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Consultation Paper

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MODERNISING NHS COMMUNITY PHARMACY IN SCOTLAND

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MODERNISING NHS COMMUNITY PHARMACY IN SCOTLAND EXECUTIVE SUMMARY & CONSULTATION ARRANGEMENTS

This consultation document outlines the Executive's proposals for legislation that will allow the NHS in Scotland to deliver a number of the community pharmacy objectives set out in its pharmaceutical strategy *The Right Medicine* and, in particular, to support the future implementation of a new community pharmacy contract.

In February 2002 the Department published its strategy for pharmaceutical care in Scotland, *The Right Medicine*. This followed the publication in 2001 of the Scottish Health Plan *Our National Health: a plan for action, a plan for change*. Collectively these documents set an agenda for modernising and redesigning pharmacy services. The overarching aim is to improve patient care and to better utilise the skills of community pharmacists and their support staff to meet the local needs.

In summary this consultation document lists proposals to introduce:

- Provisions to enable the implementation of a New Community Pharmacy Contract.
- New requirements for NHS Boards with regard to planning and securing the provision of pharmaceutical care services in their respective areas.
- A requirement for all registered pharmacists providing community pharmacy services to be entered on an NHS Board's pharmaceutical list.
- An amended definition for 'supervision' of pharmaceutical services so that it follows the approach taken in the Medicines Act 1968.
- Powers for NHS Boards to secure the provision of pharmaceutical services from outwith their area.
- A power that would enable Ministers to designate which elements of community pharmacists' remuneration should be paid from NHS Boards unified budgets.

The document has a separate section for each of the proposals listed above and there is an additional section (Section 1) that provides the statutory background to the proposals with a general overview of how community pharmacy services in Scotland are delivered.

Full implementation of the proposals would require a combination of both primary and secondary legislation and administrative direction. Implementation of any primary legislation requirements would be subject to a suitable legislative vehicle arising.

It is the Scottish Executive's intention that every piece of new policy be consulted upon as widely as possible before receiving final policy approval by Ministers. A fuller note of the Executive's consultation process is provided at Annex B.

Written responses to this consultation paper are invited by Tuesday 1st June 2004:

By e-mail to:

Pharmacyconsultation@scotland.gsi.gov.uk

or by post to:

Susie Braham
Scottish Executive
Health Department
St Andrew's House
1ER
Regent Road
Edinburgh
EH1 3DG

If you have any queries please contact Anne MacLeod on 0131 244 2532.

We would be grateful if you could clearly indicate in your response which questions or parts of the consultation paper you are responding to (using the consultation questionnaire if appropriate) as this will aid our analysis of the responses received. **We would also be grateful if, in responding, you would complete the Respondee Information Form enclosed.**

For future engagement:

If you wish to access this consultation online then please go to <http://www.scotland.gov.uk/view/views.asp>. You can telephone Freephone 0800 77 1234 to find out where your nearest public internet access point is, if you prefer to submit your response by e-mail to pharmacyconsultation@scotland.gsi.gov.uk

SEConsult

A new email alert system for SE consultations (SEconsult) was launched in December 2003. This system will allow stakeholder individuals and organisations to register and receive a weekly email containing details of all new SE consultations (including web links). SEconsult will complement, but in no way replace SE distribution lists, and is designed to allow stakeholders to 'keep an eye' on all SE consultation activity, and therefore be alerted at the earliest opportunity to those of most interest. We encourage you to register as soon as possible.

Access to consultation responses

We will make all responses available to the public in the Scottish Executive Library by Monday 21 June 2004 and on the [Scottish Executive consultation web pages](#) by Monday 25 June 2004, unless confidentiality is requested. All responses not marked confidential will be checked for any potentially defamatory material before being logged in the library or placed on the website.

SCOTTISH EXECUTIVE HEALTH DEPARTMENT

March 2004

MODERNISING NHS COMMUNITY PHARMACY IN SCOTLAND

SECTION 1: LEGISLATIVE BACKGROUND AND GENERAL OVERVIEW

Introduction

1.1 The purpose of this section is to provide a brief overview of the legislative framework within which pharmaceutical services are currently secured and provided. Where appropriate, subsequent sections refer to this section or, where necessary, expand on the summary detail below.

Summary Overview

1.2 Under the terms of National Health Service (Scotland) Act 1978 (“the 1978 Act”) , NHS Boards (“Boards”) are required¹ to make and administer arrangements for the provision of pharmaceutical services to people in their area. Pharmaceutical services consist primarily of dispensing the drugs and appliances prescribed by doctors and other health professionals. Arrangements for the provision of these services are normally made with community pharmacies and, to a lesser extent, appliance suppliers. Boards may also arrange for general medical practitioners (GPs) to provide dispensing services to their patients where there is no ready access to a community pharmacy. However, except where explicitly stated, the proposals in this consultation paper do not extend to dispensing doctors.

1.3 The arrangements made by Boards with community pharmacists and appliance suppliers must comply with regulations made under the 1978 Act . Those regulations (the National Health Service (Pharmaceutical Services)(Scotland) Regulations 1995² - “the 1995 Regulations”) govern the selection of persons to provide pharmaceutical services and set out the terms and conditions under which those services will be provided.

