

fnj/del

SHETLAND AREA PHARMACEUTICAL COMMITTEE

**SJURNA
Bridge End
SHETLAND
ZE2 9LD
29 May 2004**

**SUSIE BRAHAM
SCOTTISH EXECUTIVE
HEALTH DEPARTMENT
St ANDREW'S HOUSE
1ER
REGENT ROAD
EDINBURGH
EH1 3DG.**

Dear Sirs,

**We write in response to the consultation MODERNISING
NHS COMMUNITY PHARMACY, and attach our
response. The response may appear similar to others,
which we know you will receive, but would urge that it is
read in full. The areas in which we substantially differ have
been underlined to assist you in your consideration.**

**We have approached our deliberations on the document
from the viewpoint that any new contract needs to meet the
needs of the whole of Scotland including remote and rural
locations such as ours and would make the following points.**

- **Pharmaceutical care must be delivered to the patients of dispensing GPs.**
- **9 out of the 10 GP practices in Shetland provide a dispensing service.**
- **Pharmaceutical care is difficult to provide in remote and Island communities.**
- **Pharmaceutical care needs proportionally higher funding in the remote and Island setting.**
- **The “Arbuthnott” formula is fundamentally flawed with regard to funding of remote Island boards.**

We trust that you will take the points we have made into consideration, and would of course be willing to discuss any of them further.

Yours faithfully

A handwritten signature in black ink, appearing to read 'James A Donald', with a horizontal line underneath.

**James A Donald MRPharmS
Chairman.**

Modernising NHS Community Pharmacy in Scotland.

Overview of Consultation Document.

Lays down proposed changes to legislation required both to implement potential changes in the community pharmacy contract based upon *The Right Medicine* whilst seeking to introduce proactive planning and delivery

of pharmaceutical services within a more controlled environment. While this discussion document alludes to detail it has to be recognised that little detail will exist in the initial enabling legislation and that the true detail will come with the 'Regulations' and statutory instruments to be discussed in detail later. This does not preclude ensuring at this stage that the general tone and tenor of the consultation is acceptable to community pharmacy contractors.

Section 1 Legislative Background and General Overview.

Require a consistent approach 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.
- Dispensing is a key activity that must be protected. (2.5)
- 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 minimum standards and tariff.
- Pharmacists will require additional skills, with associated training and locum costs.
- Local negotiation should be used to define further service refinements in addition to the national standards 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)
- Remote and rural areas, is same standard to be applied to dispensing GPs?

General Comment:

The danger of over regulation and audit/monitoring could create disincentives to provide patient care with an excess focus being placed on 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 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 financial assistance would be required to make such services viable. (3.9 & 3.12)
- A robust and transparent structure for the decision making process is essential and must demonstrate independence from vested interests.
- Will Dispensing GPs association still be able to appeal?

Further Clarification Required:

- Who would be involved in the development of the PCSP?
- How long would a PCSP last?
- How will over/under 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.
- 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)
- Who will act as independent arbiters?

General Comment:

The main hurdles to further improvements in pharmaceutical service in areas of need/remote and rural 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 density and has given stability to that service.

This should not be lost in the rush for change.

Counter Proposal:

- 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 density.
- All local directed services used nationally should as previously mentioned have a minimum 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 health care professionals.

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?
- How is accreditation achieved?

Area of Concern

- System unlikely to work without a National list.
- Concern about ease of checking this list.

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.
- Limits of 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 INITIALLY 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.
- 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?
- **Major concern, Arbutnott formula is fundamentally flawed for remote areas.**

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.