

Modernising NHS Community Pharmacy in Scotland

Section 1 The general overview explains the existing arrangements as far as Health Boards and their requirement to provide Pharmaceutical Services. I don't feel competent to comment on what legislative changes are required but I feel strongly that the basic "control of entry rules" are not change (1.14). There is room for increasing the number of criteria to be considered when deciding whether to approve an application and if successful a method of monitoring the provision of services promised by the applicant. The new core services when undertaken in the Pharmacy will ease the prescriber's workload. It is important that the funding follows the effort and that there is no conflict with the new GMS contract.

Section 2 Remuneration should be service based and less dependent on the purchase price of medicines. Therefore the fees for services must reflect the cost of providing the services in particular the key activity of dispensing prescriptions (2.5). Negotiations for these must be carried out nationally and not locally. Additional services or local refinements should be the only items discussed locally. While agreeing that the new contract should deliver quality pharmaceutical care it must not be over regulated or over audited creating disincentives to provide improved patient care (2.10).

Section 3 I am in agreement with identifying areas of deprivation or under provision of service and with the need to plan pharmaceutical core and additional services where required. The PCSP will be a useful tool but only one of the factors to be taken account of when considering an application. There must be an appeal mechanism put in place for when a health Board proposes to relocate or rationalise pharmaceutical services (3.7) I do not feel that areas of so called over provision can be managed by the introduction of Holding Contract (3.9). This would certainly destabilize the current structure and deter future investment to provide the new contracted services. If financial assistance is offered to relocate existing services to an area of deprivation it must be considered that long-term support will also be required to maintain viability. When considering an application to open a pharmacy the test on necessity and desirability should remain, as I believe that it still provides for local needs.

Section 4 I agree that there is a need for a more comprehensive pharmaceutical list including all pharmacists and not just principals. The contract must remain with the principal (4.6).

National and local accreditation details would be very useful but raises concerns about working in different Health Board areas.

Section 5 I believe that a pharmacist should be on the premises at all times but some of the dispensary responsibilities be delegated to a trained technician allowing the pharmacist to devote more time to direct patient care(5.6). This will have obvious cost implications to be considered.

Section 6 There may be an advantage in the future from some services being provided from a distance but it must be accessed through existing contractors within a board's area. I believe that it is important that the medicines are supplied by the pharmacy where the prescription form is held. It may be that the contractor chooses to outsource the dispensing service but the dispensed medicine should be supplied by the pharmacy with the prescription form (6.6).

Section 7 Boards must be required to fully fund and ring fence the monies to pay for core services that are nationally agreed (7.8). It is a concern that local variation on drug budget management could lead to inequalities and undermine the national agreement.

Section 8 I feel that Option 3 is the way forward but we must be sure that the inevitable costs of extra staff and their training are fully covered (8.25). It is essential that the proposed changes do not destabilise the market as this could lead to a disincentive to investment in pharmacy.

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