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Date
Your Ref 4 June 2004
Our Ref

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Ms Susie Braham
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Dear Ms Braham

MODERNISING NHS COMMUNITY PHARMACY IN SCOTLAND – CONSULTATION PAPER

Thank you for the opportunity of responding to the above consultation document.

A copy of the response from NHS Lanarkshire is enclosed. This was considered and approved by the Lanarkshire NHS Board at its meeting on Wednesday 2 June 2004.

In approving the response, the Board wished to take the opportunity to highlight the potential resource implications in implementing whatever is agreed as a result of the consultation, and ask that this is considered at Departmental level, given the financial pressures which local systems, including Lanarkshire, currently face.

I hope that this response is helpful.

Yours sincerely

P.P. DAVID PIGOTT OBE
CHIEF EXECUTIVE

MODERNISING NHS COMMUNITY PHARMACY IN SCOTLAND – CONSULTATION PAPER

RESPONSE BY NHS LANARKSHIRE

Section 2 - Introduction of New Community Pharmacy Contract.

The policy intention is to amend existing legislation so that steps to modernise pharmaceutical care services and improve patient care through the introduction of a new community pharmacy contract can be effected in the future.

Specific proposals are made, which essentially revolve around the development of a quality system to assure delivery of services to a set standard.

Q. Are there any specific or additional powers we need to consider in order to modernise pharmaceutical care services and further improve patient care?

The key elements of a quality system which ensure delivery of suitable standards of patient care include:

- Patient registration.
- Adherence of practitioners to recognised standards of practice – both in terms of infrastructure of the premises through which community pharmacy services are provided and also in terms of the standards of the clinical care services provided.
- A sharing of data and information including internal quality assurance/audit information with the Health Board/SEHD in order to demonstrate that adequate standards are being delivered.

Some of these principles are long-term and are unlikely to change. It therefore seems fitting that they be enshrined in legislation.

However, some other aspects will evolve as community pharmacy practice evolves and it therefore seems unsuitable to include them in primary legislation. E.g. the precise standards which would be deemed appropriate for the provision of certain chronic medication services for all or any disease states, will change over time. It is therefore more appropriate that the legislation directs that when national or Scottish standards are prepared for the delivery for a certain type of service, then the requirements are that patient care is provided in accordance with these standards. It is inappropriate for the standards themselves to be made part of the legislation.

The opportunity to define standards of practice for core and additional pharmaceutical services is welcomed as is the opportunity to associate these with a minimal benchmark tariff for the whole country. This does not preclude the opportunity for local negotiation

around supplements to these services, both in terms of quality standards and/or financial recompense.

The issue of patient registration is a critical one for the development of chronic medication services in particular. We can only expect quality pharmaceutical care if there is a continuity of care between patient and service provider.

Currently, patient registration is also a requirement for the provision of the minor ailment service. Such registration is currently required for administrative reasons rather than clinical reasons, and in some ways this requirement restricts the usefulness of that service, e.g. patients cannot access the minor ailments service from late night opening pharmacies unless they happen to be registered with that particular pharmacy for that purpose. It may be therefore opportune, to consider alternatives for administering the minor ailments service at this time of legislative change.

A requirement of community pharmacists to participate in internal quality assurance and audit techniques is very valuable and will be a key driver for ensuring that high standards of care are provided. It is also important that certain elements of the data collected via the internal quality assurance systems, are shared with the NHS Boards and the Scottish Executive Health Department in order that they too may be assured of the quality of care being provided. Clearly the way in which the data is handled, interpreted and publicised requires great care.

Section 3 – Planning & Provision of Pharmaceutical Care Services.

The policy intention is to improve the planning process for establishing and securing the pharmaceutical care services (PCS) by ensuring that service provision is based on locally identified care needs and that patients have convenient access to a full range of services.

The commentary discusses the potential for a pharmaceutical care services plan, which may identify areas of under, over or matched provision of pharmaceutical care services and it also describes a potential mechanism for incentivising pharmacies currently practicing in an area of over-provision to move to an area of under-provision. Importantly, the commentary also indicates that NHS Boards would have a responsibility to provide or secure provision of pharmaceutical care services that they consider necessary to meet all reasonable needs of persons in the Boards areas.

Q. Do these proposals offer a comprehensive way of ensuring patients have convenient access to a range of pharmaceutical care services that takes account of their care and access needs?

