

Dear Ms. Braham,

Re: Modernising NHS Community Pharmacy in Scotland

As a leading provider of pharmacy services within Scotland, we are pleased to respond to the above consultation. We recognise that legislation changes may be required in order for The Right Medicine and the new pharmacy contract to be successfully delivered.

We have considered the proposals carefully. Our response covers our position in terms of the areas that we support and the changes that we seek, our outstanding questions, and our thoughts on the specific questions posed by the consultation.

We would welcome the opportunity to meet with you to discuss the proposals further so that we can gain a complete understanding of the full range of issues being addressed and the intended outcomes. Such a discussion would be useful to clarify the proposals (especially those contained within section 6), address some of our concerns and questions, and overcome any misunderstandings that we may have drawn from the consultation.

The consultation covers a wide range of issues. Whilst we recognise the benefits of addressing the issues in principle without the distraction of too much detail, we believe that a second consultation stage is necessary to clarify the range of initiatives, the impact that they will have on community pharmacy and the impact on current legislation.

We are happy for our response to be made public, and for the Scottish Executive to contact us to discuss any issue further.

I would appreciate it if you could confirm receipt of this e-mail. A hard copy of our response is in the post.

With best wishes,

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Modernising NHS Community Pharmacy in Scotland

Response from Boots The Chemists

Section 1: Legislative background and general overview

Our position

We advocate that all directed services provided by pharmacists be delivered by 'full service' pharmacy contractors alongside the Core Service offer.

We also believe that Pharmaceutical Care Services (PCS) should be complimentary to the services being delivered within the nGMS contract. We consider this essential both in terms of service to patients and to encourage closer working with GPs.

Questions

Paragraph 1.9 states that pharmacists providing directed (locally commissioned) services must appear on the pharmaceutical list, and that some of these directed services can be provided by other organisations.

With respect to pharmacists providing directed services, is it intended that the opportunity to provide such services will only be open to contractor pharmacists (or their pharmacist employees) who provide the full range of Core Services, or will 'peripatetic' pharmacists also be authorised to provide such services?

Section 2: Introduction of the new pharmacy contract

Our position

The following comments are preliminary given that the detail of the Core Services of the new contract has still to be agreed.

We support:

- A system of remuneration that provides incentives to improve and deliver quality healthcare services.
- The central negotiation of terms of service and remuneration for the Core Services within the new pharmacy contract.
- The inclusion of additional services within the contract for local commissioning.
- The plan for Core Services to be provided by all pharmacy contractors across Scotland and for these services to include those listed in paragraph 2.7.
- The principle that standards need to be set nationally for quality of services, standards of clinical practice, the training and qualifications of staff and the standard of premises and equipment. However, these may be best set out in a clinical governance framework as opposed to legislation.

We advocate that:

- Core and locally commissioned pharmacy services be subject to national pricing and specification.
- Patients have the freedom to choose their preferred pharmacy for each service (including supply) and on each occasion, as opposed to being restricted to the use of one pharmacy as is implicit under a patient registration scenario (2.9). Continuity of patient care for pharmaceutical care services could be ensured through the provision for pharmacists to have read/write access to patient care records.
- A centralised enforcement body, acting on behalf of Boards, monitors and ensures pharmacy contractor compliance with the terms and conditions of service, the contract and regulatory requirements. This monitoring and audit activity must be proportionate to ensure that the focus on patient care continues to be paramount.
- Clinical protocols/SOPs for pharmacy services within the new contract are not written so as to be unduly prescriptive in directing how such services are provided, but instead concentrate on the outcomes required.
- The reference to patient counselling in paragraph 2.9 be clarified as this could cover the handing out of medicines to patients through to a full medication review.
- The greater emphasis in the future on the clinical management of patients will not jeopardise the quality of the current supply service.
- Adverse incidents are reported to a single body rather than to individual Boards for reasons of efficiency (for community pharmacy and Boards), and for consistency of reporting and interpretation. We believe that patients' interests would be best served if Scotland commissioned the National Patient Safety Agency to be this single body so that its responsibilities could apply seamlessly across Scotland and England. This would provide comparability across countries and an increased rate of learning for Scotland.
- All requirements placed upon contractors for the delivery of NHS services be appropriately funded as part of the new pharmacy contract. This should include the work required to maintain e-pharmacy initiatives (this is excluded from the impact assessment provided in section 8).
- A comprehensive impact assessment needs to be undertaken prior to implementation of the new pharmacy contract.

