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Modernising NHS Community Pharmacy in Scotland

Response to consultation document.

Section 2 Introduction of New Community Pharmacy Contract

We have agreement with the policy intention and the principles to develop high quality and readily accessible care systems with appropriate governance and controls on procedures and standards. It is important however, to recognise that the existing infrastructure, community pharmacy services, and methods of medicine supply, serve our communities needs very well and have an extremely high level of support from the general public, as witnessed by their response to the recent OFT report. In the process of change this existing cherished infrastructure must not be destabilised to the point that local community pharmacy services are compromised. It is also important to recognise that introduction of the new contract will present change management issues that will require significant training, support, and resource.

- A system of remuneration that provides incentives to improve and deliver quality health care is desirable but dispensing and medicine supply must remain a key activity of community pharmacy. (2.2)
- Core service contract must be uniform across Scotland. (2.4)
- A national specification of practice & premises standards should be established. (2.8) (2.9)
- Minimum benchmark standards and payments for locally negotiated services should set nationally to assist the development and maintenance of high pharmaceutical care standards and to avoid post-code pharmacy.

Clarification is required on:

- Who will monitor the set quality standards and competencies?
- The types of areas envisaged for patient counselling and appliance fitting as many existing premises may have space limiting considerations.
- Whether patient registration would have an impact on patient choice and direction of prescriptions.
- Registration is not suitable for AMS – assume this remains volume based.

Section 3 Planning and provision of Pharmaceutical Care Services (PCS).

While agreeing that a proactive system applied by the NHS Boards may assist in planning and securing PCS, particularly in remote, rural, or deprived areas, we have a number of concerns and questions on the implementation proposals of this policy and the true benefit to be derived by either the patient or NHS.

- The concept of over provision is very controversial and difficult to define. The criteria for identifying overprovision and the mechanisms for awarding new contracts in areas of under provision need clarification.
- The concept of a holding contract is very destabilising and would act as a potent disincentive to invest in the infrastructure required for the new contract. It surely would be a legal minefield if a holding contract was imposed on a viable existing contractor who was providing a high quality service and met all the care needs of the PCS but was somehow now identified to be excess to requirements due to its location.
- What would be the financial assistance to re-locate? Would it take into consideration contractors existing liabilities such as leases and other non transferable contracts, would it include minimum income guarantees, and if so, for what period of time?
- The PCSP would require significant extra funding, particularly in remote and rural areas that are not well served by the existing contract.
- Would the PSCP exclude speculative applications from individuals with innovative new models of pharmaceutical care and delivery?
- Who would be involved in the development of the PCSP? Professional involvement would be essential and must include pharmacy contractors, APC, and PCC, and possibly locality groups.
- How long would the PSCP last and how often would it be reviewed? Again this could have serious disincentive consequences.
- Any PSCP must be flexible and able to respond to change as it occurs while taking into consideration the need for stability in the pharmaceutical care system.
- What would be the future for pharmacies that do not meet the needs plan (3.8)? Would they be guaranteed a holding contract or is there a third option?
- There has to be an appeal process in the system.
- The existing pharmacy network gives good access for patients and a degree of competition in the market that drives innovation and improved service provision. Moving pharmacies from areas of ‘overprovision could have negative effects on access, competition and choice.

Section 4 Pharmaceutical lists

Pharmacy contractors that have invested in the infrastructure to support the new contract and developed their premises appropriately must hold all components of the contract. This is required for continuity of services and accountability. The transient and mobile nature of employee pharmacists and the need to employ locums due to our six or seven day service provision demands a registration system free of over bureaucracy and takes into account emergency situations when pharmacist cover is required urgently.

Section 5 Persons Authorised to Provide Pharmaceutical Services

This change would allow more flexibility in working practice. It would allow the pharmacist spend more time with patients. It is important however, that a named pharmacist is available for patient consultation and medicine advice at all times in the pharmacy otherwise the unique and much valued role of the readily accessible health care professional on the high street and in the community would be lost. Periods of absence and unavailability would be detrimental to the level of pharmaceutical healthcare community pharmacy provides to the public and the value it contributes to the NHS. A named pharmacist should be responsible for and supervise only one pharmacy at any given time. Placing greater responsibilities on support staff will result in significant increases in costs due to higher salaries and training requirements of the staff

Section 6 Cross Boundary & Distant Provision of Pharmaceutical Services

We agree the need to recognise the potential of new technology in assisting to deliver some services. Care must be exercised to ensure that local access to comprehensive PCS is not damaged and the infrastructure and current high levels of service provision of the community pharmacy network are maintained. Dispensing and the supply of medicines from community based pharmacies is an essential key activity and one which is identified by the general public as an extremely important and much trusted and valued component of community pharmacy. Removal of volume dispensing from community pharmacy would have a consequential reduction in stock availability and a knock on negative effect on the ability of local community pharmacies to respond to immediate or emergency supply. In any form of distant dispensing it is vital that all prescriptions are first presented through a pharmacy contractor for clinical pharmaceutical assessment. This is essential in the delivery of quality pharmaceutical care.

While accepting the policy intentions in the document and in total agreement with the need for change and the Scottish Executives strategy Document *The Right Medicine* it is our firm belief that it will be impossible to deliver them without significant extra funding. Community pharmacy is a vital component in a primary care system designed to deliver quality healthcare outcomes and assist the NHS in reaching health targets, priorities, and agendas. We look forward as a community pharmacy company to working with the Executive in helping to achieve its aims in a manner that properly recognises the need for appropriate funding and resource.

Yours sincerely

Jim Rae
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