

Susie Braham
Scottish Executive
Health Department
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Dear Susie

Thank you for the opportunity to comment on the above consultative paper.
I would largely like to endorse the view expressed to you by Dr A Gunning, Chief
Exec Community Health Care Division, NHS Ayrshire & Arran in his letter dated 25
May 2004, but also add further comment below.

Respondee Information:
Morag McConnell
Superintendent Pharmacist
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I am responding as an individual and agree to this response being made available to
the public, with my name & address available. I give consent for SE to contact me
regarding future consultations.

With regards
Morag McConnell

Section 1 Legislative Background and General Overview.

Require a consistent approach to the to the development of each area of the new
contract from the S.E., inclusive of those areas which may bring pharmacy into conflict
with G.P.'s.

Section 2 Introduction of the New Community Pharmacy Contract.

Areas of agreement:

- Requirement to incentivise community pharmacy to improve and deliver quality health care in Scotland. (2.2)
- Serviced-based remuneration will deter current criticisms levelled against community pharmacy currently.
- The final agreed core contract should be uniform across Scotland. (2.4)

- Additional services need not be applied generally, but by local agreement. (2.4)

Areas of Concern:

- Additional services, which are applied nationally, should have national minimal standards and tariff and **not be left to local remuneration negotiation**.
- Local negotiation should only be used to define further service refinements in addition to the national standard or wholly locally developed schemes.

Further Clarification Required.

- The detail of the new core services will have to be agreed.(2.7)
- How defined will the service provision be?
- Will overly detailed definition stifle service delivery?
- Who will monitor service standards in practice? (Premises previously R.Pharm.Soc.)
- Clearer definition of counselling required. (2.9)
- How will the 'nature & standards of equipment' be monitored? (2.9)
- Registration currently only refers to the MAS pilot and is not generally acceptable for all services. (2.9)

General Comment:

The danger of over regulation and audit/monitoring could create disincentives to provide patient care with an excess focus being placed standards monitoring. The need to keep patient care as the focus is paramount.

Section 3 Planning and provision of Pharmaceutical Care Services.

Areas of Agreement:

- Rural, remote or deprived areas are not well served under the current contract.(3.2)
- The current reactive system does not allow enough flexibility to give a more uniform service provision.
- The positive identification of areas of greatest need would aid planning and provision of pharmaceutical services whether they are core or additional services.

Areas of Concern:

- The introduction of 'Holding Contracts' would destabilise the both the current service structure and act as a disincentive to invest in the new contract structure. Such destabilisation cannot be an option. (3.9)

- The comparative short-term nature (undefined) of a PCSP would place investment of both time and monies in the development of pharmaceutical services an unviable proposition given the high cost of investment in pharmacy. (3.9)
- The PCSP cannot be used as the only indicator of need as it does not allow for innovation or dramatic change.(3.5)
- A process or system has to be in place to decide the need for a contract using the PCSP as a tool in that judgement.(3.6)
- Financial assistance, on a one off basis, to relocate to areas of need would not support long term provision. Continued assistance would be required to make such services viable. (3.9 & 3.12)
- No appeal process is evident, which could result in an increase in court actions seeking resolution if a robust structure for the decision making process is not in place.

Further Clarification Required:

- Who would be involved in the development of the PCSP?
- How long would a PCSP last?
- How will over-provision be defined?
- What provision would be made for change over the short term?
- Professional involvement in the PCSP is an absolute; this should be the role of the Area Professional Committees as independent arbiters.
- Clear national guidelines for the production of the PCSP will be required and the process will have to be transparent.(3.3)
- It is unclear as to whether the PCSP would allow contracts for individual direct services? Direct services should primarily be offered via core contract holders and only offered as one off contracts in exceptional circumstances. (3.5)

General Comment:

The current distribution and numbers of community pharmacies out with low population density and areas of deprivation is not greatly dispirit with the needs of the population of Scotland, with 90% of the public stating there pharmacy location was convenient.

The main hurdles to further improvements in pharmaceutical service in areas of need are determined by the reward structure and the ineffective ESP scheme, which needs reviewed.

The limitation of contract determined by regulation 5(10) has delivered a sustained improvement in pharmaceutical services distribution out with areas of deprivation or low population intensity and has given stability to that service.This should not be lost in the rush for change.