1.4 There is no formal ‘contract’ as such between the Board and a person or business providing pharmaceutical services in its area. The role of the Board in whose area the pharmacy is located is to administer the framework set up by the 1978 Act and regulations. Nevertheless, pharmaceutical service providers are generally referred to as ‘pharmacy contractors’, which for the purposes of this document includes appliance suppliers, and the services are said to be delivered through the ‘community pharmacy contract’.

1.5 Community pharmacists and appliance suppliers with whom a Board has arranged for the provision of pharmaceutical services are included in the Board’s “pharmaceutical list”. An application for inclusion in the pharmaceutical list is, therefore, essentially an application to provide pharmaceutical services in the relevant Board’s area. The procedure for consideration of applications is also set out in the 1995 Regulations and explained in more detail at paragraphs 1.13 to 1.15.

1.6 Although NHS Boards are responsible for arranging the provision of pharmaceutical services in their area, the community pharmacy contract under which they are delivered comprises both centrally and locally negotiated services. Consultations for the former (national contract items) are conducted between the Scottish Executive Health Department (SEHD) and the body acknowledged to represent the general body of community pharmacists in Scotland, namely the Scottish Pharmaceutical General Council (SPGC).

¹ Section 27

² SI 1995/414

1.7 The fees and allowances payable to pharmacy contractors for centrally negotiated services, and amounts they are reimbursed for certain dispensed items, are recorded in the Scottish Drug Tariff³.

Present Definition of pharmaceutical services

1.8 In terms of section 27 the of the 1978 Act 'pharmaceutical services' comprise:

- Dispensing Services, i.e. the provision of proper and sufficient drugs and medicines and listed appliances⁴ ordered by a duly authorised health practitioner. This is a national contract item.
- Additional professional services, i.e. services prescribed by Ministers⁵. These are national contract items and detailed at regulation 4 of the 1995 Regulations and in the Scottish Drug Tariff. Currently, these services cover a range of requirements linked to the payment of a professional allowance (but not to appliance suppliers). In summary the pharmacy contractors must:
 - Set aside areas for displaying health education material
 - Provide advice and counselling to the public on medicines and appliances
 - Arrange the keeping of records of medicines supplied to NHS patients
 - Undertake clinical audit within NHSScotland structures
 - Produce a practice leaflet giving customer advice on NHS services offered
- Additional Pharmaceutical Services – dispensing and advisory services subject to local NHS Board negotiation. These are local contract items covering services that Ministers have directed⁶ NHS Boards to negotiate, and which are listed in the Scottish Drug Tariff⁷. These are generally referred to as 'directed services' and at present comprise:
 - Advisory Services to Residential Homes
 - Methadone Dispensing Services
 - Oxygen Supply Services
 - Needle Exchange Schemes
 - Disposal of Pharmaceutical Waste
 - Out of Hours Services
 - Collection and Delivery Services

1.9 Where the directed service is provided by a pharmacist, it must be a pharmacist on the pharmaceutical list. Some of these directed services can, however, be provided by other organisations, e.g. needle exchange, disposal of waste.

³ See regulation 9 of the 1995 Regulations

⁴ See section 27(1)(a) to (d) of the 1978 Act

⁵ See section 27(1)(d) of the 1978 Act and regulation 4 of the 1995 Regulations

⁶ See section 27A of the 1978 Act

⁷ In terms of section 27A(3) of the 1978 Act Scottish Ministers must publish any directions made under that section in the Drug Tariff or in such other manner as they think appropriate

Persons who may provide pharmaceutical services

1.10 The 1978 Act⁸ sets out the persons with whom a NHS Board may arrange the provision of pharmaceutical services. Generally, arrangements may only be made with a registered pharmacist, or a person lawfully conducting a retail pharmacy business in accordance with the Medicines Act 1968⁹, who undertakes that medicines will be dispensed by, or under the direct supervision of, a registered pharmacist. Additionally, Boards are authorised to make arrangements with a supplier of appliances for pharmaceutical services by way of the provision of appliances.

Regulations

1.11 The 1978 Act enables¹⁰ Scottish Ministers to make regulations governing the provision of pharmaceutical services. As mentioned above, those regulations are the National Health Service (Pharmaceutical Services) (Scotland) Regulations 1995 (“the 1995 Regulations”)¹¹. The 1995 Regulations set out, amongst other things, the “terms of service”¹² for pharmacy contractors. They require pharmacy contractors to dispense, with reasonable promptness, every prescription for drugs or medicines which they are presented with as well as covering a range of other service delivery issues. Such issues include, for example, premises and hours of business, handling of complaints, the application of professional standards and the circumstances in which a pharmacy contractor may withdraw their name, or be removed, from a pharmaceutical list.

1.12 For the purposes of the 1995 Regulations “pharmaceutical services” apply only to dispensing and additional professional services (see paragraph 1.8) and excludes ‘directed services’¹³. However, a pharmacy contractor with whom a Board arranges the provision of any directed service is required to comply¹⁴ with the terms and conditions of the arrangement, as set by the Board.