Q. Are there alternative models for fulfilling the policy intention for patients?

The concept of preparing a pharmaceutical care services plan which will be an objective assessment of care needs is useful. It is also useful that NHS Boards will have the facility and indeed the duty to secure services for patients whose access to pharmaceutical care

services do not meet the minimum standards as laid down in the that Boards Pharmaceutical Care Services Plan.

The development of the Pharmaceutical Care Services Plan services plan is vital, and it would be valuable to have legislation defining the key processes by which this should be carried out e.g. by listing statutory consultees such as

The Area Pharmaceutical Committee
The Area Pharmacy Contractors Committee
The Area Medical Committee
The Local Health Council
The Community Health Partnership

In paragraph 3.5, the consultation document alludes to the potential for national standards in terms of "convenient access" for the resident population to core services. It may be that further detail with regard to national standards for the criteria to be assessed in preparing the pharmaceutical care services plan is required in order to minimise the possibility of "post code access" for pharmaceutical services and it would be valuable to commission research to ensure this is done robustly.

There is a paradox between the suggested requirement that all pharmacy contractors need to provide all of the core elements of the new community pharmacy contract, and the need for the pharmaceutical care services plan to consider locally negotiated services as well as the core services. For example, there may be some areas within a Health Board, where all elements of the core service are readily provided, but there is a deficit in terms of the provision of some of the locally negotiated services, e.g. needle syringe exchange. It then becomes incumbent upon the Board to secure a contractor who will provide such services or, start providing these services via the managed service.

If there already is a comprehensive provision of the core services, then there is by definition no need for another community pharmacy contractor to start providing these core services again, plus a new needle syringe exchange service, since that is the only deficit in the area. Thus, consideration should be given within the regulations to the possibility of providing a "partial contract" with the aim of topping up the totality of service provision so that it meets all the needs identified within the pharmaceutical care services plan. This concept of a "partial contract" may also provide a viable mechanism for the care elements of a pharmaceutical contract to exist along with dispensing doctor service provision.

The concept of over provision of pharmaceutical services will be controversial, but it is important. Depending on the outcome of the negotiations for the new pharmaceutical contract, it may be cost-inefficient for NHS Boards to be paying practice allowance fees for community pharmacies which exist in an area of over provision. Also, given some of the workforce problems within the profession, it may be inefficient for a preponderance of community pharmacies, and therefore community pharmacists, to be concentrated in a particular area when there is a dearth of pharmaceutical services being provided in other parts of the county. Thus, the opportunity to incentivise and/or demand change in areas of

over provision and to incentivise development in areas of under provision is welcome. The precise details of how this may be done in practice is however very complicated. Great care would be required in the legislation to provide a robust mechanism for awarding "holding" contracts.

Thinking to the future, there may be relatively little practical problem, however, because as we look for the comprehensive provision of chronic medication services, minor ailment services and public health services, over and above the traditional dispensing service and the current locally negotiated services, it may be argued that it is very unlikely that there will be significant over provision of pharmaceutical services in any part of a Health Boards area and our main challenge will be in securing services for those areas which are currently under provided.

Section 4 – Pharmaceutical Lists.

The policy intention is to strengthen clinical governance, quality assurance and to benefit patients by extending the listing arrangements to pharmaceutical non-principals, thereby bringing them within the current framework for the administration and management of family health services in Scotland.

The commentary discusses the concept of pharmaceutical lists being extended from non-principals to include all pharmacists providing services from a particular premises, including trainees. It also indicates that the specific qualifications of the pharmacists providing services could be included on the pharmaceutical lists.

- Q. Are there any further actions which would serve to improve clinical governance in the community pharmacy sector and provide patients with an additional quality assurance (e.g. having the clinical component of the contract placed with the named pharmacist providing the service)?**

This proposal seems valuable and sensible. It will facilitate communications with all pharmacists in a particular Health Board area and also provide each Health Board area with an awareness of the number and the skills of the pharmacists practising within that area. In addition, it provides an opportunity for discipline of poorly performing pharmacists via the NHS tribunal system, with the potential sanction of erasure from the pharmaceutical list, should that be necessary. This is potentially a more responsive system and safer to the NHS in Scotland than the only current option of barring a non-principal pharmacist from practice which is via erasure from the Royal Pharmaceutical Society of Great Britain's register.