Counter Proposal:

- The definition of holding contracts should be dropped allowing the current live contracts to evolve or change dependant on the forces of commercial pressure.
- The PCSP should be used to initially identify areas of under or perceived over provision. This would allow all Health Boards to identify three separate categories of any neighbourhood;

Category 1: Area of under provision requiring positive action on pharmaceutical service provision.

Category 2: Area not falling clearly into either extreme, which may be open to innovative application.

Category 3: Areas of over provision that will not accept applications during the period of the current PCSP.

Given the current acceptable distribution it would be the norm that most areas would fall into category 2 allowing for continued growth and innovation to stimulate pharmaceutical services.

- The test 5(10) on necessity or desirability should remain using the PCSP as the basis for its decision making process while taking all pertinent facts and changes into consideration in its decision, thus including recent neighbourhood changes and innovation.
- This provides a structure for the decision
- Is well defined and supported in Law
- Provides for local needs.
- A complete review of the Essential Small Pharmacy Scheme (ESP) should be undertaken to address the provision of services in areas of deprivation or low population intensity.
- All local directed services used nationally should as previously mentioned have a minimal national specification and tariff.

These proposals allow for positive planning of pharmaceutical provision while not precluding innovation and change.

Section 4 Pharmaceutical Lists

Areas of agreement:

- Recognition of the need for improved clinical governance and personal professional responsibility and accountability.
- Would not effect the 'principles' responsibilities with regards to contractual issues.
- Would bring pharmacy in line with other professional health care workers.

Areas for Clarification:

- What would be held on the lists?
- Would it include details of accreditation for local and national services?
- Who would be responsible for making and maintaining the registrations?

- Detail on the ease of multiple registration required?

General Comment:

- All local schemes used nationally should have national accreditation criteria to facilitate cross boundary working *Example EHC schemes across Scotland.*

Section 5 Persons Authorised to Provide Pharmaceutical Services.

Areas of Agreement:

- Need to bring the regulations into line with the Medicines Act (1978).

General Comment:

- This in itself will not enable community pharmacists to devote more time to direct patient care but is a first step.
- Continued developments in staff such as checking technicians are required.
- The cost implications of such development have to be considered.
- A named pharmacist would still carry responsibility for all provision undertaken and could only do so for one named premises at any one time.
- Limits of time or reason have to be in place, for any absence from the pharmacy by the pharmacist in charge.

Section 6 Cross Boundary & Distant Provision of Pharmaceutical Services.

Areas of Agreement:

- Need to clarify the potential for the use of technology in improving pharmaceutical services.
- Need to ensure distant provision does not effect local access to full pharmaceutical care. (6.6)
- Access to such services should be via existing core contractors. (6.10)
- Recognition of new form of controls required ensuring patient and public safety. (6.13)

Areas of Concern:

- While the concept of funds following the costs is generally agreed there is the potential to create an industry of paperwork to balance such minimal changes. (6.14)

General Comment:

- This entire section requires very clear detail to avoid destabilisation or loss of the core services out with dispensing services due to the potential for adverse effects on funding and provision locally.

Section 7 Funding of Pharmaceutical Services

Areas of Agreement:

- Fiscal accountability goes with planning of service provision.
- Ten-year period to move from indicative funding to local needs requirement formula (Arbuthnott). (7.6 & 7.7)
- Requirement for Boards to remunerate fully for core services on the basis of the nationally negotiated contract arrangements. (7.8)

Areas of Concern:

- Local variation on drug budget management especially of new drugs will result in postcode pharmacy.
- Core pharmacy budgets would require to be ring-fenced.
- How would potential overspend be dealt with in this model?

Section 8 Partial Regulatory Impact Assessment

Areas of Agreement:

- Option 1 is not viable for the future.
- Option 2 provides for an interim solution pending legislative changes.
- Option 3 gives the greatest potential gain with also the greatest risk dependant on the detail.

Areas of Concern:

- Much of what is proposed is highly dependent on the success of the ePharmacy project.
- Facilitation of partnership will be difficult to work in practice. (8.17)

- Costs related to pharmaceutical supervision will not be cost neutral. Given the need for increased staff capability and training and therefore staff expectation, this will be a major extra burden on contractors. (8.25)
- Implementation and continuing audit/verification costs are liable to increase for all contractors.
- Current control of entry costs are minimal if the applicants costs are discounted as an application fee. (8.20)

General Comment:

- General stability in the pharmacy financial market has to be maintained to attract sufficient investment to ensure delivery of quality standards.