Inclusion in pharmaceutical lists

1.13 The 1995 Regulations also require¹⁵ Boards to prepare lists of the persons with whom they have made arrangements for the provision of pharmaceutical services. Separate lists are to be prepared in respect of persons who undertake to provide drugs and those who undertake to provide appliances.

1.14 The 1995 Regulations detail how an application for inclusion in a pharmaceutical list is to be made. In most cases ‘control of entry rules’ apply, and an application may only be granted if the local Pharmacy Practices Committee, acting on behalf of the Board, is satisfied that it is “necessary or desirable”¹⁶ to do so in order to secure the adequate provision of pharmaceutical services in the neighbourhood in which the premises in question are located¹⁷. Cases of minor relocation, or where a new provider applies to take over existing arrangements for the provision of services, are excepted from the control of entry rules¹⁸.

⁸ Section 28 of the 1978 Act

⁹ Section 69 of the Medicines Act 1968 (c.67)

¹⁰ See section 27(1) and (2) of the 1978 Act

¹¹ 1995 No. 414.

¹² See Schedule 1 to the 1995 Regulations

¹³ See the definition of “pharmaceutical services” in regulation 2 of the 1995 Regulations as amended by SI 1998/2224, regulation 2(3)

¹⁴ See paragraph 3A of Schedule 1 to the 1995 Regulations as inserted by SI 2001/70, regulation 4(4)

¹⁵ Regulation 5 of the 1995 Regulations

¹⁶ See section 27(3)(c) of the 1978 Act and regulation 5(10) of the 1995 Regulations

¹⁷ See section 27(3)(c) of the 1978 Act and regulation 5(10) of the 1995 Regulations for the ‘control of entry rules’.

¹⁸ See regulation 5(3) to (5) for the circumstances in which the ‘control of entry rules’ do not apply.

1.15 On receipt of an application to which the control of entry rules apply, the Board must notify relevant local committees and persons already included in a pharmaceutical list whose interests might be affected if the application were granted¹⁹. The persons notified are entitled to make representations to the Board and thereafter must be given notice of the Board's decision. Such persons and the applicant are entitled to appeal against the decision. Such appeals are determined by an independent National Appeals Panel.

Funding

1.16 Remuneration for pharmacy contractors comprises two elements, i.e. fees and allowances for service provision, and reimbursement for the cost of NHS drugs/appliances dispensed. The fees and allowances payable for dispensing and other services are paid by the Board on whose list the contractor is included. Payments in respect of locally negotiated services are funded from Boards' cash limited allocations, generally referred to as 'unified budgets'. Payments to community pharmacy contractors for nationally negotiated services are funded from a centrally held 'global sum' with Boards drawing down the amounts they require on a monthly basis.

1.17 The 'global sum' is determined annually through consultations between the Health Department and the Scottish Pharmaceutical General Council. In effect it is a capped sum with any over or under payment in any one year being accounted for in the subsequent year's discussions and by appropriate adjustments to the fees and allowances scales.

1.18 The costs of drugs that the pharmacists dispense for the NHS are reimbursed by the Board with responsibility for the prescriber concerned. Items for NHS dispensing are first purchased by community pharmacists who are subsequently reimbursed according to prices in the Scottish Drug Tariff for generic medicines (previously proprietary medicines but now off-patent) and listed appliances, or on manufacturers' price lists for proprietary items. In both cases the reimbursement arrangements are covered by protocols agreed between the Health Department and the Scottish Pharmaceutical General Council. The protocols provide for the recovery of discounts that community pharmacists can obtain from wholesalers under volume purchasing and other market deals.

1.19 Whilst Boards are accountable for the payments made to community pharmacists the function of calculating and paying the amounts due is undertaken by the Common Services Agency on Boards' behalf.

Conclusion

1.20 To put the above into some context, there are currently around 1,150 pharmacy contractors in Scotland who will dispense something in the region of 70 million items against NHS prescriptions per annum. It is expected that the cost of providing pharmaceutical services in 2003-04 will be in the region of £920 million, comprising:

- | | |
|---|--------------|
| • Nationally negotiated remuneration: | £ 97 million |
| • Locally negotiated remuneration: | £ 14 million |
| • Reimbursement for provision of medicines/appliances | £809 million |

¹⁹ See Schedule 3 to the 1995 Regulations for the procedure in respect of applications to be included in the pharmaceutical list.

MODERNISING NHS COMMUNITY PHARMACY IN SCOTLAND

SECTION 2: INTRODUCTION OF NEW COMMUNITY PHARMACY CONTRACT

The Policy Intention

2.1 To amend existing legislation so that steps to modernise pharmaceutical care services and improve patient care, through the introduction of a New Community Pharmacy Contract, can be effected in the future.

The Need for Change

2.2 A specific action point in the Scottish Executive's strategy document *The Right Medicine* was that the Executive would work with the profession to develop a new system of remuneration for community pharmacists, one that provides incentives to improve and deliver quality care health services.

