PRIMARY CARE DIVISION

RESPONSE TO THE CONSULTATION DOCUMENT, *MODERNISING NHS COMMUNITY PHARMACY IN SCOTLAND*

The general thrust around the proposals to revise and modernise the General Pharmaceutical Services Contract is welcomed. It is recognised that this consultation is around a high-level proposals and elements of detail have yet to be considered. However, in addition to responses to specific questions, other comments of a more detailed nature have also been included in respect of certain sections.

<u>SECTION 2</u>: INTRODUCTION OF THE NEW COMMUNITY PHARMACY CONTRACT

<u>Question</u>: ***Are there any specific or additional powers we need to consider in order to modernise pharmaceutical care services and further improve patient care?***

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. Additional powers may require to be granted to Boards to enable them to act in the event of non-compliance.

Other comments:

- Patient registration is essential for care provision and is desirable for supply.
- The effective use of competent, skilled and experienced technicians and other support staff, working in premises that are fit for purpose and in accordance with safe and effective processes will be essential in releasing pharmacists to deliver pharmaceutical care. The development of this infrastructure is likely to be a major rate-limiting factor. Staff competencies and training needs to be addressed nationally and services need to be delivered within uni-and multi-disciplinary governance frameworks. It is proposed that individual contractors could develop their own governance arrangements. However, since the delivery of health and healthcare services is a team function, there is a need to be assured that governance arrangements around pharmaceutical services are compatible and integrated with those for other care providers and provide assurance to the organisation around the management of clinical risk.
- Standard processes should be implemented for the reporting of critical incidents that enable sharing of anonymised data.

<u>SECTION 3</u>: PLANNING AND PROVISION OF PHARMACEUTICAL CARE SERVICES

<u>Question</u>: ***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?***

Equity of access is to services is vital and the proposals allow Boards to plan for equitable and convenient access. However, the translation of this into a service may be challenging. A national template would be

important to enable objective assessment of pharmaceutical need by Boards and to minimise the risk of "postcode services".

Other comments:

- The market value of a pharmacy business is a function of the value of capital assets (buildings, fixtures and fittings and stock at valuation) and the "goodwill". This latter element is often considerable. However, in the event that a business was deemed to be associated with over-provision and placed on a holding-contract, since it would be unable to be sold as a "going concern", goodwill would have no value. This would represent a considerable loss to the principal. Who will be accountable for this loss, the contractor or the Board?

- With the need for periodic review of PCS plans by boards it is possible that existing businesses could move from the PCSP contract to a "holding contract" – this may prove to be a disincentive for principals to invest in infrastructure and make long-term plans for service development.

- What sort of financial provisions will Boards be required to make in order to secure pharmaceutical services in areas of underprovision and what central support will be provided to assist them in so-doing?

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

Potentially contracts for delivering care could be made with multi-disciplinary teams working from private or NHS premises. However, given the level of politics around professional contracts this is unlikely to be acceptable.

SECTION 4: PHARMACEUTICAL LISTS

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)?***

Placing the clinical component of contract with named pharmacists would improve governance. However, in order to maintain continuity of service provision taking account of holidays, sickness etc, several pharmacists would need to be engaged. Either a cohort of pharmacists would need to be identified in respect of any given service (with a nominated service lead) or each action would need to be directly attributable to an individual.

Other comments:

- The process for placing a pharmacist on the list would need to be clear and responsive as occasional situations arise where a local shortage of professional staff can result in the need for staff/locums to be brought in from out-with the Board area at short notice.

- The situation requires to be clarified around managed staff who are employed to provide services in areas of under provision where it has not been possible to secure a contract. Will these staff be included on the pharmaceutical list?

- Clarification is required around the term "pharmacist in training" – is this a pre-registration pharmacist or a qualified pharmacist who is undergoing additional training to enhance competence and skills?

- Inclusion on the Board's list does not imply that all pharmacists are equally able to deliver all functions. There must be some system to assure the competence and skills of individuals involved in the delivery of particular services.

- Practice accreditation could be used to assure the competence and skills of staff and the suitability of premises, equipment and processes involved in the delivery of care.

- Protected time for learning would be helpful.

SECTION 5: PERSONS AUTHORISED TO PROVIDE PHARMACEUTICAL SERVICES

<u>Question</u>: ***Will the action proposed enable community pharmacists to devote more time to direct patient care?***

The proposals will free-up pharmacist time that could be used to deliver, or to support the delivery of, pharmaceutical care (through providing time for governance, audit, training etc.)

SECTION 6: CROSS-BOUNDARY AND DISTANT PROVISION OF PHARMACEUTICAL SERVICES

<u>Question</u>: ***Do you agree that it is desirable to have powers that will encourage and allow innovative ways of providing pharmaceutical services in the future?***

Yes, existing arrangements are inhibiting service developments.

Other comments:

- It would be important to ensure that new arrangements did not result in unnecessary delays in patients receiving medicines and services

<u>Question</u>: ***Do the proposals offer sufficient flexibility for patient choice, convenience and safety or should they go further?***

- Provision of pharmaceutical care should be not be bound by constraints around premises – care should be offered in the most convenient location, particularly if disassociated from the supply function. Pharmacists could provide care from community pharmacies, GP surgeries, Health centres, clinics, hospitals and outpatient settings. Flexibility in contracting and planning is essential for the development of innovative and equitable services.

- Where services are provided from out-with Board areas, Boards should still be able to specify standards for service provision.

SECTION 7: FUNDING OF PHARMACEUTICAL SERVICES

<u>Question</u>: ***Are there any other options for assisting Boards to financially manage the planning and delivery of pharmaceutical care service requirements as proposed in section 3?***

Yes, resources could still be held and administered from "the Centre". There is a balance between local flexibility and efficiency and current arrangements incorporate a level of economy of scale. There will be additional costs for developing local infrastructures to administer the proposed new arrangements.

Other comments:

- The proposals will have additional resource implications for Boards, particularly during the implementation phase. Will additional support be made available in the same way as for the GMS contract to assist in implementation?

- Will central support be made available to assist those Boards who are required to secure additional services to address areas of under-provision?

- CHPs will eventually have a key role in determining local pharmaceutical needs. Support for these organisations will be key to the development and implementation of new models of service.

- Change in the system of payment and the move to weighted capitation are likely to have implications around the viability of some pharmacy businesses. This may involve sensitive discussions of a commercial nature with local contractors. Expertise and skills will be required.

SECTION 8: PARTIAL REGULATORY IMPACT ASSESSMENT

Option 3 would be the preferred option.

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