

Response to

MODERNISING NHS COMMUNITY PHARMACY IN SCOTLAND

By Lindsay & Gilmour

Lindsay & Gilmour

Lindsay & Gilmour is one of the largest Scottish based pharmacy groups, operating 23 pharmacies in East Central Scotland and the Scottish Borders.

Summary

Lindsay & Gilmour welcome the proposals as an opportunity to work together to improve patient health and to give enhanced value to the NHS from community pharmacy. For this to be truly effective a realistic approach to the additional costs of providing new services and the benefits that could flow from them is required.

Community pharmacy is one of the oldest and most efficient examples of private businesses providing a public service and is a model for public-private partnership. We share the aims of this document, but the authors often show insufficient understanding of how the industry and market forces work. Further thought needs to be given to how to maximise efficiency by working co-operatively, with pharmacy businesses and encouraging investment in new services, with each partner focusing on what they do best. The industry is expert at efficient and cost effective delivery. Health Boards' powers should be focused on setting and measuring outcomes.

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?

We have concerns over local negotiation. Although there are benefits in fine tuning services to meet local needs, the parameters within which a national framework for the provision and remuneration of services can be varied at local Health Board level, need to be carefully defined if we are to avoid having every Board reinventing the wheel and some of them coming up with new innovative square ones.

Section 3 - PLANNING AND PROVISION OF PHARMACEUTICAL CARE SERVICE

Are these proposals a comprehensive way of ensuring patients have convenient access to a range of pharmaceutical care services that takes account of care and access needs?

No. The proposals for holding contracts are impractical and divisive. They could undermine industry confidence; stifle investment and set patients and contractors on a collision course with Boards. It opens up all kinds of potential conflicts over who decides

who gets what contracts, whether or not they are comparable and who is going to compensate for the difference if they are not. They are also unnecessary.

Are there alternative models for fulfilling the policy intentions for patients?

Yes. By understanding why the market is under-providing in certain areas and over-providing in others, it can be manipulated to work more efficiently, working with the industry not against it.

Inadequate provision of services may result where there are barriers to providing them, where it is impractical or not cost effective. Otherwise the industry would already be providing them. Additional support or remuneration may be required to incentivise higher levels of provision in certain areas, e.g. by more realistic essential small pharmacy payments. Offering new contracts in underprovided areas to contractors with holding contracts will not address the underlying problems of why the service is inadequate or uneconomic.

Since its introduction contract limitation has generally served to prevent waste of manpower and resources through pharmacy clustering; however repeated scares that it will not be permanent have prevented investment in rationalisation of the clusters which grew up prior to its introduction. The key to rationalisation of pharmacy distribution is to provide the industry with assurances that money invested in amalgamating neighbouring businesses will not be wasted; that there will be no return to a free for all, despite the OFT's zeal for de-regulation, and that pharmacy closure cannot be used as justification for a new contract, if there is adequate provision by the remaining contractors. The process could be accelerated by sharing some of the savings to the NHS with the amalgamated pharmacies and if this was conditional on providing additional services, patient care could also be enhanced at a reduced cost. (SEE APPENDIX)

Section 4 –PHARMACEUTICAL LISTS

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)

The issue of how continuously to provide specialist clinical services when the main pharmacist qualified to provide them is unavailable needs to be addressed. Boards should work with the industry and the Pharmaceutical Society towards that end.

The fluidity of the labour market needs to be recognised and taken into account in the planning process. Restricting labour movement will not turn the clock back to a time when people stayed in one job for life, it will create barriers to the efficient management of the modern labour market.

Lindsay&Gilmour have already had the experience of being unable to run clinics while the pharmacist responsible was on maternity leave, not because we couldn't find a pharmacist qualified to run them, but because the local Health Authority insisted on having a pharmacist who had attended their own course and would not recognise a qualification gain under another authority. We need to ensure that the new Health Boards have enabling powers, but that they are not allowed to become blockers of the efficient working of the industry.

