurin Bevan

3.1 Atebodd y tystion gwestiynau Aelodau'r Pwyllgor am gyfraniad fferylliaeth gymunedol i wasanaethau iechyd yng Nghymru.

3.2 Cytunodd y tystion i ddarparu rhagor o wybodaeth am yr adolygiad o wasanaethau fferylliaeth.

4. Cynnig o dan Reol Sefydlon 17.24(vi) i benderfynu gwahardd y cyhoedd o'r cyfarfod ar gyfer eitem 5

4.1 Derbyniodd y Pwyllgor y cynnig o dan Reol Sefydlog 17.42(vi) i benderfynu gwahardd y cyhoedd o'r cyfarfod ar gyfer eitem 5.

5. Ymchwiliad i leihau'r risg o strôc – trafodaeth breifat am y prif faterion

5.1 Bu'r Pwyllgor yn trafod y papur ar y prif faterion ar gyfer yr ymchwiliad i leihau'r risg o strôc. Cytunodd y byddai'n ystyried prif negeseuon ac argymhellion y papur yn y cyfarfod nesaf.

6. Papurau i'w nodi

6.1 Cytunodd y Pwyllgor y byddai'n parhau i gael cofnodion y cyfarfodydd blaenorol fel papurau i'w nodi, ac y dylai Aelodau hysbysu'r Clerc am unrhyw faterion y maent am eu codi mewn perthynas â nhw.

6.2 Bu'r Pwyllgor yn trafod y llythyr oddi wrth y Pwyllgor Deisebau ynghylch y ddeiseb am eli haul ar gyfer plant dan 11 oed. Cytunodd y Pwyllgor bod y ddeiseb yn fwy perthnasol i gylch gwaith y Pwyllgor Plant a Phobl Ifanc, sy'n gyfrifol am faterion iechyd plant.

6.3 Nododd y Pwyllgor y llythyr oddi wrth y Gweinidog Iechyd a Gwasanaethau Cymdeithasol am wasanaethau iechyd meddwl i oedolion.

6.4 Nododd y Pwyllgor ei flaenraglen waith hyd at doriad y Nadolig.

TRAWSGRIFIAD
Trawsgrifiad o'r cyfarfod.

Eitem 4a

Assembly Health & Social Care Committee

Supplementary Submission for Inquiry into the Contribution of Community Pharmacy to Health Services in Wales

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November 2011

1. Introduction

1.1 This paper is submitted as Supplementary Evidence by Community Pharmacy Wales (CPW) to the Assembly Health & Social Care Committee to inform their inquiry into the contribution of Community Pharmacy to Health Services in Wales. This Supplementary Evidence specifically deals with CPW comments on the operation of the community pharmacy contract in Scotland.

1.2 An exchange of information and experience on the operation of community pharmacy across the 4 devolved administrations is maintained by means of **quadripartite meetings** of the community pharmacy negotiating bodies. These meetings are held 4 times a year and are hosted by each country in turn.

1.3 Attendees at the quadripartite meetings are Community Pharmacy Wales (CPW), Community Pharmacy Scotland (CPS), Community Pharmacy Northern Ireland (CPNI) and, from England, the Pharmaceutical Services Negotiating Committee (PSNC).

1.4 This mechanism of quadripartite meetings assists in exchange of good practice across the 4 devolved administrations in an equal manner and can also prevent duplication of effort between countries where we can learn from experience of our pharmacy colleagues elsewhere. This takes advantage of devolution of health policy throughout the UK. It has also enabled CPW to be more aware of the operation of the contract in Scotland than we would otherwise have been.

1.5 CPW finds it useful to make comparisons between the operation of the contract in Wales and in Scotland as a fundamentally different way of organising community pharmacy to that used by the current England and Wales contract. It shows us that if a separate Welsh contract is developed the current England and Wales contract is not the only template within the UK NHS.

1.6 In this Supplementary Evidence CPW comments in particular on 5 aspects of community pharmacy in Scotland: structure and funding; minor ailments; public health service; chronic medication service and IT infrastructure.

2. Structure and Funding of Scottish Community Pharmacy Contract

2.1 The structure of the Community Pharmacy Contract in Scotland has two main characteristics that distinguish it from the contract as it operates in Wales: It is **commissioned nationally not at local level** and, it is a **mainstream part of health policy and delivery** in Scotland.

