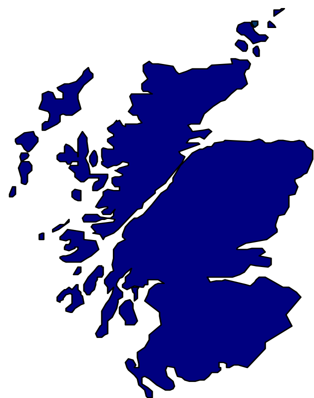

Association of Scottish Chief Pharmacists

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Date	28th May2004
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Dear Ms Braham

MODERNISING NHS COMMUNITY PHARMACY in SCOTLAND

Thanks you for the opportunity to respond to this important consultation.

The Association of Scottish Chief Pharmacists welcome the consultation and our detailed response is attached.

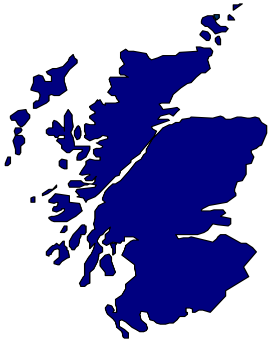
Overall, we consider that the general direction of the proposals will make a vital contribution to modernising community pharmacy practice and thus help patients benefit from quality pharmaceutical care.

Kind regards

Yours sincerely

George Lindsay

George Lindsay
On behalf of The Association of Scottish Chief Pharmacists



Association of Scottish
Chief Pharmacists

MODERNISING NHS COMMUNITY PHARMACY IN SCOTLAND – CONSULTATION PAPER RESPONSE

Section 2 - Introduction of New Community Pharmacy Contract.

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

The key elements of a quality system **which require legislation changes** to ensure delivery of suitable standards of patient care include:

- Patient registration.
- Adherence of practitioners to recognised standards of practice – both in terms of infrastructure of the premises through which community pharmacy services are provided and also in terms of the standards of the clinical care services provided.
- A sharing of data and information including internal and external quality assurance/audit information with the Health Board/SEHD in order to demonstrate that adequate standards are being delivered.

Some of these principles are long-term and are unlikely to change. It therefore seems fitting that they be enshrined in legislation.

However, some other aspects will evolve as community pharmacy practice evolves E.g. the precise standards for the provision of certain chronic medication services will change over time. **It is therefore more appropriate that the legislation directs that when national standards are prepared for the delivery for a certain type of service, then the requirements are that patient care is provided in accordance with these standards.**

The opportunity to define national standards of practice for core and additional pharmaceutical services is welcomed as is the opportunity to associate these with a minimal benchmark tariff.. This does not preclude the opportunity for local negotiation around supplements to these services.

Patient registration is critical for the development of chronic medication services in particular. We can only expect quality pharmaceutical care if there is a continuity of care between patient and pharmacist. Currently, patient registration is also a requirement for the provision of the minor ailment service. This is for administrative reasons, and in some ways it restricts the usefulness of that service, e.g. patients cannot access the minor ailments service from late night opening pharmacies unless they happen to be registered with that particular pharmacy for that purpose. This time of legislative change provides an opportunity to consider alternative methods for administering the minor ailments service.

A requirement of community pharmacists to participate in internal quality assurance and audit techniques is very valuable and will be a key driver for ensuring that high standards of care are provided. It is also important that certain elements of the data collected via the internal quality assurance systems, are shared with the NHS Boards and the Scottish Executive Health Department in order that they too may be assured of the quality of care being provided. NHS community pharmacies would also benefit from participation in relevant NHS QIS programmes. Clearly the way in which the data is handled, interpreted and publicised requires great care.

Section 3 – Planning & Provision of Pharmaceutical Care Services.

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?

The concept of preparing a pharmaceutical care services plan which will be an objective assessment of care needs will facilitate equity of care for patients. This is especially so because NHS Boards will have the facility and indeed the duty to secure services for patients whose access to pharmaceutical care services do not meet the minimum standards as laid down in the that Boards Pharmaceutical Care Services Plan.

The development of the Pharmaceutical Care Services Plan services plan is vital, and legislation should define the key processes by which this should be carried out e.g. by detailing the criteria to be considered and by listing statutory consultees such as

The Area Pharmaceutical Committee
The Area Pharmacy Contractors Committee

The Area Medical Committee
The Local Health Council
The Community Health Partnerships

In paragraph 3.5, the consultation document alludes to the potential for national standards in terms of "convenient access" for the resident population to core services. **Further detail with regard to national standards to be achieved is required to minimise the possibility of "post code access" for pharmaceutical services and it would be valuable to commission research to ensure this is done robustly.**

There is a paradox between the suggested requirement that all pharmacy contractors need to provide all of the core elements of the new community pharmacy contract, and the need for the pharmaceutical care services plan to consider locally negotiated services as well as the core services. For example, there may be some areas within a Health Board, where all elements of the core service are readily provided, but there is a deficit in terms of the provision of some of the locally negotiated services, e.g. needle syringe exchange. It then becomes incumbent upon the Board to secure a contractor who will provide such services or, start providing these services via the managed service.

If there already is a comprehensive provision of the core services, then by definition there is no need for another community pharmacy contractor to start providing these core services **again**, plus a new needle syringe exchange service. **Thus, consideration should be given to the potential value of awarding a "partial contract" with the aim of topping up the totality of service provision so that it meets all the needs identified within the pharmaceutical care services plan.** This concept of a "partial contract" may also provide a viable mechanism for the care elements of a pharmaceutical contract to exist along with dispensing doctor service provision.