Placing elements of the contract with employee pharmacists rather than the main contractor will create further problems for the efficient management of human resources

and could cause uncertainty and instability in the industry undermining investment and the roll-out of new services. Young pharmacists who are often the ones learning the clinical skills required for new services, like all other young professionals are highly mobile, often changing jobs and places of work frequently . Even when based in one place, pharmacists are not at their place of work six days a week 52 weeks of the year, and problems such as the example above of how to find cover during maternity leave would be exacerbated, not relieved, by the proposed changes.

Duplicating the work of the Pharmaceutical Society in checking professional standards and introducing barriers to the free movement of labour from one Board to another by having different requirements for different Boards will raise costs and exacerbate the Human Resource problems the industry is already experiencing.

National standards need to be set for the requirements needed to provide each clinical service, to prevent a proliferation of different standards and levels of qualification being set by different Boards.

Section 5 – PERSONS AUTHORISED TO PROVIDE PHARMACEUTICAL SERVICES

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

A more liberal interpretation of supervision, to allow more delegation and flexible working practices, would be desirable. However, there should normally be a pharmacist on the premises, available for patients and staff to consult. Absences should be the exception rather than the norm.

Section 6 – CROSS BOUNDARY AND DISTANT PROVISION OF PHARMACEUTICAL SERVICES

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

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

Innovations which reduce cost, and improve service, safety and public health are of course to be encouraged. They do however need to be properly trialed and tested before full implementation. This has not been done for remote dispensing. Whether or not there are genuine benefits from relaxation of the distance dispensing restrictions and whether or not the proposals offer sufficient protection against degeneration into an inferior service are far from clear. Off-site packing of compliance aids could give efficiency savings. Remote dispensing of normal prescriptions which are primarily in patient packs could undermine local services while providing no real cost saving.

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

Money allocated to Health Boards for community pharmacy services needs to be ring fenced to ensure it reaches its intended destination and contractor pharmacists need to be involved in the decisions over how the money is to be spent to ensure that proposals are practical and workable and properly costed.

“The Right Medicine” could improve public health, reduce hospital admissions and reduce waste within the health service. The benefits will substantially outweigh the costs, but there will be additional costs. The Global Sum is a tiny fraction of health care costs and the increases needed are small, relative to the benefits they will bring, but without a significant increase in the Global Sum for pharmacy, the benefits will never materialise. The dispensing service is grossly under funded and only survives because of the discounts the industry extracts from the manufacturers. To pursue a “cost neutral” policy of trying to squeeze funding for new services out of existing budgets will doom them to failure and squander the opportunities they represent.

APPENDIX

RATIONALISATION OF PHARMACY DISTRIBUTION

Proposal

In areas where there would still be adequate pharmacy provision following the closure or amalgamation of a pharmacy. No new pharmacies allowed to open following closure. Professional allowance paid to amalgamating/acquiring pharmacy for 7 years, for which they must agree to offer enhanced services. Participation voluntary.

The primary task for the Boards should be to set the conditions which encourage willing buyers and willing sellers, to come together, and to make amalgamation attractive where this would give a more rational distribution of pharmacies within their area. If this is done the main cost of compensating contactors would be met by the pharmacy business(es), benefiting from the closure of their neighbour and would not need to be born by the taxpayer. Any attempt at forced closure or re-location would greatly escalate both the financial and political cost. If exits are voluntary and adequately compensated, industry confidence would not be undermined and there would be no local “save our pharmacy” campaigns, political lobbying and adverse media coverage. All these would be likely results if Health Board managers start trying to dictate where pharmacies are to be located and placing them on holding contracts.

Following take-over or amalgamation, contactors could operate more efficiently from a single site, saving on both establishment and wage costs. The patients would benefit from enhanced services, if these were part of the deal, and the NHS would save, initially on drug costs as the combined pharmacy would pay a higher “clawback”, and ultimately on the Professional Allowance as well.