

FIFE AREA PHARMACEUTICAL COMMITTEE

MODERNISING NHS COMMUNITY PHARMACY IN SCOTLAND – CONSULTATION PAPER.

The following is the response from the Fife Area Pharmaceutical Committee, and is structured by section as detailed in the consultation paper.

SECTION 1 - LEGISLATIVE BACKGROUND AND GENERAL OVERVIEW

This consultation does not apply to those dispensing services provided by Dispensing Doctors, but the Group wished to ask whether a review of these dispensing services will be carried out in the light of changes made to the delivery of services provided by community pharmacies. The Group continue to support the need for Dispensing Doctors and would not wish the current service to be destabilised. However, how the pharmaceutical care needs of patients receiving dispensing services from Dispensing Doctors are met need to be considered.

SECTION 2 - INTRODUCTION OF NEW COMMUNITY PHARMACY CONTRACT.

The proposal outlined in 2.8 is supported by the APC as it will enable clear definitions of the quality of service, standards of clinical practice, the training qualifications of all staff working in community pharmacies and the standard of premises. These components are key to ensuring the consistency of delivery of the new community pharmacy contract, and should apply to core and additional services. Wherever possible, there should be a national framework, including all the key elements noted above, for all additional services to ensure as much consistency for additional services as for core services across Scotland.

Innovative ways of ensuring the key elements in 2.10 are monitored must be sought, and lessons learned from the implementation of the GMS Contract. The concept of self-assessment, and the accountability that this brings, and the use of IT Networks should be pursued to establish a clinical governance framework that allows NHS Boards to be assured that the clinical governance aspects of the services provided by community pharmacy are met.

SECTION 3 - PLANNING AND PROVISION OF PHARMACEUTICAL CARE SERVICES.

The APC support the move away from the current reactive process of awarding community pharmacy contracts to one that is based on identified pharmaceutical care needs. The APC would not like to see any destabilisation of the current strong network of community pharmacies but understand that a process is required to ensure that a suitable number of community pharmacies are providing pharmaceutical care services to the population.

There was strong support that the first step should be to identify areas of “under provision” using nationally developed tools to ensure that the same criteria are used throughout Scotland. There was more contention around the idea of “over provision” and the issue of how and when a “holding” contract would be used. The APC felt that this needed careful thought and would like to see this proposal piloted in Scotland to inform the use of such a contract. The local process would need to be robust and tested to reduce any possibility for legal challenge.

The development of a national PCS Plan framework was supported which should include all relevant stakeholders eg. NHS Planning Departments, Health Council, NHS Contract Managers, NHS QIS, NHS Finance and Pharmacy Representation. Fife APC felt that the national PCS Plan framework required the skills and expertise for areas other than Pharmacy to provide a robust framework and tool.

The APC felt that there may need to be an additional contract type where a community pharmacy only chooses to provide core rather than core and additional services.

The APC felt that there needed to be a defined review period built in for any “holding” contracts, as the pharmaceutical care needs in an area may change over time. It was suggested that a “holding” contract be awarded for 3-5 years with review every 1-2 years. It was suggested that all contract holders are awarded contracts initially then “holding” contracts issued when required using the robust framework that had been developed and tested. APC felt that as long as the PCS Plan framework and tool and the local processes are robust, then there should be no need for a national appeals process. Appeals should then only be required if the due process had not been followed.

SECTION 4 – PHARMACEUTICAL LISTS.

Fife APC was extremely supportive of the introduction of a list of all registered pharmacists providing services in an NHS Board area, and that this list be split into Two Parts. This would be an important clinical governance element and bring community pharmacy in line with other contractor groups.

We wished to suggest extending the List to include all pharmacists that work within Primary Care, including Practice Pharmacists, LHCC Pharmacists etc. The clinical governance of these practitioners of these practitioners is included within the governance of the managed service but there is no list of all practitioners. Including all practising pharmacists in an NHS Board area would allow for the first time, a full and comprehensive list of all pharmacists providing services in the area. The List could be annotated in some way to indicate the area of practice for each individual.

The introduction of a List for each NHS Board area will require the larger multiples to change the way that they manage their locum pools. However, this would ensure that the pharmacists working in a Board area understand and are trained in the service delivery expected of them in that Board area.

SECTION 5 – PERSONS AUTHORISED TO PROVIDE PHARMACEUTICAL SERVICES.

Fife APC supported the proposal to replace the current description of supervision to that detailed in the Medicines Act 1968, but support that the responsibility remains with the pharmacist to ensure that safe systems of work are in place and are regularly audited and monitored. The infrastructure is being established to ensure safe and efficient systems of work in community pharmacy. Regulation and registration of pharmacy technicians and assistants, together with the introduction of Standing Operating Procedures, will bring about a culture change which will form part of the clinical governance agenda. The time is right to facilitate pharmacists, technicians, and support staff to explore new ways of working within a flexible supervisory framework. This change will allow the widespread introduction of Accredited Checking Technicians and other systems which should enable community pharmacists to devote more time to direct patient care. A set of “supervision principles” should be established nationally, which will then allow interpretation at local level based on patient and service need. This will allow change and innovation to take place with new modern ways of working being imbedded in the new contract.

SECTION 6 – CROSS BOUNDARY AND DISTANT PROVISION OF PHARMACEUTICAL SERVICES.

The APC supports the proposal that pharmaceutical care services would still occur through contractors holding a contract to provide core services. There may be a need for a contractor to sub-contract in or out of a component of the core contract to ensure that the full range of core pharmaceutical services are available to patients in areas where there is a shortfall. It would be useful to have the powers to examine alternative methods of service provision, but IT systems must be able to support these innovative delivery methods. Patients will need to be convinced of the need for alternative supply methods other than the traditional methods currently used. The majority of users of community pharmacy services are the elderly and young mothers with children and their current expectations are to attend the community pharmacy and receive the full range of pharmaceutical services. Any changes to this service delivery or any components of it must be discussed with service users and their views taken into account. The current network of community pharmacists must not be destabilised or the public’s view of pharmacy confused.

SECTION 7 – FUNDING OF PHARMACEUTICAL SERVICES.

The allocation of elements of the “global sum” to NHS Boards will provide little flexibility to Boards, at least initially, as the majority of the “global sum” will be agreed through national contract arrangements. However, allocation of some elements to Boards will allow some flexibility and to support local accountability and responsibility.

Any allocation would require a robust process and a nationally agreed needs based formula which would require to be developed nationally.

SECTION 8 – PARTIAL REGULATORY IMPACT ASSESSMENT.

Fife APC felt that it was difficult to comment, but felt that the changes suggested would add an additional workload to NHS Boards which would be partially offset by the funding already in the system, but did not have sufficient information to comment on whether there would be any shortfall in funding. Further work is required nationally to map out the resources required by NHS Boards to support the new aspects of the contract.

Alan Mentiplay,
Chairman, Fife Area Pharmaceutical Committee,
May, 2004.