Our concerns:

- The expectation that the new pharmacy contract will add little to Boards' existing financial commitments probably understates the likely position. Advantage needs to be taken of relevant experience gained from implementing the nGMS contract.

Questions

- a) How will the commissioning volume of each pharmacy service within any Board area be determined?
- b) How will the distribution of each patient service be determined between contractors?
- c) Will the core and locally negotiated services be subject to a national specification? How detailed will these specifications be?

- d) Is it intended that locally negotiated services, as well as the core pharmacy services, will be remunerated on the basis of a nationally agreed pricing structure?
- e) Is it intended that patients will be required to register with a single pharmacy for all non-supply services, or for named specific services?
- f) How will Boards monitor and ensure compliance by contractors?
- g) Will designated areas for patient counselling be defined and, if so, how? What services will require the use of such areas?
- h) What information will contractors need to provide to Ministers or Boards?

Consultation question

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

We welcome the intention for pharmacies to become more closely involved with the clinical management of individual patients but have noted the lack of reference to the provision of seamless patient care, particularly in partnership with GPs. Is this omission intentional?

It is important that community pharmacists continue to work towards greater integration with the wider primary care team to support patient care. Read/write access to patient care records is essential to optimise the delivery of seamless and high quality care to individual patients.

Legislative changes to extend pharmacists prescribing responsibilities and the right to amend quantities, dosage form etc. need to be considered, especially within the context of serial dispensing.

We believe that independent prescribing by pharmacists offers significant benefits to patient care and advocate that this is given serious consideration.

Section 3: Planning and provision of pharmaceutical care services

Our position

We support:

- The need for Boards to plan and secure the provision of pharmacy services under both national and local contracts to ensure patient access, especially those in rural, remote and deprived areas.
- The requirement for Boards to publish their plans and to consult with appropriate professionals, patient representatives and the general public. (We assume that the consultation process will include pharmacy contractors and Area Professional Committees? This is a must).
- The need for Boards to identify areas of 'under-provision' and to secure services to address unmet patient needs. We also support the principle of Boards being required to follow a formal staged process to secure its pharmacy services, and we agree with the process outlined for securing Core Services.

However, we believe that underprovision of locally required services needs to be approached slightly differently to the underprovision of national contract services. Core Services PCSP

contractors should be offered the opportunity to provide locally required services in the first instance.

Our concerns:

- We disagree with the proposal to replace the current 'necessary or desirable' test with a more objective assessment for determining where pharmaceutical care services are to be located or delivered. The current test is sufficiently flexible to allow for local variation in service requirements and its definition has been clarified over the years by various National Appeal Panel judgements and judicial reviews. It is difficult to envisage a more objective assessment than 'necessary and desirable'.
- We believe that it is unnecessary for Boards to review all existing NHS pharmacy contracts against the PCS Plan, and to grant 'new' PCSP contracts that continue to operate as they did previously. This seems unnecessarily bureaucratic and expensive, particularly given our expectation that most of the contracts will not change under the proposals. This is reinforced by the acknowledgement documented in the consultation that '90% of the public find the location of their pharmacy convenient' with a statement that the issue is the under-provision of pharmacy services in areas of high deprivation and in rural and isolated communities.

This suggests that, while some improvements to access and services can undoubtedly be made, a wholesale shake-up of pharmacy contracts is not necessary. Any perceived 'over-provision' is best dealt with by market forces. Individual pharmacies cannot continue to be viable without patients and the public voting with their feet to support the business.

