- make arrangements for the continuing professional development of staff
- comply with good human resource management
- carry out audits of their services
- where required, report adverse incidents or near misses to Scottish Ministers, or specified 3rd parties, in a format determined by them

2.11 As indicated above, the listed terms of service items are illustrative and should not be taken as definite or fully comprehensive at this stage.

2.12 Boards will be directed to monitor and ensure compliance by contractors with the terms and conditions of service and other regulatory requirements associated with the provision of pharmaceutical services.

**Question**

- **Are there any specific or additional powers we need to consider in order to modernise pharmaceutical care services and further improve patient care?**

POLICY MUST BE AGREED WITHIN THE NHS.
IN THIS MONOPSONY SCENARIO, NAMELY ONE CUSTOMER, AS OPPOSED TO THE MONOPOLY OF ONE SUPPLIER
WITHIN THE PARAMETERS OF STATUTORY POLICY, STRATEGY TO ACHIEVE THE OBJECTIVES MUST 'AB INITIO' ESTABLISH DEFINITIVE REWARDS BY WAY OF INDUCEMENTS AND PROFESSIONAL RECOGNITION, NAMELY FINANCIAL AND SPECIFIC INCLUSION OF PHARMACY IN ALL MATTERS OF PHARMACEUTICAL/MEDICATION CARE,
TACTICAL INTERPRETATION WOULD ONLY THEN BE ACCEPTABLE. BY WAY OF MANDATORY CPD, PREMISES CONDUCIVE TO PRIVATE CONSULTATION, ET AL.

N.B. THE GOVERNMENT IS OBLIGED TO ADOPT THE "CARROT"
RATHER THAN THE "STICK" WITH THE MEDICAL/DENTAL CONTRACTS

3.17 The holders of all PCSP contracts would be subject to the same provider requirements as currently exist for community pharmacy contractors. The service will have to be provided from authorised premises, delivered by or under the direct supervision of a registered pharmacist with the contractor being listed on the Board's pharmaceutical list. The same terms and conditions of service will apply with additional or more specific terms being set where appropriate.

**Questions**

- **Do these proposals offer a comprehensive way of ensuring patients have convenient access to a range of pharmaceutical care services that takes account of their care and access needs?**

- **Are there alternative models for fulfilling the policy intention for patients?**

IT MUST BE CONSIDERED THAT PATIENT NEEDS ARE COMPREHENSIVE AND AS SUCH CARE CONCERNS THE UNUSUAL AND UNEXPECTED. CONSEQUENTLY 'VESTED' INTEREST, NAMELY MULTIPLE CORPORATIONS BY DEFINITION IPSO FACTO – ARE GEARED TO MAXIMISE PROFIT,
THEREFORE THE MONOPOLY OF THE NATIONAL COMPANIES MUST BE GUARDED AGAINST

PATIENT INTERESTS ARE BEST SERVED BY A NAMED PHARMACIST (PF) PATIENTS INVARIABLY PREFER "THEIR OWN DOCTOR"
'LEAPFROG' DISASTERS ARE A LIVING TESTIMONY TO CARELESS ACQUISITIONS EG. TWO PHARMACIES IN JUXTAPOSITIONS – ANNIESLAND CROSS GLASGOW & OTHERS.

→ THE MODEL OF ONE PHARMACY PER 5,000 [@ 10 scripts per patient per annum] WOULD BE PROFESSIONAL AND ECONOMICAL

4.7 Applications from principals to be entered on Part A will require certain undertakings, consents and declarations to confirm their fitness to provide pharmaceutical services under a NHS contract. This will include, for example, confirmation of registration with the Royal Pharmaceutical Society of Great Britain or confirmation that the principal is not subject to national disqualification by the NHS Tribunal.

4.8 Part B would list all non principals i.e. registered pharmacists who will perform NHS contracted pharmaceutical services in a Board area as an employee, a pharmacist in training or on a locum basis. The application requirements for these non principals would be similar to those for entry to Part A of the list.

4.9 Administrative arrangements would be established to enable pharmacists who wish or need to be registered on the lists of other Boards to do so as part on the initial application process at their 'host' Board, on a 'fast track' basis already developed for listing GPs.

4.10 From the date of implementation of the new arrangements, a pharmacy principal would not be able to employ a pharmacist who was not listed on their local Board's pharmaceutical list. All listed persons would be individually responsible for their own acts or omissions in the course of providing NHS pharmaceutical services.

**Question**

- **Are there any further actions that would serve to improve clinical governance in the community pharmacy sector and provide patients with an additional quality assurance (e.g. having the clinical component of the contract placed with the named pharmacist providing the service)?**

- CONSIDERATION MUST BE GIVEN TO THE SIGNIFICANT NUMBER OF REGISTERED PHARMACISTS ≈ 30% WHO HAVE OPTED TO WORK AS A LOCUM PHARMACIST.
- WITH THE INCREASING EXPANSION OF NATIONAL MULTIPLES, PHARMACY IS ESSENTIALLY BECOMING AN EMPLOYEE PROFESSION.
- PART B PHARMACISTS WOULD REQUIRE A CONTRACT STIPULATING PRIVILEGES AND RESPONSIBILITIES

# MODERNISING NHS COMMUNITY PHARMACY IN SCOTLAND

## SECTION 5: PERSONS AUTHORISED TO PROVIDE PHARMACEUTICAL SERVICES

### The Policy Intention

5.1 To standardise the legal references to persons authorised to provide pharmaceutical services.

### The Need for Change

5.2 As indicated at Section 2 of this document, one of the aims of the New Contract is to encourage community pharmacists to spend more time with patients and less time on the mechanics of dispensing.