As community pharmacy practice moves forward, certain additional qualifications or registrations are required to provide certain services. The most obvious of these are the qualification for supplementary prescribing and the need for individual pharmacists to sign patient group directions in order to apply them in practice. If the pharmaceutical lists evolve to an extent whereby these additional qualifications/registrations are annotated within a list for provision from a certain pharmacy, then this facilitates

quality assurance by the NHS Board in terms of assuring that pharmacies which contract to provide certain elements of the service are staffed by pharmacists who have the necessary skills.

An natural follow-on from this concept is the possibility of contracting certain elements of care to individual pharmacists (including non-principal pharmacists) rather than to the pharmacy contractor themselves. Whilst such a concept would be theoretically possible, it is in direct opposition to the concept mentioned in section 2, which indicates that contracts will only be provided to premises which are providing the full range of core pharmaceutical care services.

Section 5 – Persons Authorised to Provide Pharmaceutical Services.

The policy intention is to standardise the legal references to persons authorised to provide pharmaceutical services.

The commentary indicates the current conflict between the regulatory definition between the use of the term ‘direct supervision’ in the 1995 regulations versus the term ‘supervision’ as is used in the Medicines Act.

It is proposed to change the legislation to use the term ‘supervision’.

Q. Will the action proposed enable community pharmacists to devote more time to direct patient care?

This change, is welcome and will move us in the direction of more flexible methods of practice. It is therefore useful. While it is valuable, this change in itself will not radically change the methods of community pharmacy practice.

Other changes in practice such as the registration of pharmacy support staff and the provision of training and support for such staff will be more powerful drivers in this regard.

Section 6 – Cross Boundary & Distant Provision of Pharmaceutical Services.

The policy intention is to clarify and extend the current pharmaceutical list and control arrangements to allow for innovative ways of providing dispensing and supply services to NHS patients, and so give patients and pharmacy contractors greater flexibility in the way that pharmaceutical care services can be accessed and delivered.

The commentary describes the possible interrelationship between Boards, pharmacy contractors to that Board and distant dispensing operations.

It is suggested that the opportunity for Boards or pharmacy contractors to use distant dispensers, may facilitate new methods of practice which will ultimately encourage community pharmacists to provide a greater emphasis on the “care elements of the service”.

- Q. Do you agree that it is desirable to have powers that will encourage and allow innovative ways of providing pharmaceutical services in the future?**
- Q. Do the proposals offer sufficient flexibility for patient choice, convenience and safety or should they go further?**

We know that a vast number of prescriptions are dispensed in community pharmacies each year. This looks likely to continue for the foreseeable future, and it represents a very significant component of the overall workload within a community pharmacy - both for support staff and for the pharmacists themselves. The volume of work is a natural barrier to the provision of the “care elements” which we aspire to and which are described in *The Right Medicine; A Strategy for Pharmaceutical Care in Scotland*.

Further, we know that approximately 75% of the medications which are dispensed are repeat medications and that new methods of practice may allow these to be dispensed in an efficient way and in a time frame which is both suitable for patients and suitable for workflows within the pharmacy. This could be particularly true if a community pharmacy contractor could in effect, “sub contract” some of these dispensing functions to a distant dispenser.

Clearly, all professional aspects of such an arrangement would need to be fully developed, robust, and to a standard which ensures safe and effective practice.

It is not the purpose of the legislation to define exactly how this should be done, but it is useful for legislation to indicate that this would be an “allowable” method of practice. It does seem a very useful mechanism for potentially harnessing the use of modern technology such as robotics to make the very sizeable dispensing function more efficient, and therefore potentially release time resource for the provision of care elements of the service.

It is important, that patients have access to the supply of medications and the supply of care services. Hence, the suggestion that access to the distant dispensing services should be via a pharmaceutical contractor who can make an assessment of the totality of the patients needs is useful. Direct access to distant dispensing service who will solely provide the provision of the product, rather than the totality of care for a patient does not seem appropriate.

The administrative arrangements associated with this may be complicated. The principle set out in paragraph 6.14, which indicates that even if a pharmaceutical service is provided by a distant dispenser outwith that Board’s area, the Board will still be liable for the payment if it is for a patient who resides in that Board’s area seems sensible.

Section 7 – Funding of Pharmaceutical Services.