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Your Ref
Our Ref CH/Letters

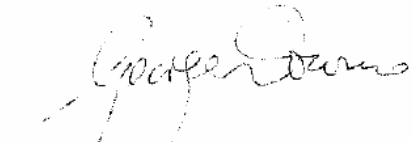
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Dear Ms Braham

Re: Modernising NHS Community Pharmacy in Scotland – Consultation Paper

Thank you for allowing us to comment on the proposed changes to the NHS community pharmacy contract. I have attached a paper detailing the response from NHS Grampian. The new contract provides the foundations to allow us to shape community pharmacy for delivery of service in the future. It is important that we grasp this opportunity and ensure the contract meets the desired requirements. I hope our comments help you to do this.

Yours sincerely

A handwritten signature in black ink, appearing to read 'George Downie', written in a cursive style.

George Downie
Director of Pharmacy & Medicines Management

NHS Grampian

Comments on Modernising NHS Community Pharmacy in Scotland

13 May, 2004

A new pharmacy contract that is based on quality of pharmaceutical care and not only on the numbers of prescriptions dispensed is to be welcomed. Developments in community pharmacy can only go forward as long as there is appropriate and adequate remuneration. Any new contract however, must be easy to administer and have sufficient flexibility within the remuneration structure for new developments to be funded. It would be valuable if the new pharmacy contract could have been taken forward in parallel with the new GP contract to build on the opportunities for sharing of data, disease registers and the use of joint technologies. The consultation document also does not really address the issues arising from shared electronic prescribing and this may be an important omission.

Section 2: Introduction of new community pharmacy contract

- It would be helpful to define what will be meant by the term pharmaceutical care within the core service of the proposed new contract. Will this involve patient medication review and the maintenance of complete and full records? The expectation is that the contract will include provision for "pharmaceutical care for certain specified conditions" – what does this mean? The incentives could be related to "certain specified conditions" but pharmaceutical care should be available for any patient if there is a need. The Right Medicine: A Strategy for Pharmaceutical Care in Scotland is a plan for action for development of pharmaceutical services but unfortunately this is not fully taken into account within the consultation document. Modernising Community NHS Community Pharmacy in Scotland lacks clarity and direction and needs to be much more focused on service and manpower development.
- A clear definition is required of how legislation can "modernise pharmaceutical services and improve patient care" and how "incentives will be provided to improve and deliver quality care health services". The new GP contract is based on high quality of care indicators. Will the incentives in the community pharmacy contract be linked to those in the GP contract?
- It would also be helpful to state what diagnostic tests will be expected to be provided if this is to be part of the core contract and how this testing and associated care will be integrated into existing services e.g. is it envisaged that diagnostic testing will be undertaken opportunistically by pharmacy or on referral from a GP or a mixture of both? There could well be significant implications such as harmonisation of patient care records, training, development of facilities in pharmacies to undertake such testing. If Health Boards are to be expected to support these developments locally there will be significant resource implications.
- Registration of patients with pharmacies has the potential to offer significant benefits e.g. continuity of pharmaceutical care, but also potentially raises some concerns with regard to provision of advice. One of the key factors for community pharmacy is their easy accessibility and the fact that people can walk in off the street and get advice e.g. on OTC medicines, minor ailments health improvement. We live in mobile society and within larger towns and cities people may choose to get advice from a number of different pharmacies if they happen to be passing and yet may get their prescriptions dispensed at the pharmacy closest to their GP surgery. If pharmacies were only contracted to provide services to patients registered with the pharmacy a valuable resource could

potentially be lost. The answer may lie in a mixed economy approach whereby pharmacists offer one level of service to their registered patients and another to non-registered.