The concept of over provision of pharmaceutical services will be controversial, but it is important. Depending on the outcome of the negotiations for the new pharmaceutical contract, it may be cost-inefficient for NHS Boards to pay practice allowance fees for community pharmacies which exist in areas of over provision. Also, given some of the workforce problems within the profession, it may be inefficient for a preponderance of community pharmacies, and therefore community pharmacists, to be concentrated in a particular area when there is a dearth of pharmaceutical services elsewhere. **Thus, the opportunity to incentivise change is welcome but the detail will be very complicated. Great care would be required in the legislation to provide a robust mechanism for identifying which pharmacies would be awarded a "holding" contract.**

Thinking to the future, there may be relatively little practical problem, however, because as we look for the comprehensive provision of chronic medication services, minor ailment services and public health services, over and above the traditional

dispensing service and the current locally negotiated services, it may be argued that it is unlikely that there will be significant over provision of pharmaceutical services in any part of a Health Boards area and our main challenge will be in securing services for those areas which are currently under provided.

Section 4 – Pharmaceutical Lists.

Are there any further actions which 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)?

This proposal is welcolmed. It will facilitate communications with all pharmacists in a particular Health Board area and also provide each Health Board area with an awareness of the number and the skills of the pharmacists practising within that area. In addition, it provides an opportunity for discipline of poorly performing pharmacists via the NHS tribunal system. This is potentially a more responsive system and safer to the NHS in Scotland than the only current option of barring a non-principal pharmacist from practice which is via erasure from the Royal Pharmaceutical Society of Great Britain's register.

As community pharmacy practice moves forward, certain additional qualifications or registrations are required to provide certain services. The most obvious of these are the qualification for supplementary prescribing and the need for individual pharmacists to sign patient group directions in order to apply them in practice. If pharmaceutical lists evolve to an extent whereby these additional qualifications/registrations are annotated within a list for provision from a certain pharmacy, then this facilitates quality assurance by the NHS Board in terms of assuring that pharmacies which contract to provide certain elements of the service are staffed by pharmacists who have the necessary skills.

A natural follow-on from this concept is the possibility of contracting certain elements of care to individual pharmacists (including non-principal pharmacists) rather than to the pharmacy contractor themselves. **Whilst such a concept would be theoretically possible, it is in direct opposition to the concept mentioned in section 2, which indicates that contracts will only be provided to premises which are providing the full range of core pharmaceutical care services.**

Section 5 – Persons Authorised to Provide Pharmaceutical Services.

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

This proposal is welcome and will move us in the direction of more flexible methods of practice. While it is valuable, this change in itself will not radically change the methods of community pharmacy practice.

Other changes in practice such as the registration of pharmacy support staff and the provision of training and support for such staff will be more powerful drivers in this regard.

Section 6 – Cross Boundary & Distant Provision of Pharmaceutical Services.

Do you agree that it 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?

We know that a vast number of prescriptions are dispensed in community pharmacies each year. This looks likely to continue for the foreseeable future, and it represents a very significant component of the overall workload within a community pharmacy - both for support staff and for the pharmacists themselves. Further, we know that approximately 75% of the medications which are dispensed are repeat medications and that new methods of practice may allow these to be dispensed in an efficient way and in a time frame which is both suitable for patients and suitable for workflows within the pharmacy. ***This could be particularly true if a community pharmacy contractor could in effect, "sub contract" some of these dispensing functions to a distant dispenser with robotic technology.***

Clearly, all professional aspects of such an arrangement would need to be fully developed, robust, and to a standard which ensures safe and effective practice. It is not the purpose of the legislation to define exactly how this should be done, but it is useful for legislation to indicate that this would be an "allowable" method of practice.

The intention that access to the distant dispensing services should be via a pharmaceutical contractor who can make an assessment of the totality of the patients needs is important. **Direct access to a distant dispensing service which will solely provide the provision of the product, rather than the totality of care for a patient is not appropriate.**

The administrative arrangements associated with this may be complicated. **The principle sent out in paragraph 6.14, which indicates that even if a pharmaceutical service is provided by a distant dispenser outwith that Board's area, the Board will still be liable for the payment if it is for a patient who resides in that Board's area seems sensible.**

Section 7 – Funding of Pharmaceutical Services.

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?

It is proper that a Board which takes responsibility for developing a pharmaceutical care services plan also takes responsibility for financing the results of that plan.

This provides a driver and a mechanism for ensuring that the plan prepared by the individual Health Board area finds the appropriate balance between services for its resident population and affordability.

Experience with the nGMS contract and other services that have been devolved from central government level, illustrate the complexities involved in this. **Thus, the suggestion of a "pace of change" model, which will allow this practice to happen over a ten year period is welcomed.**

It is expected that methods of pharmaceutical practice will change significantly over that period of time. Thus current proportions of the global sum provided to each Health Board area may change significantly, partly because of the greater emphasis on clinical care, but also because of the new opportunities for distant dispensing and the requirement of Boards to pay for the services provided for patients within their resident area, rather than pay for services which are provided by pharmacies within their area. **While agreeing in principle with the concept of devolvement, we recommend research is commissioned to facilitate the appropriate provision of monies to Health Boards to cover their service requirements.**