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**AREA PHARMACEUTICAL COMMITTEE**

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Date 28<sup>th</sup> May 2004  
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Dear Mr Naldrett,

**Modernising Community Pharmacy in Scotland**

Borders Area Pharmaceutical Committee welcomes the opportunity to comment on the consultation paper – **Modernising NHS Community Pharmacy in Scotland**, which was considered at their recent meeting.

The committee welcomes the Scottish Executive's commitment to improve patient care and to better utilise the skills of community pharmacists and their support staff to meet local needs. The committee in common with many individual pharmacists, feel that the present structures in which community pharmacy currently practices, does not meet the needs of their patients or their own professional development. The administrative arrangements, which may have been suitable in 1948, no longer reflect the needs of the NHS in the 21<sup>st</sup> century.

Our detailed comments follow as **Appendix 1**.

Yours sincerely

DAVID J DALGLISH  
Head of Pharmacy

## Appendix 1

### Section 2 - Introduction of New Community Pharmacy Contract.

**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 require legislation changes** to 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 and external 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 e.g. the precise standards for the provision of certain chronic medication services will change over time. **It is therefore more appropriate that the legislation directs that when national 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.**

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

**Patient registration is critical 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 pharmacist.** Currently, patient registration is also a requirement for the provision of the minor ailment service. This is for administrative reasons, and in some ways it 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.**

### **Out of Hours Services – Direct Supply Scheme**

Pharmacy is one of the professions, which is being asked to contribute to patient care during the hours that no general medical practitioner service is available and in particular during weekends. This may be possible using the Direct Supply Scheme, Patient Group Directions or Pharmacist Prescribing, **however, given the time which we will require to train all existing community pharmacists as pharmacist prescribers, legislation or accelerated roll out of the Direct Supply Scheme may need to be considered.**

### **2.7 New Pharmacy Contract -Timescale**

The committee expressed concern that the schedule for the introduction of the new pharmacy contract seemed very tight and will community pharmacy be ready for the introduction of the new contract

### **2.8 Terms and conditions of service - Training**

The committee expressed some concern as to the provision relating to the quality of services and in particular training. **Will the Scottish Executive have a system of accrediting training or will this be provided by NHS NES?**

**The committee also felt that a career progression structure underpinned by a national training programme akin to that developed for hospital pharmacists in Scotland, which would then reflect on individual pharmacists capability to provide services.**

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. It would also be useful for NHS community pharmacies to participate in relevant NHS QIS programmes. Clearly the way in which the data is handled, interpreted and publicised requires great care.**

### **Section 3 – Planning & Provision of Pharmaceutical Care Services.**

**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?**

**Are there alternative models for fulfilling the policy intention for patients?**

#### **Funding issues**

**The committee while welcoming the introduction of processes which could lead to a properly planned local pharmaceutical service which reflects local care needs, is concerned that rural areas such as the Borders have many remote geographical areas which may be considered as under provided for. Thus any relocation of pharmaceutical services would be potentially more expensive than in urban areas and funding to NHS Boards should reflect this.**

#### **Dispensing doctors**

**The committee felt strongly that, as part of the planning and provision process, dispensing doctor services should be included in any needs assessment.**

**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 legislation should define 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. Further detail with regard to national standards to be achieved 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 by definition there is no need for another community pharmacy contractor to start providing these core services **again**, plus a new needle syringe exchange service. **Thus, consideration should be given to the potential value of awarding 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 pay practice allowance fees for community pharmacies, which exist in areas 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 elsewhere. **Thus, the opportunity to incentivise change is welcome but the detail will be 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 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.**

**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)?**

**While welcoming the proposals for extended pharmaceutical lists to include all pharmacists practising in a Health Board area, the committee felt that a ‘smart’ process was `required to register those pharmacists who practice across Board boundaries. This is particularly relevant in rural areas such as the Borders where we rely on locum support from out with the area.**

**With this caveat the 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. 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 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.

### **Who should the contract sit with**

**The committee felt that there was some merit in the contract being with an individual pharmacist/s, providing they then contracted to provide pharmaceutical services from premises, which met the necessary standards. For example this could mean that the services could be provided from a health centre/surgery. They felt that this concept was worthy of further consideration.**

## **Section 5 – Persons Authorised to Provide Pharmaceutical Services.**

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

**The committee endorses the relaxation of the present supervision requirements, which do not reflect the requirements of patient care. However, we feel that it is essential that a debate be held with the profession to reach a consensus with which all pharmacists can comfortably work within.**

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. **It is therefore imperative that the need to properly fund the training of support staff is recognised by the new contract.**

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

**Do you agree that it is desirable to have powers that will encourage and allow innovative ways of providing pharmaceutical services in the future?**

**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. 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 with robotic technology.**

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.**

The intention 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 Area Pharmaceutical Committee was not convinced of the patient benefit of this proposal.**

The administrative arrangements associated with this may be complicated. **The principle sent out in paragraph 6.14, which indicates that even if a pharmaceutical service is provided by a distant dispenser out with 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.**

**Are there any other options for assisting Boards to financially manage the planning and delivery of pharmaceutical care service requirements as proposed at Section 3?**

**It is useful that a Board, which takes responsibility for developing a pharmaceutical care services plan, also takes responsibility for financing the results of that plan.** This provides a driver and a mechanism for ensuring that the plan prepared by the individual Health Board area finds the appropriate balance between services for its resident population and affordability.

Experience with the new GMS contract and other services, which have been devolved from central government level, illustrate the complexities involved in this. **Thus, the suggestion of a “pace of change” model, which will allow this practice to happen over a ten year period is useful.**

It is expected that methods of pharmaceutical practice will change significantly over that period of time. Thus current proportions of the global sum provided to each Health Board area may change significantly, partly because of the greater emphasis on clinical care, but also because of the new opportunities for distant dispensing and the requirement of Boards to pay for the services provided for patients within their resident area, rather than pay for services which are provided by pharmacies within their area. **While agreeing in principle with the concept of devolvement, we recommend research be commissioned to facilitate the appropriate provision of monies to Health Boards to cover their service requirements.**

**The committee hopes that the Scottish Executive will ensure that the added costs of providing pharmaceutical services in rural areas is taken into consideration when allocating funding to Health Boards. Consideration should be given to the special needs of rural areas, for example the difficulty in maintaining clinical pharmaceutical services to small community hospitals.**