It follows that we do not support the transfer of existing pharmacy contracts to 'holding contracts' in the case of 'over-provision'. We also do not support the regular review of existing contracts against a background of a threat of termination. Whilst we appreciate the need for Boards to continually review their PCS Plans, this should be on the basis of meeting unmet needs. Both proposals will only serve to create considerable uncertainty and a significant barrier to investment on the part of contractors.

- We are sceptical that Boards will be able to provide sufficient assistance and financial incentives to enable 'over-provision' contractors to re-locate, particularly if large numbers are involved. Assistance would need to cover business sustainability as well as the initial re-location.
- The proposals omit to discuss the process by which Boards will identify unmet pharmaceutical needs and the need for a contract. A nationally defined process consistent across Boards is required.
- There is also no reference to an appeals process. This needs to be included.
- All directed services provided by pharmacists should be delivered by 'full service' pharmacy contractors alongside the Core Service offer. We are not clear from the proposals whether this is the intention.
- It is imperative that a full regulatory impact assessment is completed once more details are available for the new pharmacy contract and for all of the proposals contained within this consultation. The partial regulatory impact assessment does not appear to be comprehensive as it excludes, for example, the proposed requirement outlined in paragraph 6.9 for each Board to control every pharmacy in their area (with duplication between Boards), and the additional administration required to support proposal 6.14.

Questions

- a) How will the PCS plans be developed and reviewed, and by whom? How frequently will the reviews take place? Who will be consulted? Will the process be consistent across Boards?
- b) What criteria will be applied to determine 'under-provision'? Will neighbourhoods still be defined geographically? How will the need for specific pharmaceutical services be determined? What is the definition of out of hours services?
- c) What criteria are being considered to determine 'over-provision'? What would the arrangements for assistance look like? How will they enable contractors to combine forces?
- d) What 'more objective assessment' is being considered to replace 'necessary and desirable'?

Consultation questions

1. *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 access needs?*

Possibly, if Boards concentrate on maintaining the existing level of provision of pharmacy services (range and accessibility) in conjunction with meeting unmet patient needs. It is difficult for us to comment further without the benefit of further detail and answers to the questions that we have raised above.

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

We recommend that the proposal to allocate 'holding contracts' to a proportion of existing contractors be dropped so that all existing contractors can continue to deliver and develop services for their patients and customers. The proposal to review all contracts on a regular basis, with the threat of withdrawal, should also be removed to encourage business sustainability.

The "necessary or desirable" test should be retained as the basis of the control of entry regulations to avoid disruption to current provision of pharmaceutical services and to ease implementation of the new national contract. In addition, steps should be taken to improve the current application and appeals processes, by reducing bureaucracy and the costs to both business and the taxpayer. For example, an application fee should be introduced to reduce the number of speculative applications.

The role of Boards should be to focus on identifying areas of lack of provision, to secure services to meet these unmet needs and to ensure that existing services continue to be delivered satisfactorily. Any issues of 'over-provision' should be left to the market (i.e. patients and the public) to decide.

The Essential Small Pharmacy Scheme should be reviewed to maximise its role in serving rural, remote and deprived areas.

Section 4: Pharmaceutical lists

Our concerns

- We do not accept the proposal as we believe that non principals in pharmacy are already responsible for their own actions or lack of action, and are effectively held to account for their actions or omissions by their employer contractor, the RPSGB and, when appropriate, the

police and public. A comprehensive list of pharmacists is already available in the guise of the register of the Royal Pharmaceutical Society of Great Britain.

- We believe that the NHS should consider carefully the consequential risks to the delivery of pharmaceutical services. The use of pharmaceutical lists for non principals may lead to inefficiencies and loss of service to patients, as many pharmacies rely on non principals to provide pharmaceutical services on a day to day basis. Unless the pool of employees is registered with all Health Boards there is a serious danger that false shortages of pharmacists will be created, leading to unexpected loss of service and an adverse impact on patients.
- Any NHS decision to refer a non principal to a NHS Discipline Committee or the NHS Tribunal will drive implications for the NHS.

