104/004

Susie Graham,
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26/5/04

Introduction to my response to
'Modernising NHS Community Pharmacy'

Dear Ms Graham,

I have attached the main detail of my response to SEHD's consultation document on community pharmacy services.

As deregulation of community pharmacy was comprehensively rejected by the Scottish Parliament, I explored the opportunity to respond to this document shaping the future of my profession and its practice. I sincerely hope it provides a framework to build upon the strengths recognised by the Scottish Parliament in its dismissal of OFT. A framework that will benefit patients, communities and pharmacists alike.

Yours Sincerely
Campbell Shimmins

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RESPONSE TO MODERNISING NHS COMMUNITY PHARMACY

I welcome the document which sets out an enabling legislative framework for the delivery of an enhanced community pharmacy service, allowing community pharmacists to largely deliver their part of 'The Right Medicine.'

While I recognise the intent to enhance patient care by increasing the use of pharmacists and their support staffs skills. Improving patient accessabilty to healthcare services and advice through the community pharmacy network, and by acknowledging that the stability of this network is key to delivering the strategy. However the lack of a clear timescale is disappointing with respect to a return of 'OFT' in 2006, and the introduction of EU legislation on competition for professional services.

Putting aside these concerns about the future political hurdles, I have the following comments on the document itself.

Introduction of Contract

Section 2 Paragraph 2.4

If local legislation is to be adapted for 'Additional Services' then lessons have to be learned from past and existing problems with this method of service development. Namely the lack of funding within boards and competition with other local service priorities or managerial/ political expediences. In other words community pharmacy has to be better recognised or its' funding 'protected' within these organisations.
CHP representation is a good start – but it will take time for local pharmacy champions to develop and gain influence. A better solution is to have a national framework and tariff for service development which will reduce the likelihood of inequitable patient access to services.

Paragraph 2.5

This recognises the transition from the current key activities (dispensing) to a more clinically orientated service, and therefore it also must recognise a reasonable timescale for such a shift in activity/working practice.

Section 3 – Planning and Provision of Pharmaceutical Care Services

I agree with the policy intent 'to improve planning for Pharmaceutical Care Services.' The ability to plan for future location and provision of PCS is something that patients, contractors and Boards must surely benefit from.
Care must be taken not to undermine the existing network. While it is recognised that there are areas of current and future underprovision, there are no (or few) areas of overprovision – and flexibilty from a real estate perspective is difficult, with leaseholds, property availability etc.

The word convenient is used throughout this section. I would like to see a definition in terms of reasonable access to PCS as well. Patients are not viewed solely as consumers in Scotland, or are they?

Paragraph 3.4

I would support the introduction of PCSP and also the inclusion of patient and contractors in their consultation. There are resource implications for Boards here.
Also any local pharmaceutical needs assessment has to follow a national template to avoid inequality of access and care provision, subjectivity or indeed Boards 'doing their own thing!'

Paragraph 3.5 and 3.6

The application of PCSP to 'additional services' in an area will lead to clearer indentification of service gaps, however existing contractors must be given the first opportunity to meet those needs within a Board's strategy to fill those gaps (including financial incentives).

Paragraph 3.7

The change of the 'necessary and desirable' test for control of entry must result in national and objective criteria for inclusion. It mustn't introduce instability, must be inclusive of existing contractors, and must contain some flexibilty to respond to local circumstances. It should also recognise the need to provide 'full' PCS, not just selected profitable services, and finally be legally robust.
This does beg the question – 'Why change this?'
Why not objectify the existing test, allowing for management and future planning of services too.

Paragraph 3.9

Under/over provision needs to be defined. While the policy intent is clear I don't believe this provides any solution. As stated earlier there are gaps in provision but little 'overprovision.'

Paragraph 3.10 , 3.11 , 3.12

Holding contracts are a mistake. This introduces instability and discourages investment and entrepreneurship.

Paragraph 3.16

Reviews are necessary but change only if the existing plan or network is not flexible enough to adapt. The process would need to be inclusive and not threatening – has potential to undermine service provision.

Section 4 – Pharmaceutical Lists

Any register of pharmacists (principals) or otherwise would need to be both flexible and updated regularly (to an almost 'live' level). Again this would require resource and technology (smart cards/NHS registration codes etc.).
I agree with the need to establish some form of clinical governance for PCS – especially post Shipman. As locums are such a big part of community pharmacy I believe the responsibility for providing PCS should be the employing contractors, not the pharmacists otherwise more 'gaps' in service provision will be created depending on the supervising pharmacists qualifications. Robust SOP's should be adequate to ensure continuity of service, especially during periods of absence of the principal pharmacist.
Is the intent to ensure competence in the pharmacist providing services or to ensure public safety here? It has been regularly pointed out that Shipman was an excellent and more than competent physician!

Paragraph 4.9

Any administrative burden should rest elsewhere

Paragraph 4.10

There seems to be a degree of duplication with RPSGB in much of this, or at least a degree of synergy, perhaps closer dialogue here would avoid or resolve some of the duality.

Section 5 – Persons authorised to provide PCS

I agree there is a real need to increase the use of pharmacists clinical skills and 'free up' their time from the dispensing process.
Paragraphs 5.5 and 6 help with this, though my interpretation is the pharmacist is still responsible for accuracy of the final product and the 'package of care' surrounding it.
I also take the term supervision to mean the pharmacist is responsable for all PCS provided at the site and that this extends to one premises only.

Section 6 Cross Boundary and Distant Provision.

Potential methods of service delivery must not be excluded under the new contract if patients are to benefit fully from technology and efficiency improvements. This section recognises this.

Paragraph 6.13

This gives power to methods of controlling distant provision in order to maintain the stability of the network. Thus recognising the value of the face to face relationship between patient and community pharmacist and also the value of the accessibilty and location of that community pharmacy.
I believe a balance has to be struck between ongoing access to medicines supply and information and the ability to deliver PCS at a local level. I see cross boundary dispensing potentially as a tool to allow this but also as a threat to it, therefore its tight control is essential.

Section 7 – Funding

Experience with local negotiations concerns me that all monies allocated to plan and secure PCS may not be entirely utilised this way. This scenario has to be avoided in legislative guidance in order to ensure adequate local funding for PCS. I do welcome (paragraph 7.8) the addition of more money if an enhanced service is offered or sought.

Paragraph 7.7

Finally I would seek some reassurance that there will be no 'loses' amongst contractors in the legislative and financial transition to the new contract. Lack of assurance again may result in instability or disincentives to invest in their businesses and services.

As a final comment I would note the lack of reference to the educational needs of pharmacy support staff and technicians. Their education, development and retention is fundamental to delivery of 'The Right Medicine.' There are large resource implications for SE, contractors and NES in this area.