



THE SCOTTISH PHARMACEUTICAL FEDERATION

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Secretary
Francis E J McCrossin CA

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Ms Susie Braham
Scottish Executive
Health Department
St Andrew's House
1ER
Regent Road
Edinburgh
EH1 3DG

Dear Ms Braham

MODERNISING NHS COMMUNITY PHARMACY IN SCOTLAND

I am writing on behalf of the Scottish Pharmaceutical Federation (SPF) in response to the Scottish Executive's consultation document *Modernising NHS Community Pharmacy in Scotland*.

The Scottish Pharmaceutical Federation is the trade association which represents the professional and commercial interests of the owners of the vast majority of Scotland's community pharmacies, and is the principal body representing the community pharmacy sector.

We are broadly supportive of the proposals contained in the document, but there are a number of points which merit further consideration.

Section 2: Introduction of New Community Pharmacy Contract

2.8 We appreciate the need to introduce terms and conditions for contractors with provisions relating to "*quality of services provided, standards of clinical practice, the training and qualifications of staff, the standard of premises and other matters related to the infrastructure of pharmaceutical services.*" Nevertheless we hope that reward for improvement to services would not act as a disincentive to those contractors who would invest in the above regardless of financial support.

We believe that the driver for improvements to the service infrastructure should be the rewarding of excellence.

With regard to 'training and qualifications of staff' we feel that it is essential that training requirements for non-core pharmaceutical services are harmonised throughout Scotland. The current situation where locum pharmacists and relief managers may be qualified to undertake certain services in one Health Board area but may be unqualified to undertake the same service in an adjacent Health Board area is unsustainable. (See also Section 4, Pharmaceutical Lists.)

2.9 *“Legislation would be expected to detail (for example) ... the people to whom services may or must be provided, eg to patients referred by a GP and who register with the community pharmacist...”*

Whilst we are content with registration of patients with a pharmacy for specific services, we would not support formal registration for all patients for pharmaceutical services.

Barriers to free movement of patients between community pharmacies would reduce competitiveness and have a detrimental effect on standards of pharmaceutical care.

2.12 *“Boards will be directed to monitor and ensure compliance by contractors...”*

We welcome the intention to raise standards. However we would warn against time-consuming reporting processes as these rarely result in better services, and would prefer a “low-bureaucracy, high-trust” approach. We also expect NHS Boards to work with the current statutory inspection body to develop a consistent approach across Scotland.

We hope a workable and transparent monitoring structure will emerge with clear rules and accountability, no duplication, and without additional financial burden on contractors.

Section 3: Planning and Provision of Pharmaceutical Care Services

“Do these proposals offer a comprehensive way of ensuring patients have access to a range of pharmaceutical care services that take account of their care and access needs?”

We welcome the intention to provide services which will meet the pharmaceutical needs of the whole population.

However, we are concerned that these proposals allow Health Boards to create local definitions of under- and over-provision. We recommend that the Executive consult and agree a set of definitions applicable nationally to ensure countrywide consistency.

We also wish to see a transparent local decision making process, with contractor involvement and a proper appeals procedure.

We have reservations about the ‘holding contract’ concept which we feel would have a destabilising effect on the community pharmacy network. However, we suggest that in order to encourage movement of ‘holding contracts’ into areas of under-provision - which by their nature may not be commercially attractive - it is essential that proper financial recompense be made for any losses incurred. A fully-funded decommissioning scheme should be established, perhaps on similar lines to the ‘set-aside scheme’ for farming.

Furthermore, whilst Boards are expected to be more pro-active in the planning of pharmaceutical care services, it must also be recognised that other parties may continue to identify areas of under-provision, as is currently the case. In such circumstances any attempt to award the new contract to an existing contractor would stifle the drive to identify need.

Finally, where there is an “absence of one or more locally required services, eg methadone or out of hours services” (para 3.10) the Board should be required to negotiate with existing contractors for the provision of services to cover any identified shortfall.

“Are there alternative models for fulfilling the policy intention for patients?”

Deregulation was comprehensively rejected by the Scottish Parliament and the Health & Community Care Committee and we take this further opportunity to applaud that decision.

Section 4: Pharmaceutical Lists

“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 (eg having the clinical component of the contract placed with the named pharmacist providing the service)?”

We welcome the general intention of pharmaceutical lists.

However, we suggest that whilst the list of principals should be maintained by the Health Board, the list of non principals should be maintained nationally. This would obviate the unnecessary bureaucracy of holding 15 lists and the potential to limit the mobility of individual pharmacists.

A central list of non principals could also include details of training and qualifications. (See also Section 2.8.)

We would argue against any contract between Boards and named pharmacists. All contracts must be with the principal (ie the proprietor). However, we recognise that in order to empower others involved in delivering pharmaceutical services any contracts granted for non-core services should reflect the skills and abilities of the non principal delivering the service, and such contracts should be strictly monitored for compliance with this principle. In this way, non principals could expect fair remuneration for the higher level of service provided, and would be encouraged to provide such services.

Section 5: Persons Authorised to Provide Pharmaceutical Services

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

We are happy with the proposals contained in this section which we see as offering greater flexibility of working. However, we firmly believe that in order to maintain the highest standards of patient care and clinical governance the pharmacist should be easily available throughout the day, a minimum of one per pharmacy. This important principle should be fiercely defended. Clearly, short absences are acceptable but we would deplore the emergence of simultaneous supervision of multiple pharmacies, or of remote supervision in any form.

Section 6: Cross Boundary and 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?”

We welcome innovative ways of providing pharmaceutical services, particularly in remote rural areas where service provision is currently poor. We also support the desire to protect the role of community pharmacists in face-to-face patient care. However, safeguards are essential. We suggest that income from distant dispensing should not exceed a minimal part of NHS income for those contractors also providing core services. The co-location (real or virtual) of distant dispensing facilities within a fully-contracted pharmacy should be prevented as this would circumvent the intention of this section.

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 in Section 3?”

We make only one point in response to this section. Any monies not distributed centrally must be ring-fenced. If the Executive wishes to implement its ambitious plans for a modern community pharmacy service all funding must be directed towards community pharmacy contractors. Furthermore, local under-spends should be carried forward to subsequent years and not diverted towards other NHS functions.

We would welcome the opportunity to discuss our views with you and to respond to any further questions you may have.

Yours sincerely

A handwritten signature in black ink, appearing to read 'James B Semple', written in a cursive style.

James B Semple
Chairman