For example, where a decision is taken by the NHS to prevent an employee pharmacist practising in a Health Board area we would expect the NHS to meet the cost of implementing this decision. Under current arrangements, contractors are responsible for addressing issues that relate to employee performance, including inadequate standards, and are required to meet any associated costs. Should the proposal go ahead we would wish to know that the NHS had fully considered the proposal against the various responsibilities placed on employers, and that the proposals for the NHS to hold employees to account are consistent with the responsibilities of contractors to employee pharmacists.

Secondly, if a pharmacist were to be prevented by the NHS from practising in one or more Health Board area(s), the principal would be left with little alternative but to terminate employment. In such circumstances, the likelihood of employment tribunal claims for unfair dismissal would be high, and the Board would inevitably be drawn into these proceedings.

Finally, how would NHS decisions sit with the responsibilities of the Statutory Committee of the Royal Pharmaceutical Society of Great Britain?

- We do not agree with the comment made in paragraph 8.23 of the regulatory impact assessment that 'no costs attach to this policy proposal'. The proposed requirement for non principals to be entered onto pharmaceutical lists will significantly increase the administrative burden that is placed on all pharmacy contractors, particularly given the significant use of locums within community pharmacy and the need for non principals to cover different pharmacy premises within multiple chains.

Questions

- a) What is the nature of the benefits being sought under this proposal, particularly as most/all pharmacists will need to be listed on all NHS Boards given the proposals contained within section 6?
- b) What data will be held on the lists?
- c) What 'certain undertakings, consents and declarations' will be required to be provided with applications from principals and non-principals?
- d) What will be the nature of the 'fast track' process based on the applicant having a 'host' Board?

Consultation question

Are there any further actions that 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)?

A high standard of clinical governance would best be achieved by developing a clinical governance framework as part of the new pharmacy contract, and by developing specifications for the core pharmacy services, as well as an agreed list of services for local negotiation.

For a small number of specialised new services, it may be necessary for individual named pharmacists to receive additional training and accreditation prior to them providing services to patients. This training and accreditation should be specified nationally. However, contracts for individual services should not be placed with named pharmacists. All contracts with Boards for pharmacy services should remain with pharmacy contractors i.e. principals.

Section 5: Persons authorised to provide pharmaceutical services

Our position

We support:

We welcome the proposal to remove the requirement for 'direct supervision' to an amended requirement for 'supervision'. This will provide consistency with the Medicines Act and will remove any necessity for the meaning of 'direct' supervision to be clarified in the courts in the future.

Our concerns:

The partial regulatory impact assessment assumes that there will be no policy or implementation costs. We agree that this would be the case for the proposal as written as we do not envisage any change in pharmacy practice materialising as a result (see below). However, if supervision and personal control were to change materially from status quo, significant changes in practice and skillmix could ensue with a consequential change in the cost of service provision and staff training/development.

Consultation question

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

We do not believe that this amendment alone will create any opportunity for change in pharmacy practice, given that the requirements of the Medicines Act for supervision and personal control will remain unchanged.

We would support a review of pharmacist supervision to enable pharmacists to spend more time with patients whilst retaining the presence of a pharmacist in each pharmacy for all (or possibly most) of the time during opening hours. This would ensure that people continue to have continuous access to the full range of pharmacy services, together with expert professional information and advice. This is what patients, and the public as a whole, expect and deserve.

In any revised arrangements, a named pharmacist must remain accountable for a maximum of one pharmacy. If a pharmacy is to be allowed to continue to trade without a pharmacist at any time, such absences should be tightly defined and be supported by appropriately trained staff who are working to robust protocols, and who can access the pharmacist at all times.