2.3 Discussions with the community pharmacists' representative body, the Scottish Pharmaceutical General Council (SPGC), on the New Contract have been ongoing during 2003 and are expected to be concluded in the first half of 2004. Subject to any required legislative provisions being in place, the intention is that the New Contract will come into operation in 2005-06 although, again subject to legislative cover, elements of the contract may be phased in during the course of 2004-05.

2.4 Although the contract discussions are ongoing, the Department and SPGC have agreed an outline framework for the New Contract. In summary it will comprise two main elements, namely:

- Core Pharmaceutical Care Services – centrally negotiated (terms of service and remuneration) and comprising:
 - Chronic Medication Service
 - Minor Ailments Service
 - Acute Medication Service
 - Public Health Service
- Additional Services – these services will, as now, be locally negotiated. A list of the current additional pharmaceutical services is at Section 1.8 above.

2.5 The Core Services will form the national contract and be provided by all community pharmacists in Scotland. Overall the aim of the New Contract is to improve the range and quality of care provided to patients through the development and better utilisation of community pharmacists' skills, and those of their support staff. Whilst dispensing is a key activity, in future greater emphasis will be placed on the clinical management of an individual patient's condition(s) or wider health care needs.

2.6 Sections 1.8 and 1.11 to 1.12 summarise the legislative framework for the provision of pharmaceutical services. Legislation will be required to ensure the implementation of all aspects of the finally negotiated New Contract provisions.

The Proposals

2.7 Whilst the detail of the New Contract core services has still to be agreed, the expectation is that it will include provision of (for example):

- pharmaceutical care for certain specified conditions
- diagnostic testing and the provision of advice in connection with self-testing
- care for people with minor ailments, without a GP prescription
- pharmaceutical advice to patients on request (unconnected to a particular supply)
- provision of public health services

2.8 Legislation will require to ensure that the terms and conditions of service for pharmacy contractors providing the new or redesigned services are capable of being set out. In keeping with the aims of the New Contract it is expected that the provisions will relate to the quality of services provided, standards of clinical practice, the training and qualifications of staff, the standard of premises and other matters related to the infrastructure of pharmaceutical services.

2.9 In terms of the quality of services and the premises from which they are provided, legislation would be expected to detail (for example):

- 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
- how specific services are to be provided, e.g. in accordance with clinical protocols or standard operating procedures
- the type and format of patient records to be maintained for specific services
- the standards to which the services are to be provided
- where services may or may not be provided, e.g. patient counselling to be undertaken in designated types of area, likewise for the fitting of appliances
- the nature and standards of equipment (clinical and IM&T) used in, or in connection with, the provision of pharmaceutical services

2.10 In terms of facilitating the management, audit and clinical governance of pharmaceutical services, it is envisaged that legislation would require contractors to (for example):

- comply with the requirement for continuing professional development (CPD) through meeting duly designated clinical competencies
- provide information to Scottish Ministers or NHS Boards about the services they have provided
- institute their own clinical governance or other quality assurance activities and/or take part in those organised by others

- make arrangements for the continuing professional development of staff
- comply with good human resource management
- carry out audits of their services
- where required, report adverse incidents or near misses to Scottish Ministers, or specified 3rd parties, in a format determined by them

2.11 As indicated above, the listed terms of service items are illustrative and should not be taken as definite or fully comprehensive at this stage.

2.12 Boards will be directed to monitor and ensure compliance by contractors with the terms and conditions of service and other regulatory requirements associated with the provision of pharmaceutical services.

Question

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

MODERNISING NHS COMMUNITY PHARMACY IN SCOTLAND

SECTION 3: PLANNING & PROVISION OF PHARMACEUTICAL CARE SERVICES

The Policy Intention

3.1 To improve the planning process for establishing and securing Pharmaceutical Care Services (PCS) by ensuring that service provision is based on locally identified care needs and that patients have convenient access to a full range of services.

The Need for Change

3.2 Paragraphs 13 to 15 of Section 1 provide an outline of the current arrangements by which persons or businesses secure a NHS contract to provide pharmaceutical services. These are generally referred to as the 'control of entry' arrangements, i.e. control of entry to pharmaceutical lists. The system is re-active on the part of the Board, i.e. the steps to establish a pharmacy contractor are initiated by potential contractors rather than by the Board actively planning and securing the services. The result is that there are instances where, particularly in rural, remote and deprived areas, patients do not have either complete or ready access to a full range of pharmaceutical services. There is, therefore, a need to place the arrangements for securing community pharmacy services onto a more pro-active footing.

The Proposals

3.3 The intention is to place a statutory duty on NHS Boards to provide or secure the provision of pharmaceutical care services that they consider necessary to meet all reasonable needs of persons in the Board's area.

3.4 Boards would be required to publish, and thereafter keep under review, their plans for where and what pharmaceutical care services (PCS) are to be provided in their area. Amongst other things, the PCS Plan should state where the Board considers there to be over or under provision of pharmaceutical services. In determining or reviewing the plan a Board would be required to consult with appropriate professional and patient representatives as well as with the general public.