- Will the contract set out a specific set of clinical protocols or SOPs or will it be up to individual contractors to do so and if the latter is the case who will assess the quality. What will the role of the Health Boards be in this? Will this be a possible role for the RPSGB inspector.
- In order for the monitoring role of Health Boards to be delivered efficiently it will be necessary to clarify and define many of the elements of 2.10 e.g.: good human resource management monitoring. It will need to link in with current NHS standards. Bringing such human resource standards into community pharmacy is likely to have resource implications e.g. training and monitoring for both contractors and Health Boards. It would be helpful if more specific examples of monitoring requirements were provided in order to be able to quantify the workload. Central support in some elements of monitoring may be required
- Will the Health Boards have any power to censor a contractor if they are deemed to be not performing well in one area? Clear definitions of non-compliance will also be required.
- The inclusion of a public health element to the contract is welcomed. The current lack of detail around this element makes meaningful comment difficult. However, it is hoped that this element will include the flexibility required to allow both activity in national priority areas as well as local initiatives reflecting local health improvement needs and priorities. One possible model is that used for the model schemes with a tiered approach with perhaps the first tier being core based around national priority areas with further tiers reflecting increasing specialisation and activity. In order to maximise the benefit of community pharmacy's contribution to the public health agenda it will be vital that any activity is proactive rather than the current passive activities relating to leaflet display and reactive activities such as advice giving. Clarity is required over what the public health aspect of the core contract will be, how will it be provided, monitored and checked?
- Audits should be carried out by community pharmacy as part of the requirements to receive the professional fee. We are not aware that this is monitored at present. There will need to be built into the contract a mechanism for appraisal and revalidation in to ensure CPD and clinical governance. This may be a role for the Society inspector.
- The question at the end relates to powers needed. We realise these are in process but it should be remembered that independent prescribing for pharmacists will be on the agenda for 2005. Shared access and recording to shared patient records will be required to avoid situations whereby pharmacy and medical based records are separated.

Section 3: Planning a Provision of Pharmaceutical Care Services

- The proposal is broadly welcomed – it begins to unlock pharmacy from the issues that arise from the OFT report i.e. makes it a core service needed within the NHS which is provided on a planned basis rather than viability. The definition of need and methodology to undertake needs assessment for community pharmacy services should be led and developed through the SSiPPH group with associated stakeholders
- The proposal to improve the planning process for community pharmacy services in order to deliver services based around the needs of the local community rather than service

organisation being based on the local market economy is to be welcomed as it reflects the importance of pharmaceutical care in the modern NHS.

- The Statutory requirement for NHS Boards to provide/secure the provision of pharmaceutical care service is an onerous one, and one which will require resource in order to identify need and develop plans to services within an area. The planning element is welcomed as an opportunity to develop services to meet local needs and have a planned infrastructure of community pharmacies. Public health will be central to the assessment of this need and the development of plans. The development / implementation of the plan will require resource
- There is a complex task in deciding if there is over-provision in one area and under provision in another, as most pharmacies will work to their current capacity. If 2 or 3 pharmacies are sited within a few hundred yards of each other what criteria should be used to determine which pharmacies should only be given a holding contract, or asked to move to another area deemed to be under-provided, and which should be given a permanent contract? How long can a contractor have a holding contract?
- If a contractor with a holding contract is asked to move to another area and they do not wish to do so would the Board have the authority to discontinue the holding contract?
- Will the Board have the power to force / dictate contractors to take on additional services e.g.: needle exchange if a need is determined?
- What within the contract will be determined as under-provision and how will this be measured, as this may be a source of contention between contractor and Health Board? The "more objective assessment for determining whether PCS are to be located or how they are to be delivered" needs to be defined. Will this be defined as pharmacies per head of resident population per square kilometre and how will this take into account mobile populations e.g. patients who visit the pharmacy to or from work or in their lunch hour?
- Will the contract make provision for additional resources in order for Health Boards to provide assistance and incentive arrangements in order to secure services in under provided areas or will this additional cost be expected to be borne by Health Boards out of their existing allocations? If the latter is the case then it is likely that there will be different priorities in place for PCS provision across the various Health Board areas depending on financial pressure.
- Currently community pharmacies open/survive in areas where they are commercially viable, it may be likely that Health Boards would be required to give considerable financial support to pharmacies to open in remote rural areas where PCS were "considered necessary" in order to ensure a service could be provided. The need of patients has to be balanced with cost effective use of resource when considering providing PCS. It would not be cost effective to provide PCS in every small rural village.
- Where a PCS cannot be supplied by a community pharmacy the Board is required to secure services either by provision itself or from another contractor in their own area. It is difficult to see how this differs from the current system in that if there is no pharmacy in one village then the patient goes to one where there is. The only difference may be that the patient may require to be registered with that pharmacy and this may limit the choice and options for that patient. What is the role of the dispensing doctor in this situation? The issue here may be one of accessibility i.e. if you have to travel too far then localised provision will be necessary. Will there be provision both in the regulations and the

RPSGB guidance for satellite pharmacies to run local clinics in the same way that GPs do?