Section 6: Cross boundary and distant provision of pharmaceutical services

Our position

We support:

- We agree in principle that pharmacies need to be regulated and inspected to ensure that patients receive high quality services and standards of care.
- On the proviso that our first concern is met (see below), we agree that distant dispensing contractors should only be able to dispense and supply medicines/appliances direct to a patient if the prescription is presented at or through a pharmacy contractor who provides a full pharmaceutical care service under the national contract.
- We agree in principle that some regulatory powers may be required to ensure an appropriate level of control e.g. to prohibit the supply by distant means of CDs, and appliances that require fitting. However, these controls must not be unnecessarily restrictive.

Our concerns:

- We have recently launched an UK-wide internet distant dispensing offer to widen patient and public access to the pharmaceutical services provided by Boots The Chemists. This service is delivered from a pharmacy that provides a full NHS pharmaceutical service and allows patients to present their prescription to the pharmacy remotely, via the internet with the prescription being posted to the premises. We believe that these proposals provide for such a service, but would appreciate positive confirmation that this is the case.
- The proposals appear to assume that dispensed medicines will be supplied from pharmacy premises, or be delivered to the patient's address. It is currently legal for medicines to be delivered to any address requested by the patient or their representative, and we believe that this should continue so that patients can be guaranteed continuity of supply irrespective of their personal circumstances.
- The rationale for the requirements described in paragraph 6.9 for cross-boundary or distant dispensing services are not clear to us i.e. the nature of the benefits of individual pharmacies being named on the pharmaceutical lists of multiple Boards, and the need for pharmacies to be controlled by every Board on which they are listed.

We advocate that individual pharmacies should only be inspected and controlled by a single body, and that this body should be a national body to ensure that consistent standards are applied across Scotland. Individual Boards should adopt 'lead' status for pharmacies located within their area, and should work with the national inspectorate body to ensure that a high standard service is delivered.

The proposals will place a significant burden of increased bureaucracy and costs on both pharmacies and Boards, much of which could be avoided through the use of a single national agency. These costs have not been recognised in the partial regulatory impact assessment.

- As previously discussed under section 2, we believe that patients should be able to enjoy freedom of choice to receive dispensing and non-supply pharmaceutical services from the pharmacy that best meets their needs on each occasion, based on convenience, personal relationships, service offer etc. A requirement for patients to register with a single pharmacy for one or more services will significantly restrict patients' freedom to choose.

- Whilst we agree with the principle that Boards pay for services received by their patient population, we are concerned that this may only be achievable for non-supply pharmaceutical services through pharmacy contractors undertaking a significant increase in administration on behalf of Boards. This has not been recognised by the partial regulatory impact assessment. (We assume that the appropriate payment of dispensing fees/allowances could be handled centrally by the Common Services Agency in the same way as they do now for medicines and appliances).

Questions

- a) How feasible will it be for a distant dispensing pharmacy to make legal supplies against a copy of a prescription held by a pharmacy under different ownership?
- b) Could legal accountability for pharmaceutical assessment and supply be split satisfactorily between pharmacies, under the same ownership or under different ownership?
- c) Will those internet /mail order pharmacies that do not have a 'bricks and mortar' premises with public access be able to meet all the requirements of the full pharmaceutical service?
- d) How willing will Boards be to list Scottish distant dispensing pharmacies located within a different Board? What will the 'patient needs' criteria look like? Will the nature of the distant dispensing pharmacy (i.e. whether the pharmacy premises offers public access) have any bearing on the decision?
- e) Will it be possible for pharmacies offering a full pharmaceutical service in England to obtain distant dispensing contracts with Health Boards in Scotland?
- f) The proposals cover the delivery of medicines to patients' home addresses. Will patients or their carers be able to continue enjoying their current freedom to choose other appropriate locations for the safe delivery and/or collection of their medicines?
- g) Will it be feasible to enforce the proposed legal requirement that a pharmacy must be named on the pharmaceutical list of a Board if it wishes to deliver medicines direct to patients at addresses located within the Board?
- h) Do the powers referred to in paragraph 6.14 relate to dispensing fees/allowances and fees for non-supply pharmaceutical services?
- i) Will patients have complete freedom of choice to (a) present their prescription to any pharmacy within Scotland (and England/Wales) and to (b) receive a NHS service from any pharmacy irrespective of whether the pharmacy is located within or outside of the Board area in which the patient resides?