5.3 Section 28(2) of the 1978 Act states that medicines provided by pharmacies providing NHS pharmaceutical services must be dispensed by or under the 'direct supervision' of a registered pharmacist.

5.4 Taking the words 'direct supervision' literally implies that the pharmacist must oversee every dispensing and, as such, this will have a limiting factor on the time that can be spent with patients. Also, the reference to 'direct supervision' contrasts to the approach taken in the Medicines Act 1968, which refers only to 'supervision'.

### The Proposal

5.5 It is proposed to replace the current 1978 Act requirement that medicines are supplied under 'direct supervision' with a requirement that medicines will be supplied under the description of supervision that is consistent with the approach taken in the Medicines Act 1968.

5.6 It is considered that the change would allow a more liberal interpretation of supervision to mean ensuring safe systems of work and, under this wider interpretation, community pharmacists would be able to devote more time to engaging in direct patient care activities.

– MEDICATION PACKED & SEALED & LABELLED WITH PATIENT'S NAME & ADDRESS TO BE HANDED OVER, ON CONFIRMING NAME & ADDRESS OF PATIENT BY THE DISPENSER [TURNOVER OF 250 SCRIPTS PER DAY SERVING 5000 PATIENTS] –

N.B. MINIMUM OF TWO QUALIFIED DISPENSERS ON DUTY PLUS THE PHARMACIST

**Question**

- **Will the action proposed enable community pharmacists to devote more time to direct patient care?**

YES – PHARMACIST TO HAND OVER MEDICATION WITH COUNSELLING IN PRESCRIBED AREA/ROOM

PROTOCOLS FOR DISPENSING PROCEDURES MUST INCLUDE

- PARENT CONTAINER TO BE CHECKED
- WEIGHINGS AND MEASURING TO BE CHECKED
- PMR CONTENT TO BE CONFIRMED

} BY CO-DISPENSER

- NEW PATIENT & NEW MEDICATION DEMAND DIRECT SUPERVISION BY THE PHARMACIST (SUPERVISED CONSUMPTION)
- CD RECORDS AND DISPENSING/BY DISPENSERS SUBJECT TO CONFIRMATION

- Stipulate the records and information to be maintained when dispensings or cross-boundary services are being provided.

6.14 Currently, pharmacy contractors are paid by the Board in whose list they are included and from where the services are provided. The cost of the drugs and appliances that they dispense are paid by the Board where the prescription was written. In view of the changes proposed, powers will be sought so that where necessary or appropriate Boards can be authorised or required to make payments in respect of pharmaceutical services delivered to people in their respective areas but provided by pharmacy contractors in another Board area.

6.15 It is envisaged that payment for distant dispensing services will be a matter for the respective service (product and care) providers to settle between themselves.

**Questions**

- **Do you agree that is desirable to have powers that will encourage and allow innovative ways of providing pharmaceutical services in the future?**

- **Do the proposals offer sufficient flexibility for patient choice, convenience and safety or should they go further?**

- PATIENTS SHOULD BE DIRECTED AT ALL TIMES TO THEIR OWN COMMUNITY PHARMACIST WHO HAS A PRIVILGED HOLISTIC KNOWLEDGE OF RESPECTIVE PATIENTS.
- IN THIS AGE OF COMPUTERISATION AND THE TRANSMISSION OF ELECTRONIC DATA, AD HOC DISPENSING AND SUPPLY CAN BE ADDRESSED E.G. PATIENTS ON HOLIDAY OR INADVERTENTLY GONE AWAY WITHOUT THEIR MEDICATION.
- CURSORY SELF-MEDICATION SHOULD NOT BE ENCOURAGED, OTHERWISE OTC TREATMENT AND PRESCRIPTIVE MEDICATION CAN PREDISPOSE THE PATIENT TO INCREASING IATROGENIC INTRUSIONS TO WELL BEING.
- DESPITE THE CURRENT DRUG CULTURE, NO COMPROMISE MUST BE OFFERED FOR THE MANDATORY PRESENCE AND POWER OF THE PHARMACIST ON POSOLOGY.

Question

- **Are there any other options for assisting Boards to financially manage the planning and delivery of pharmaceutical care service requirements as proposed at Section 3?**

SCALE OF FEES FOR SCREENING TESTS:

- BLOOD PRESSURE.
- CHOLESTEROL
- BLOOD SUGAR
- WELL-BEING VIS-A-VIS BODY MASS & LIFE-STYLE
- IMMUNISATION E.G. INFLUENZA
- VALIDATION OF EXEMPTION FROM PRESCRIPTION CHARGES
- PHARMACIST CONSULTATION AND PRESCRIBING FOR MINOR AILMENTS
- "STOP SMOKING CAMPAIGN
- REDUCE TEENAGE PREGNANCY BY COUNSELLING ON VALUE RELATIONSHIPS, NAMELY MARRIAGE RATHER THAN THE PATENTLY FAILED POLICY OF MECHANICS (IUDS) CHEMICALS (PILL) & RUBBER (CONDOM)
- RESTRICT METHADONE TO SERIAL DISPENSING OF REDUCING ACTIVE PRINCIPAL BY 1mgm PER WEEK THROUGH CLINICS ONLY. THE ESCALATING CHRONIC CONSUMPTION OF METHADONE AND THE PANDEMIC ABUSE OF ILLICIT DRUGS CONFIRMS THE FAILURE OF THE "HARM REDUCTION" (SIC) POLICY.
- POLICY TO BE INCLUDED ON THE DESTRUCTIVE WATERFALL FROM ALCOHOL ABUSE

ADVOCATE ABSOLUTES TO CHALLENGE & CHANGE CULTURE

* NO SMOKING *

* DON'T DRINK AND DRIVE *

* NO SEX BEFORE MARRIAGE *