2.2 The **national nature of the Scottish contract** makes it more akin to there being a range of national enhanced services. This is what CPW has supported for many years. Cross party political support for common services that are delivered throughout Wales and are not subject to local differences has often been expressed in Community Pharmacy debates in Assembly Plenary sessions. The last two new community pharmacy services to be introduced in Wales: Emergency Hormonal Contraception in April 2011, and the Hospital Discharge Medicines Review Services in November 2011 have both been national services. The successful public health campaign in June 2011 on Type 2 Diabetes Risk Assessment was also run on a national basis for the first time. CPW see advantage in national community pharmacy services and the Scottish model is one way of achieving this.

2.3 The **mainstreaming of community pharmacy in delivery of health policy in Scotland** is evident in many aspects. There is a clear Government Vision for community pharmacy in Scotland that does not exist in Wales. The Chief Pharmaceutical Officer in the Scottish Government is of equal status to the Chief Medical Officer. In Wales the Chief Pharmaceutical Officer reports to the Chief Medical Officer. The resourcing of operating the community pharmacy contract within the Scottish Government is very substantial in terms of quality and quantity, whereas within the Welsh Government it is minimal. It is not possible to envisage the Welsh Government operating a full Welsh community pharmacy contract unless there is a reallocation of resourcing within the civil service. It is likely that the Welsh Government can benefit from work already done by the Scottish Government on a national community pharmacy contract, for instance on the ePharmacy infrastructure.

2.4 The funding of the Scottish contract is based on **global sum plus retained purchase profit.** CPW believes there is value in considering this as one option to take forward in Wales as opposed to the current funding basis of the England and Wales contract. CPW believes that the Scottish model has advantages as it enables a critical mass of services to be developed both across the country and for each pharmacy. While the Scottish contract is partly funded through retained purchase profit it is not transparently so on an annual basis.

2.5 CPW finds that the **overt inclusion of the so-called retained purchase profit element of the contract funding is an acknowledgment of the unique public-private sector partnership that community pharmacy constitutes**. Every year the retained purchase profit of community pharmacies in Wales has raised between £10 million and £11 million in income for NHS Wales. Since the 2005 contract was introduced this represents some £66 million NHS income in Wales alone. **For the first time, in November 2011, a service has been introduced in community pharmacy in Wales that is directly funded from these amounts.** The new Hospital Discharge Medicines Review Service is funded out of £3.6million of this money recycled back into community pharmacy.

2.6 **CPW calculates that if only half the retained purchase profit every year was recycled back into specific community pharmacy services on a regular annual basis then, over the 5 year life of this government, it would fund the seven steps to building a healthier Wales outlined in the CPW manifesto GOOD HEALTH: IECHYD DA.** The Best Medicine for Healthy Lives in Wales. This would include **a Welsh national minor ailments scheme; frontline public health services in community pharmacies; frontline social care services in community pharmacies; a Targeted Medicines Waste service; a Chronic Conditions Management Service; continuation of the Hospital Discharge Medicines Review and a network of Good Health/ Iechyd Da/Healthy Living pharmacies.** It is estimated that this, in turn would generate further potential savings of over £90 million.

2.7 The "recycling" of retained profit funds that has been used in Wales to establish the innovative Hospital Discharge Medicines Review Service, has also been used in England for a different New Medicines Service. However, this approach has not been used on a partially hypothecated basis in Scotland and we have recommended its advantages to our colleagues there for consideration.

3. Minor Ailments

3.1 The national Minor Ailments service in Scotland is a helpful comparator for a potential national scheme in Wales, as advocated in the Programme for Government. The successful scheme currently operating in Torfaen would be a good pilot on which to build for a national scheme.

3.2 To take this forward CPW would favour a **Task & Finish Group being established by the Welsh Government in early 2012 with a tight remit and timetable to determine the implementation of a national Minor Ailments scheme in Wales.** Elements of the Torfaen scheme, as well as the Scottish scheme, should be considered for incorporation, as well as the work done by CPW and WAG in 2006/07 to implement the then government's commitment to NHS Pharmacy based Drop-In Centres. This Group should report in July 2012. It is important that this Report is published so that it has a public status, unlike the final report of the Pharmacy Task & Finish Group in 2010 or the draft Community Pharmacy Welsh National Action Plan in 2008. After required preparations, including any additional accreditation and Directions, a Welsh National Minor Ailments Service should be able to be introduced in April 2013.