3.5 The PCS Plan would cover service provision under both national and local contracts (see 1.8). For national contract requirements, Boards would be responsible for ensuring that its resident population has convenient access (in terms of location and opening times) to the Core Services described in Section 2.4, i.e. Chronic Medication Service, Minor Ailments Services, Acute Dispensing Service and Public Health Services. The provision of Additional Pharmaceutical Services, i.e. locally negotiated 'directed services', would reflect local service needs as identified in the Board's PCS Plan.

3.6 In both cases it is proposed that the required services are provided through individual PCS Plan contracts.

3.7 It is proposed to replace the current 'necessary and desirable' test for control of entry to pharmaceutical lists (see 1.14) with a more objective assessment for determining where PCS are to be located or delivered. The introduction of arrangements that result in an agreed area PCS Plan (PCSP) would provide the measure against which future applications for entry to a pharmaceutical list should be assessed.

3.8 Once the proposed new arrangements are in place, pharmacies providing services that match the needs plan would be granted a 'new' PCSP contract and continue to operate as they did previously.

3.9 In the case of over provision, it is proposed that the pharmacies in question will, for a set period of time, be granted a 'holding' PCSP contract and that Boards will be granted powers to incentivise change that would result in a match between service provision and the PCSP. Under the proposed arrangements, Boards would be able to provide assistance (including financial assistance) that could, for example, enable contractors to combine forces or to move to a location where a service deficiency has been identified.

3.10 It is thought that under provision will fall into three main categories, i.e.

- complete absence of national contract cover;
- insufficient national contract cover, e.g. where recent housing developments have placed a strain on existing service provision;
- absence of one or more locally required services, e.g. methadone or out of hours services.

3.11 In all cases, Boards would be required to take steps to secure the services in question through a 'new' PCSP contract or, where they are unable to place such a contract, by arranging the service provision themselves.

3.12 It is proposed that the first step would be for the Board to offer the sought after service to pharmacy contractors with a 'holding' PCSP contract. This could be on either an individual or consortium basis with the Board able to facilitate the process through the incentive and assistance arrangements outlined above.

3.13 Thereafter, other eligible persons or businesses would be able to apply for the new PCSP contract. In the case of national contract (Core Services) provision, the fees and allowances payable will be those centrally negotiated but the intention is that Boards will be able to pay additional sums where, for example, a more enhanced service is offered by the proposed provider. Contracts for local services would be negotiated in the same way as at present and Boards would be able to add such services to the specification for a Core Services PCSP contract.

3.14 The proposal is that new PCSP contracts for Core Services and/or local services are advertised with applications, in a prescribed format, to be submitted by a set date. Determination by the Board would include measurement against the PCS Plan, consideration of any service enhancements offered and the proposed timeframe for establishing the service.

3.15 Where the above processes fail to secure the required service the Board would be required to arrange the provision itself. For example, the service could be provided by Board employed staff or pharmacy contractors located elsewhere in either their own or another Board area.

3.16 It is envisaged that all PCSP contracts will be subject to periodic review by the Board against its PCS Plan, which itself should be subject to periodic review.

3.17 The holders of all PCSP contracts would be subject to the same provider requirements as currently exist for community pharmacy contractors. The service will have to be provided from authorised premises, delivered by or under the direct supervision of a registered pharmacist with the contractor being listed on the Board's pharmaceutical list. The same terms and conditions of service will apply with additional or more specific terms being set where appropriate.

Questions

- **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?**

MODERNISING NHS COMMUNITY PHARMACY IN SCOTLAND

SECTION 4: PHARMACEUTICAL LISTS

The Policy Intention

4.1 To strengthen clinical governance, quality assurance and to benefit patients by extending the listing arrangements to pharmaceutical non principals, thereby bringing them within the current framework for the administration and management of family health services in Scotland.

The Need for Change

4.2 NHS Boards are currently required to maintain lists of the names and addresses of the 'persons, firms or bodies corporate'²⁰ that provide pharmaceutical services in their area. For the purposes of this section, these are collectively referred to as "principals". The list, known as the Board's 'pharmaceutical list', must also detail the pharmaceutical services being provided and the opening hours. Currently, the list does not include pharmacists who have been employed to provide pharmaceutical services (on a permanent or temporary basis) nor does it include pharmacists in training. For the purposes of this section, this group is referred to as "non principals".

4.3 Once on a pharmaceutical list, any principal who breaches his or her terms of service may be referred to a NHS Discipline Committee and a referral may be made to the NHS Tribunal where the practitioner has prejudiced the efficiency of pharmaceutical services or has defrauded, or attempted to defraud, the NHS or other publicly funded health services. Principals are deemed responsible currently for their own acts or omissions and also for those of the non principals they employ.

The Proposals

4.4 It is intended to introduce a requirement that all registered pharmacists who deliver pharmaceutical services in the area of an NHS Board are entered on that Board's pharmaceutical list. In this way, non principals will become responsible for their own actions or lack of action.

4.5 The same approach has already been taken with GPs and it is also being proposed for dentists and optometrists/ophthalmic medical practitioners. The proposal here would harmonise arrangements across all four family health services.