- It is not clear with these new arrangements whether care and access for patients in remote rural areas will change greatly. Consideration could be given to the use of mobile pharmacies i.e.: in vans or buses. These would have to be registered as a community pharmacy premise.
- What is also not clear from this consultation paper is whether a Health Board would be required to determine the need for individual services provided from a community pharmacy in assessing need and issuing of contracts. If for example additional 'observed methadone treatment schemes' where methadone is consumed on premises or needle exchange services were required in an individual area but a contractor was not currently providing these could that contractor be asked to provide them and would the Health Board have any power to make this a requirement for a full pharmacy contract in that area?
- The document states that this will be "comprehensive way of ensuring convenient access" but there is no definition of convenient.
- There will be big issues surrounding the resource to change, assessment of need and the development of plans will be complex.

4. Pharmaceutical Lists

- The maintenance of a pharmaceutical list of both principals and non-principals is a welcomed clinical governance initiative
- There will be additional workload on the part of Family Health Service in order to maintain those list and in particular ensuring that they are up to date with pharmacist details particularly addresses. While it is reasonably easy to maintain a list of pharmacies and their addresses doing the same for non-principals, locums and pharmacists on training will not be as easy. It must be a legal responsibility for an individual pharmacist or trainee to ensure that the Board area in which they work holds their current, correct details. There must also be a requirement on the individual to notify the Board area if they move away, otherwise Boards will have outdated lists of pharmacists who no longer live or work in their area. It should be recognised that extension of the list to individual pharmacists may well reduce flexibility in the workforce as local initiatives require locally defined training requirements in the delivery of non core services. Care will be needed to ensure that all pharmacists in an area are encouraged to undertake such training to underpin such services. Such encouragement should be through both professional and contractual means (e.g. making a requirement of participating pharmacies that registered staff will be in attendance for specified time periods / opening hours).

Section 5: Person Authorised to Provide Pharmaceutical Services

- A more liberal interpretation of the term supervision is to be welcomed if this enables more flexible use of pharmacy staff to enable enhanced service to be delivered through pharmacy.
- The mechanics of dispensing can easily be provided by a trained pharmacy technician or by use of robotics. It is important however that patient safety is not compromised and there should be requirements within the legislation to ensure that competent trained

technicians and robust systems of work are in place to ensure continued safe patient care.

- It is assumed, but it cannot be guaranteed, that changes to the act will allow pharmacists to use their time for direct patient care activities.
- What is not clear from the document is whether the "liberal interpretation of supervision" allows pharmacists to leave the premises and for prescriptions to be dispensed and supplied in their absence.

Section 6: Cross Boundary and Distant Provision of Pharmaceutical Services

- The aim of any legislative changes would appear to be to allow innovative ways of providing pharmaceutical services in the future yet the operational systems described appear to be restrictive in their depiction and it is unclear in how they will work in practice. The additional requirement for Boards to register distant dispensing arrangements will also incur additional work.
- Sections 6.10 and 6.11 with regard to businesses only wishing to provide distant dispensing services and no "provision of care" is not clear. What constitutes "provision of care".
- Restricting distant dispensing services only when a prescription is presented at or through a pharmacy contractor providing a full pharmaceutical care service though the national contract will affect many Boards who have arrangements for provision of services such as total enteral nutrition where a prescribed product (i.e.: the feed) is delivered directly to the patient's home along with all the tubing (not prescribable). Boards will have to renegotiate contracts in these cases and this may incur additional costs.
- It is not clear from the document where the powers will lie with regard to testing of services i.e.: Health Board or national.

Section 7: Funding of Pharmaceutical Services

- Again given the limited information about which items of service may be subject to inclusion in Health Board allocations it is difficult to provide informed comment. In general as there will not be provision for Health Boards to vary the remuneration terms it would be difficult to justify allocation of funding to Boards for services where there was no scope for planning or adjusting in order to remain within budget. It would be impossible for a Health Board to be able to put a cap on the number of prescriptions dispensed in order to remain within budget. This would also prevent the introduction of initiative systems to reduce medicine waste e.g.: reducing from two monthly to monthly prescriptions or weekly dispensing. The effect of new serial dispensing initiatives would need to be considered.
- Only when Health Boards are given additional funding to commission new enhanced services rather than to pay for services already in existence (that cannot be withdrawn) should funding be given as part of the unified budget. It is important within that unified budget that the pharmaceutical services allocation is clearly defined and ring fenced to avoid reallocation of this funding to other services.
- Boards cannot be expected to assume full financial responsibility for budgets for services for which they have not been party to the negotiation of remuneration terms unless those

services are fully funded within the allocation— this is the case already for other centrally agreed services though. Allocation by weighted capitation may not be appropriate to pharmaceutical services and would potentially undermine the idea of a national pharmacy service potentially leading to postcode differences in service availability.