The following commentary may provide some insight behind our question based on our interpretation of the proposals:

It would be helpful to define the meaning of cross-boundary services, as we are not completely clear of the intended meaning. For example,

- is it the delivery of medicines to a location outside of the Board in which the pharmacy is located (this would restrict the definition of cross-boundary to supply only), or
- is it the supply of a medicine or service to a patient who lives within a different Board (this would make the term applicable to all pharmacy services)?

The interrelationship between a number of statements in the proposals is also not completely clear to us:

- i.* Boards have a statutory duty to ensure that pharmaceutical services are provided to all patients who present at the community pharmacies in their area, regardless of whether they live in that Board area or another (paragraph 6.3).
- ii.* Legislation would be expected to detail the people to whom services may or must be provided e.g. to patients referred by a GP and who register with the community pharmacist (paragraph 2.9).
- iii.* Contractors who wish, or who are commissioned to provide, cross-boundary or distant dispensing services will also require to be entered on the list of the Board in whose area the services will be provided or delivered and, thereby, that Board will be responsible for the control and regulation of those services (paragraph 6.9).

Statements (i) and (ii) appear to contradict each other as (i) appears to allow patients the opportunity to access services from any pharmacy whilst (ii) introduces the idea of registration. Is there an unstated intention to amend the statutory duty placed on Boards as described under (i)?

Statements (i) and (iii) may also not sit comfortably alongside each other as (i) can only be fulfilled if all contractors wish to be cross-boundary or distant dispensing contractors and therefore wish to be listed on every Board, apply to do so, and are successful in their application. This would appear to contradict the proposal given within paragraph 3.7 for Boards to determine where pharmaceutical care services are to be located or delivered via a control mechanism of pharmaceutical lists.

Statement (iii) will lead to each pharmacy being inspected and controlled by every Board in Scotland – is this intentional given the significant implications for Boards and pharmacy contractors?

Consultation Questions

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

We agree that innovation in the provision of pharmaceutical services should be encouraged.

However, we are not clear how the proposals will fulfil this. Firstly, they appear to be associated with an increase in control and bureaucracy. Secondly, we are concerned that the intention may be to place a significant restriction on the choice of pharmacies that patients can access for services (and possibly prescriptions?).

The level of potential income from the proposed distant dispensing model is unclear and will be dependent on multiple negotiations between individual contractors. Potential demand from Core Service contractors for the services of independently owned distant dispensing only contractors cannot be assumed.

Indeed, the distant dispensing pharmacy contractor model does not appear to be overtly commercially attractive (based on the assumption that Core Service contractors will exert downward pressure on the dispensing fees that can be negotiated by distant dispensing pharmacies). The opportunity may only appeal to those Core Service contractors who own a number of pharmacies, or to a very small number of new contractors who manage to develop a near monopoly distant dispensing only service across Scotland by establishing commercial relationships with significant numbers of pharmacy contractors.

2. *Do the proposals offer sufficient flexibility for patient choice, convenience and safety, or should they go further?*

i. Patient choice and convenience:

It is not clear to us how the proposals

- 'give patientsgreater flexibility in the way that pharmaceutical care services can be accessed and delivered' (paragraph 6.1)
- 'give patients greater flexibility in the way that they can present prescriptions' – paragraph 6.6).

For example,

- Any move towards patient registration (as implied in paragraph 2.9) will significantly reduce flexibility of patient choice and convenience.
- Current legislation allows patients to have their medicines delivered to their home, or indeed to any other address. It is not certain that these proposals will drive any increase in delivery of medicines, and may constrain it unnecessarily if the intention is to restrict delivery to patients' home addresses. However, a financial incentive to pharmacy contractors definitely would drive an increase in delivery of medicines.