4.6 In more detail, the proposal is for the pharmaceutical list to be split into two parts. The intention is that principals (whether individuals, appliance suppliers or bodies corporate carrying on a retail pharmacy business) undertaking to provide pharmaceutical services are to be listed in Part A. Each entry will include names of the pharmacist(s) responsible for delivering the service/in charge of service provision at an individual pharmacy.

²⁰ See regulation 2(2) of the 1995 Regulations.

4.7 Applications from principals to be entered on Part A will require certain undertakings, consents and declarations to confirm their fitness to provide pharmaceutical services under a NHS contract. This will include, for example, confirmation of registration with the Royal Pharmaceutical Society of Great Britain or confirmation that the principal is not subject to national disqualification by the NHS Tribunal.

4.8 Part B would list all non principals i.e. registered pharmacists who will perform NHS contracted pharmaceutical services in a Board area as an employee, a pharmacist in training or on a locum basis. The application requirements for these non principals would be similar to those for entry to Part A of the list.

4.9 Administrative arrangements would be established to enable pharmacists who wish or need to be registered on the lists of other Boards to do so as part on the initial application process at their 'host' Board, on a 'fast track' basis already developed for listing GPs.

4.10 From the date of implementation of the new arrangements, a pharmacy principal would not be able to employ a pharmacist who was not listed on their local Board's pharmaceutical list. All listed persons would be individually responsible for their own acts or omissions in the course of providing NHS pharmaceutical services.

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)?**

MODERNISING NHS COMMUNITY PHARMACY IN SCOTLAND

SECTION 5: PERSONS AUTHORISED TO PROVIDE PHARMACEUTICAL SERVICES

The Policy Intention

5.1 To standardise the legal references to persons authorised to provide pharmaceutical services.

The Need for Change

5.2 As indicated at Section 2 of this document, one of the aims of the New Contract is to encourage community pharmacists to spend more time with patients and less time on the mechanics of dispensing.

5.3 Section 28(2) of the 1978 Act states that medicines provided by pharmacies providing NHS pharmaceutical services must be dispensed by or under the 'direct supervision' of a registered pharmacist.

5.4 Taking the words 'direct supervision' literally implies that the pharmacist must oversee every dispensing and, as such, this will have a limiting factor on the time that can be spent with patients. Also, the reference to 'direct supervision' contrasts to the approach taken in the Medicines Act 1968, which refers only to 'supervision'.

The Proposal

5.5 It is proposed to replace the current 1978 Act requirement that medicines are supplied under 'direct supervision' with a requirement that medicines will be supplied under the description of supervision that is consistent with the approach taken in the Medicines Act 1968.

5.6 It is considered that the change would allow a more liberal interpretation of supervision to mean ensuring safe systems of work and, under this wider interpretation, community pharmacists would be able to devote more time to engaging in direct patient care activities.

Question

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

MODERNISING NHS COMMUNITY PHARMACY IN SCOTLAND

SECTION 6: CROSS BOUNDARY AND DISTANT PROVISION OF PHARMACEUTICAL SERVICES

The Policy Intention

6.1 To clarify and extend the current pharmaceutical list and control arrangements to allow for innovative ways of providing dispensing and supply services to NHS patients, and so give patients and pharmacy contractors greater flexibility in the way that pharmaceutical care services can be accessed and delivered.

The Need for Change

6.2 As previously stated, Boards are required to maintain lists of persons and businesses who provide pharmaceutical services, which includes the provision of appliances, in their respective areas. Once listed, the pharmacy contractors are subject to the terms and conditions in the 1995 Regulations.

6.3 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. Those services must be provided from premises entered on a Board's pharmaceutical list. Ordinarily pharmacy contractors will dispense prescriptions to patients who present at their listed premises but there are occasions where they will arrange for the medicines to be delivered to the patient's home or place of residence. In these circumstances the delivery may be to an address in another Board's area, i.e. a cross-boundary dispensing.

6.4 There is nothing in legislation to prevent a pharmacy contractor dispensing 'cross-boundary' but the service must be provided from duly listed premises. However, it is possible that the pharmacy contractor will not be on the list of the Board where the patient receiving the medicine or appliance actually resides. Whilst the contractor will still be subject to the terms and conditions of service it is considered that there is a need to clarify the legal framework that governs cross-boundary dispensing.

6.5 The current arrangements for securing and delivering pharmaceutical services rest largely on the premise that they will be provided directly from a duly listed community pharmacy, and that the patient or their representative will initially present at those premises to access the service. As such, the current arrangements do not fully recognise changes in the way that services in general can be delivered, for example through ordering over the internet or by mail order. More specifically with regard to community pharmacy, there is increasing potential for the development of automated or centralised dispensing services. These would allow community pharmacists to order items for dispensing from another, or 'distant', site for delivery to either their own premises or direct to the patient's home.

6.6 Collectively these developments have the potential to give patients greater flexibility in the way that they can present prescriptions and receive their medicines or appliances. They should also aid working practices within the community pharmacy. There is, however, a need to ensure that 'distant dispensing' services are managed and controlled in a way that ensures local access to the full range of pharmaceutical care services is maintained and that the provision is to appropriate standards.

The Proposals

6.7 The intention is to clarify the range of pharmaceutical services that can be provided cross-boundary and to extend the legislative framework to provide for distant dispensing arrangements.

