

EAST LOTHIAN PHARMACY LOCALITY GROUP

Response to **Modernising NHS Community Pharmacy** in Scotland consultation paper

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Section one needs to address the realities of the current situation, the magnitude of the job being done and how community pharmacy is funded. The fees paid to pharmacists are represented by only 12% of the total spend, the remainder being the cost of drugs.

70 million items per annum is an enormous task, performed with unparalleled efficiency and accuracy from manufacture, through wholesaling and finally dispensing.

Section two suggests “dispensing is a key activity”. Dispensing is “the key activity” and should not be underestimated in its complexity or value. All services revolve around dispensing.

The administrative burden on pharmacists is already onerous and further administration will require extra staff and IT to deal with it. Care should be taken not to introduce needless systems or to duplicate areas already covered under existing national frameworks.

Pharmacists are willing to take on new roles and are anxious that they will be able to deliver. This can only happen if the correct structures and appropriate funding are in place.

Section three suggests that Health Boards would form a PCS plan then be in a position to provide the services themselves. This coupled with “holding contracts” would stop investment by contractors and lead to a rapid demise of independent pharmacy contractors. These proposals are unacceptable.

While Health Boards would wish to have more say in the provision of services, contractors have in the past provided services wherever it made economic sense to do so. The OFT report stated that over 90% of the public were satisfied with the current levels of access to pharmacy services.

However, manpower is a serious issue and currently we have large numbers of pharmacists leaving the profession due to lack of confidence in the future thus compounding the problem.

Section four would appear to compound the manpower problem by introducing new boundaries where none need exist. There is a national system for governing the profession of pharmacy which works very successfully. Inhibiting the free movement of pharmacists between Health Boards would be detrimental to the provision of services and would probably fall foul of European legislation regarding restraint of trade.

Would the requirements not be served by the pharmacist in charge logging in name and registration number each day?

Section five raises the issue of supervision. Accessibility should not be compromised by the pharmacist leaving the premises as patients rely on pharmacists being available on demand. To break that link would undermine community pharmacy and lead to patients making the surgery the first port of call, not the pharmacy.

Dispensing is not a simple technical process, but requires input at all stages from interpretation, assessment of product, interactions, dosage and counselling etc. Issues can arise at any point in the process and cannot necessarily be covered by checking the prescription before dispensing. Added to this is the fact that the average pharmacy does one item every two minutes, meaning total involvement is required. Safety standards must be maintained.

Two pharmacists per outlet would solve many of the problems community pharmacy faces in the future.

Section six again refers to cross-boundary dispensing. This would appear to raise both practical and administrative obstacles to the dispensing process. Prescriptions are currently individually prepared for the patient and all aspects of supply dealt with at the source of supply, the pharmacy.

Distant dispensing would remove much of this and introduce an extra link in the chain, along with increasing the lead time. This would, undoubtedly, increase the scope for error and omission resulting in an inferior service to the patient.

Automated dispensing could make pharmacy more efficient if installed on site but investment by community pharmacists will not be forthcoming if a realistic return cannot be made.