However, the implementation of ETP technology would provide patients with greater flexibility in the way that they could present prescriptions, dependent on system and implementation design.

ii. Patient safety:

- The proposals include reference to new powers to control cross-boundary and distant dispensing arrangements. We recognise in principle that additional powers may be required to ensure patient safety but cannot comment until further detail is provided.
- Any new powers need to be accompanied by appropriate monitoring and inspection. As already discussed, we believe that this would be best achieved by a single body working to national standards on behalf of a lead Board for each pharmacy.

Section 7: Funding of pharmaceutical services

Our position

We support:

- We agree in principle that financial accountability is required at Board level, aligned with responsibility for the planning of service provision, but on the proviso that the funding for pharmacy is ringfenced to enable contractors to be fully funded for service provision under the terms of the national contract.
- We agree with the requirement that Boards must remunerate pharmacy contractors fully in accordance with the nationally negotiated contract arrangements. We also support the ability of Boards to pay additional sums where, for example, the proposed provider offers a more enhanced service.
- We support the implementation of a 'change of pace' policy for Boards to ensure that changes in financial arrangements can be implemented smoothly over time.

Our concerns:

- It is difficult for us to comment on the proposals without further information being available. Inevitably the proposals provide little insight about the potential impact of future funding arrangements on community pharmacy and individual contractors.
- We seek reassurance that:
 - pharmacy contractors will receive a 'fair return' for their services under the new contract to reward their investment in service delivery for improved patient care.
 - pharmacy contractors will benefit from a 'pace of change' policy in the same way as Boards.
 - patients will be able to enjoy access to the full range of Core Services provided at an appropriate level of volume, irrespective of where they live.
 - nationally agreed pricing and specifications will be provided for all services i.e. core and locally negotiated.
 - there will be a level playing field for the determination of service provision between pharmacy contractors.

Questions

- a) Will the 'global sum' fund the full range of Core Services within the new pharmacy contract? Will it fund Core Services exclusively or also cover other elements such as clinical governance?
- b) Will those elements of the 'global sum' allocated to Boards be ring-fenced for pharmacy contractors? What will be the impact on Boards and pharmacy contractors of decisions by Ministers to allocate 'global sum' monies to Boards for specific services?
- c) How would potential overspend be handled?
- d) Funding will be allocated to Boards on a needs based/weighted capitation formula. What will be the arrangements for funding individual pharmacy contractors across the range of services provided?
- e) What will the financial impact on individual pharmacy contractors? How will initial variations between the formula calculation and payment levels to individual contractors be handled i.e. will there be a 'pace of change' policy for contractors?

Consultation questions

1. *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?*

We would be happy to consider other options further to the provision of more information to give us better insight into the proposals.

Section 8: Partial regulatory impact assessment

Our position

We support:

- We agree that it is not possible to assess the financial impact of the proposals at this stage. We support the agreement reached between SEHD and SPGC that any new fee/allowance structure will be subject to impact analysis and that any significant changes in remuneration levels will be managed in over an agreed period of time.
- We support implementation of *The Right Medicine* and the need for any legislative changes. We are unable to comment on the relative merits of options 2 and 3 given the lack of clarity over the legislative changes that will be required to support the final proposals once these are drafted following this, and any subsequent, consultation.
- We agree with the conclusion of the impact assessment that patients would benefit from community pharmacists authorising repeat prescriptions and providing medication reviews and health checks.

Our concerns:

- We are concerned that the partial regulatory impact assessment understates the impact and cost of the proposals. A comprehensive impact assessment should be undertaken and consulted upon once more detailed proposals are available.
- We are surprised that the impact assessment does not consider the importance of a successful implementation of e-pharmacy.
- It is imperative that pharmacy contractors are rewarded with financial stability and a fair return for NHS service provision to ensure sustainable investment for improved patient care.

Our comments on the regulatory impact assessment specific to the various sections are incorporated within the discussion on individual sections.