6.8 Boards will be authorised to arrange for the provision of all pharmaceutical services to any person in their area and from a pharmacy contractor out with the Board's area. This ability will give Boards with an under provision of pharmaceutical services in their area the option to secure it from outside the area (see Section 3 on Planning and Provision of Pharmaceutical Care Services). Boards will not be allowed to arrange services for persons outwith their area from contractors who are also outwith their area.

6.9 The requirement that pharmaceutical services must be provided by a person or businesses whose name and premises are listed in a Board's pharmaceutical list will remain. 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.

6.10 It will be open to contractors or businesses to establish or become distant dispensing premises. Such contractors would be able to dispense and supply medicines/appliances direct to a patient's address but only where the prescription had been presented at or through a pharmacy contractor who provides a full pharmaceutical care service under the national contract, i.e. the Core Service (see 2.4). In this way there will be a 'provision of products' service and 'provision of care' service.

6.11 Persons or businesses that wish to provide only distant dispensing services and offer no 'provision of care' services will still be required to gain entry to a Board's pharmaceutical list. However, in such cases the business's location relative to other community pharmacies will not be the issue that it is under the current control of entry (to pharmaceutical lists) arrangements. Therefore, the intention would be to amend the control of entry arrangements for this category of contractor to place the focus more on meeting patient needs and less on where the service is located.

6.12. For contractors who wish to provide both 'distant' and 'in person' services the usual control of entry arrangements will continue to apply. Additionally, for such contractors the pharmaceutical list will detail the services that are to be provided.

6.13. Recognising that the development of cross-boundary and distant dispensing arrangements could give rise to new and possible untested ways of working, it will be necessary to have regulatory powers to limit the services or to dictate the ways in which they are to be operated. At this time, it is difficult to predict the situations for which those powers will be required but, for example, they could:

- Prevent the use of pharmacies that are not included on a pharmaceutical list as intermediaries in the dispensing process.
- Prohibit the provision of particular services by distant means or specifically across NHS Board boundaries, e.g. supply of controlled drugs; appliances that require fitting.
- Stipulate the minimum standards for the safe and secure transportation and delivery of distantly dispensed items.

- Stipulate the records and information to be maintained when dispensings or cross-boundary services are being provided.

6.14 Currently, pharmacy contractors are paid by the Board in whose list they are included and from where the services are provided. The cost of the drugs and appliances that they dispense are paid by the Board where the prescription was written. In view of the changes proposed, powers will be sought so that where necessary or appropriate Boards can be authorised or required to make payments in respect of pharmaceutical services delivered to people in their respective areas but provided by pharmacy contractors in another Board area.

6.15 It is envisaged that payment for distant dispensing services will be a matter for the respective service (product and care) providers to settle between themselves.

Questions

- **Do you agree that 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?**

MODERNISING NHS COMMUNITY PHARMACY IN SCOTLAND

SECTION 7: FUNDING OF PHARMACEUTICAL SERVICES

The Policy Intention

7.1 To provide Scottish Ministers with powers to designate which elements of community pharmacists' remuneration are to be met from Boards' unified budgets.

The Need for Change

7.2 Paragraphs 16 to 19 of Section 1 describes the arrangements for remunerating pharmacy contractors and the funding flows for doing so. Although Boards draw down their funding requirements from the centrally held 'global sum' on a needs basis, i.e. against priced dispensing data, they are given an annual 'indicative allocation' against which they should monitor spend for budgetary control purposes. In practice this achieves very little effect as Boards currently have no direct control in planning and securing the configuration and range of services relative to their perception of patients' needs.

7.3 However, as detailed in Section 3, it is proposed to make Boards responsible for planning and securing pharmaceutical care services and, therefore, there is a need to provide them with the financial flexibility to deliver and manage those plans.

The Proposals

7.4 It is proposed that Scottish Ministers are given powers to determine those elements of the 'global sum' that are to be allocated to Boards as part of their individual Unified Budgets (see 1.16).

7.5 The intention is that all elements of the global sum, i.e. covering the Core Services outlined at Section 2.4, would be allocated to Boards but as indicated above it would be open to Ministers to limit the allocation to selected or designated services. Until such time as the New Contract arrangements are settled it is not possible to suggest the circumstances in which limited allocations might be necessary.

7.6 Resources would be allocated to Boards on a needs based formula using the same principles employed in the National Review of Resource Allocation for the NHS in Scotland.

7.7 As with previous arrangements for introducing weighted capitation/needs based funding, a 'pace of change' policy would be adopted to ensure that any initial variations between the formula calculation and payment levels to contractors (at individual Board level) can be managed through over an appropriate period of time. It is envisaged that the pace of change will not exceed 10 years.

7.8 Boards will assume full financial responsibility and control for the national contract services (as designated) but will not be allowed to vary the remuneration terms, i.e. Boards will be required to remunerate pharmacy contractors fully in accordance with the nationally negotiated contract arrangements. However, as stated at paragraph 13 of Section 3, Boards will be able to pay additional sums where, for example, a more enhanced service is offered by the proposed provider.

