

31 may 2004

Susie Braham  
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Dear Ms Braham

## **MODERNISING NHS COMMUNITY PHARMACY IN SCOTLAND**

The Primary Care Division of NHS Greater Glasgow welcomes this opportunity to comment on this consultative document and offers the following comment in response. The views expressed have been canvassed from a number of individuals and groups within the Division, including the Pharmacy Practice Committee.

### **Section 1: Legislative Background and General Overview**

Within the current regulations, there is no provision which would allow a Primary Care Organisation to require pharmacy contractors to deliver 'Additional Services' where an unmet need has been identified. This is particularly relevant to those services associated with drug misusers – needle exchange and supervised methadone consumption. That the proposals contained in the document promote a degree of flexibility for partial 'additional services' is to be welcomed. Boards can now start to adopt a more proactive role in the planning of services particularly in considering new applications which meet the specific public health needs of a local population

### **Section 2: Introduction of New Community Pharmacy Contract**

The proposal to introduce patient registration is welcomed. This allows for continuity of care and the formation of a more professional relationship between the pharmacist and their patient. Reference is made in Section 2.9 to 'e.g. to patients referred by a GP...'. This may need to be more fully specified in the legislation, e.g. for patients with a defined disease state and part of a CDM programme, otherwise an interpretation may result in patients being directed to one pharmacy. There should be a simple process in place to facilitate the transfer of those patients who wish to register in another location.

The parameters instituted for clinical governance and other quality assurance activities need to be agreed with others to ensure they mirror expectations of the Service and patients. (Section 2.10)

The reporting of adverse events and near misses is welcomed and should be seen as a sharing of information within a learning culture. Details may need to be shared with other disciplines and this may be best managed by a Scottish equivalent of the National Patient Safety Agency (NPSA). It should not be seen as punitive

### **Section 3: Planning & Provision of Pharmaceutical Care Services**

It is noted that Boards will be required to prepare, publish and review their plans for where and what pharmaceutical services are to be provided in that area. This

proactive approach to the planning of such key services is welcomed although some reservation has been expressed in planning services for drug misusers. These have attracted criticism and objection in the past which is likely to become more visible following direct engagement and consultation with patient representatives and the general public on these types of service, e.g. needle exchange and supervised methadone.

Where the Board is unable to place a contract within an specified locality, the option for the organisation to arrange to provide the service themselves will have operational and financial implications that need to be more fully considered. The preferred option would be for this facility to be provided by a community pharmacy contractor with the Board only taking this on in extreme circumstances. (Section 3.11). Similarly, the proposal that Boards will be able to pay additional sums for enhanced services will also need to be more fully considered (Section 3.13)

The proposal to replace the current 'necessary or desirable' test for control of entry with a more objective assessment is welcomed. This is anticipated to become part of the process in determining the Board's Pharmaceutical Care Services Plan (PCSP). The identification of an area with an over-provision is likely to prove controversial and has the potential to threaten investment in this sector. The concept of 'holding contracts' has met with little support although a proposal might be to 'buy out' the site with the least development potential. An effective appeals process will also need to be in place to handle any disputes or challenges to these local decisions.

#### **Section 4: Pharmaceutical Lists**

The current arrangement, whereby communication to employee pharmacists and locums is largely through the contractor pharmacist, is less than satisfactory. This is further exacerbated by the high turnover of professional staff encountered in several of the large chain multiples. The proposal to be aware of named pharmacists within a location, either as principals or non-principals, is to be welcomed as a positive step. An awareness of their specialist skills would contribute to the planning process in preparation of the PCSP and also determine training issues likely to be required within an area if an under provision of service was identified, e.g. supplementary prescribing. This further emphasises the CPD links between personal and service development in community pharmacy. An effective process needs to be in place to 'fast track' the approval of locums who are not previously registered with a particular Board.

In considering the range of core services likely to be available from a particular pharmacy in the future, it is apparent that the clinical component of the contract should be linked to the individual pharmacist. To ensure continuity of care from that location, a specified notice period would need to be given to the Board that a pharmacist was withdrawing from providing a service specified in the PCSP. This would allow for the recruitment or training of a replacement pharmacist with a similar skills profile. It would be detrimental to patient care if services dependent on individual pharmacists were disrupted due to a high turnover of inexperienced staff.

An definition of the minimum standards required to enter the list needs to be made. Similar to the medical model which this imitates, will criteria be provided to maintain or remove a practitioner from these lists and will this be reviewed on a regular basis, perhaps annually? This may be developed in future along the principles adopted in the practice accreditation model for GP's.

## **Section 5: Persons Authorised to Provide Pharmaceutical Services**

It is likely that these new services will place greater demands on the pharmacist's time. Patients should continue to have ready access to the pharmacist. Although a change in skill mix ratios will occur in time, it is felt that the term 'supervision' be redefined to reflect modern practice.

## **Section 6: Cross Boundary and Distant Provision of Pharmaceutical Services**

Any development should not limit the potential to innovate and modernise pharmacy practice. The advent of e-pharmacy and automation will bring changes to the traditional route of supply. However, some reassurances need to be in place to safeguard existing services. This includes the threat to inward investment by contractors in the community pharmacy sector. Such developments would have to be considered as part of the PCSP and be managed in a controlled and planned way. Since this area is likely to attract a degree of controversy, it may be appropriate to consider this aspect at a later stage when earlier phases of the contract have been introduced and been accepted.

## **Section 7: Funding of Pharmaceutical Services**

The sum allocated to each Board area requires to be ring-fenced to secure a basic level of pharmaceutical service. Since additional monies are also apportioned locally to supplement pharmaceutical services, an indication needs to be given on the stability of such funding. Withdrawal or reduction of this investment could jeopardise the PCSP and threaten key pharmacy services, particularly in respect of harm reduction services.

The proposals contained in the document herald a significant change to current practice. The ambitious nature of the programme builds on the innovation first experienced within the Right Medicine. The proposals present a unique opportunity for the profession to take on a more active responsibility for patients within the NHS.

I can be contacted on 0141 211 0255 should you wish to discuss or clarify any aspect of this submission.

Yours sincerely

David Thomson  
Director of Pharmacy