3.3 **Registration of patients** is a key part of the logistics of the Scottish National Minor Ailments scheme. Payment to contractors is per capita based on registration rather than fee based per patient visit as in the Torfaen scheme. There are some advantages in registration including in safe access to the patient record. It is worth considering the advantages and disadvantages of registration in Wales.

3.4 At a time when GPs and secondary care are under increasing pressure from an ageing population it makes no sense for Government and Health Boards to continue to resist the transfer of this service to pharmacies where equal clinical and professional healthcare skills exist and are being under used.

3.5 CPW noted that the Royal College of GPs in their recent evidence to the Committee supported community pharmacies taking on minor ailments services.

4. Public Health Service

4.1 The national Public Health Service in Scotland is also a part of the core contract and so plays a completely different role in the national health vision and policy of Scotland than do 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.

4.2 **CPW notes that Diabetes UK Cymru, in its current evidence to the Committee Inquiry, recommends that the diabetes risk assessment public health campaign run in all Welsh community pharmacies for two weeks in June 2011 should be run throughout the year.** This would begin to be a proactive public health campaign along the lines of the Scottish model. CPW would support Diabetes UK Cymru's recommendation, although in Wales at present it might require a new national enhanced service to be developed as it would go beyond the minimal contractual requirements of the current community pharmacy contract.

5. **Chronic Medication Service**

5.1 **Patients with chronic conditions are, in many ways, the perfect demographic to benefit from community pharmacy services**. They are not ill as such, but they have a long term condition, such as asthma or diabetes, which they manage with medication. They do not necessarily need to attend at the GP surgery frequently and yet should maintain regular contact with a healthcare professional. In particular, they need to understand what their medicines are meant to do, how they work and how to use them to get the best out of them – that is, they need structured access to a medicines expert.

5.2 CPW is aware of a degree of frustration among Scottish colleagues that the national Chronic Medication Service was not swifter in development and implementation. So also in Wales there has been no Government action on the proposed Chronic Conditions Management scheme put forward in 2007.

5.3 CPW favours introduction of a national Chronic Conditions Management scheme in Wales, learning from the extensive experience in Scotland.

6. IT Infrastructure

6.1 IT infrastructure for pharmacies progresses in Scotland. We know our colleagues there are frustrated that they were partially held back by the tardiness of the labourious and over specified IT plans in England. In Wales most pharmacies now operate 2D bar code transfers of prescription information, and recent new services incorporate electronic payment claims for pharmacies.

6.2 There may be more that is relevant to Wales in the Scottish roll out than there is in the English experience where delivery in practice has been some way behind either Wales or Scotland. Committee members might be surprised at the clash of cultures that takes place in many Welsh community pharmacies where modern retailers communicate with their customers by text messaging, but where the NHS services are still stuck with slow paper based mechanisms.

7. Conclusions

7.1 CPW knows there is much that Wales can learn from the Scottish experience of community pharmacy and we appreciate our close working ties with our colleagues in Community Pharmacy Scotland. Neither would copy the work of the other in its entirety, but working together eases the load of developing and operating innovative services and so benefits our patients and healthcare services in both countries. CPW also appreciates the time and effort put in by CPS in giving evidence to this Inquiry of the Welsh Assembly.

7.2 CPW often covets the prominence given to community pharmacy in Scotland. We know that the people of Wales, as well as Welsh community pharmacy contractors, would benefit if this prominence was afforded in Wales for a critical mass of community pharmacy services that fit the healthcare needs of the Welsh population. Although CPW also recognises that Scotland had a slightly different growth of health services prior to the devolution watershed of 1999, as there was a separate original NHS Scotland Act in 1948.

7.3 In looking at what may be needed if a national contract was to be set up in Wales, CPW is mindful of the extensive support within Scottish Government for the contract, and also of the effectiveness of widespread partnership working between professionals and other agencies in much of Scottish community pharmacy. We are also mindful of the helpful check list of aims of a new contract that was used in Scotland after 1999.

7.4 As an indication of the extent and requirements of the community pharmacy contract, CPW commends to the Committee that members look at copies of the next monthly Drug Tariff that comes out. The 1st December 2011 Drug Tariff will also be of interest to Members as it will include full required information of the new Hospital Discharge Medicines Review Service.

CPW is content for this response to be made publicly available, and to respond to any further questions that Committee members may have on this or other evidence.