Section 8: Partial Regulatory Impact Assessment

- The document states that the consequences of administering the revised arrangements will add little to the existing commitment. This is unlikely to be the case given the assessment of services required and monitoring of the new contract arrangements that have to be put in place. Much of the resource of the *Right Medicine* strategy is tied up in service developments, which will not be available to offset administrative costs stemming from the new contract. As money to implement the *Right Medicine* had to be found from within an individual Health Board's allocation some boards have not funded, or not fully funded it, or have not made commitments to long term funding and so will not have this resource to call upon. It is difficult to see how the consultation document can suggest that there will be little existing resource requirements for Boards to implement the new contract and then go on to suggest methods for funding that implementation. We can clearly see from the resource required to implement the new GMS contract that new developments are never time and resource neutral.
- The phrase "Expenditure by Boards on providing incentives for service change would be an additional call on their resources" would suggest that no new money will be available to take forward service enhancement. It is unlikely that so much over-provision will exist that pharmacies will close as there will be a lower level of need and that the resource saved could be ploughed back into providing incentives. There is more likely to be under-provision. With the introduction of new and enhanced core services such as diagnostic testing and minor ailments services pharmacists' time will be at a premium and need and service uptake may well increase.
- Until such time as a true picture of pharmaceutical need both within and out-of-hours is determined in an individual Health Board area it is impossible to predict the financial effect of a new contract locally. However as a key element of the proposed community pharmacy service needs assessment will be the action plan for development emanating from the assessment and the prioritised implementation of that plan the level of resource available to deliver such plans will need to be made available. If this doesn't occur such changes will be subject to local prioritisation against the needs across other services leading to differential rates of change across NHSIS.
- Allocation by weighted capitation is likely to restrict pharmacy developments in some Health Board areas. An example of this would be in funding the provision of services for drug misuse e.g.; needle exchange and consume on premises methadone where a weighted capitation partly based on age would not reflect need. Currently these services require considerable financial input but which varies across Health Boards. It is also true that no weighted capitation system is accurate enough to be able to predict need and expenditure 100%. A system of accountability for expenditure may be more appropriate.
- The document includes both Board and business costs in assuming a spend of £1.29 million for total NHS costs (section 8.20) and this funding would therefore not all be accessible for Boards to utilise in redesign of service provision as half of the estimated expenditure is currently incurred by the pharmacy businesses themselves. Presumably (although breakdown of cost is not given), some of the cost to Board will be to support Area Pharmaceutical Committees who currently consider the requests to provision of pharmacy and it would not appear to be the intention to change the advisory structure to NHS boards. As these committee would still be expected to provide advice to the Board

on other matters these costs would not be able to be re-utilised. As reappraisal of existing expenditure that Boards can re-deploy in support of the new contract arrangements is required.

- The proposal to introduce a funding system that " may not match current payment patterns for community pharmacy" is a crisis waiting to happen where the existing payments are greater than the allocation. The expectation is that Boards will manage the change accordingly but Boards are given no scope within the new contract in order to be able to do this. Boards are expected to pay the nationally negotiated rates and have little power to restrict services should they even wish to consider this. The potential for a funding gap is likely to undermine developments taking place under the implementation of the Right Medicine. Community pharmacy services cannot be taken forward on this basis.

Conclusion

It is difficult to provide informed comment on this consultation paper as much of the detail of the contract is not available and this is essential in order to determine the full implications. What it does highlight is the increased responsibility and workload requirements of Health Boards. The devolvement of budgets to Health Board level by means of a weighted capitation method may actually impede the development of community pharmacy initiatives. The document raises concerns about the true level of the financial impact of the new contract for Health Boards and these must be considered and re-evaluated. The assumption that costs to Boards will either be cost neutral or only marginally increased would not appear to be valid. The NHS in Scotland is likely to have a significant shortfall in its budget by the end of this financial year and unless there is increase in resource allocation.

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