Question

- **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?**

MODERNISING NHS COMMUNITY PHARMACY IN SCOTLAND

SECTION 8: PARTIAL REGULATORY IMPACT ASSESSMENT

Purpose and intended effect

8.1 To modernise and redesign community pharmacy services in Scotland with an overarching aim to improve patient care and the health of the public and to better utilise the skills of community pharmacists and their support staff to meet locally identified needs.

8.2 The objective is to secure a legislative framework that will support implementation of the community pharmacy issues detailed in the Executive's strategy for pharmaceutical care, *The Right Medicine*. Legislation is required to enable implementation of New Contract arrangements for community pharmacies and address associated issues around the planning and delivery of pharmaceutical care services.

Risk Assessment

8.3 The Executive's strategy *The Right Medicine* called for a range of actions with specific regard to community pharmacy, many of which are expected to be delivered within the context of the New Contract that is currently being discussed. The current legislative framework (see Section 1) can accommodate some but not all of the required changes. The risk of not securing the necessary legislative framework is, therefore, that the sought for service benefits that the strategy seeks for patients and community pharmacists alike will not be fully deliverable.

Options

8.4 Three options have been identified:

- Option 1 – do nothing, i.e. maintain the current system
- Option 2 – implement changes in so far as they can be accommodated within the current legislative and administrative framework
- Option 3 – amend the current primary and secondary legislation to allow full implementation of the policy proposals

Benefits

8.5 Option 1: No change. Under this option the status quo continues with the skills of the pharmacist remaining under utilised and with little or no opportunity to secure added patient benefits. Whilst 90% of the public find the location of their pharmacy convenient²¹, there remains an issue of under-provision of services in areas of high deprivation and in rural and isolated communities.

8.6 Option 2: Change within existing legislation. Until the service terms of the New Contract (Section 2) are clearly established it is difficult to state how far the existing legislative framework will provide for the policy proposals listed in the preceding sections. However, as currently envisaged, the Chronic Medication and Minor Ailments Schemes will possibly require further legislation. To different degrees it is intended that these schemes

²¹ Consumer views of community pharmacies – Scottish Consumer Council report (September 2002)

will provide (amongst other things) for serial dispensing, medication reviews and health checks, e.g. blood pressure, by the community pharmacist.

8.7 A recent public survey undertaken by the Scottish Consumer Council²² found 61% would like to see community pharmacists being able to authorise repeat prescriptions. The levels of support for medication reviews and health checks were 41% and 26% respectively. It follows that any inability to implement these services, either fully or in part, will be to the detriment rather than the benefit of patients.

8.8 Legislation is likely to be required for the service planning and delivery proposals (Section 3) and the cross-boundary and distant dispensing proposals (Section 6). These proposals are targeted significantly at ensuring ready access to the full range of core community pharmacy services in all areas of Scotland, and ensuring that people with special needs, e.g. drug misusers, also have ready and appropriate access to the services they require. Here too, 'no change' would mean losing potential benefits to patients.

8.9 Option 3: New legislation. This option addresses the lost benefit (to patient) issues above and in summary would provide Ministers with powers to secure:

- ready access to pharmacies for medicines, both prescribed and over the counter, and advice in deprived, rural and isolated communities
- improved access to healthcare services for people with special needs
- a wider and higher quality range of services
- closer working between community pharmacists and other NHS professionals, in both the primary and secondary care sectors

8.10 Overall these will contribute to the delivery of the Executive's commitment in *Our National Health* that it would work with the NHS and professional bodies to ensure patients in every part of Scotland can get access to an appropriate member of the primary care team (not just GPs) in 48 hours.

8.11 The proposals to extend the pharmaceutical list arrangements (Section 4) will place community pharmacists on the same footing as other primary care contractors and so strengthen their clinical governance and quality assurance to patients.

Costs

8.12 The proposals in the preceding sections of this document are primarily about putting in place a legislative framework that will enable implementation of a New Contract for community pharmacists and associated elements of the strategy aims in *The Right Medicine*.

8.13 With discussions on the final content of the New Contract still to be completed it is not possible to quantify the financial consequences to any great degree. Nevertheless, the following paragraphs are provided to give an indication of the possible financial implications for each of the preceding sections.

²² Research Report: consumer views of community pharmacies (September 2002)

New Contract (Section 2)

Policy Costs

8.14 As previously stated the financial consequences or requirements of the New Contract itself are a matter for consultation between the Executive and SPGC and, as such, fall outwith the scope of this consultation paper (but see paragraph 8.30).

Implementation Costs

8.15 Otherwise, the financial consequences relate to the cost of administering the revised arrangements. Boards already meet the cost of administering community pharmacy services and the expectation is that the New Contract will add little to that existing commitment. At present Boards are using resources to support the development of initiatives that facilitate implementation of *The Right Medicine* strategy. As those initiatives come to fruition, the resources for their development could, if necessary, be used to off set any additional administrative costs stemming from the New Contract.

8.16 Changes to either the community pharmacists' fee structure (under New Contract arrangements) or the payment processing arrangements could have financial implications for the Common Services Agency, who currently provide those services for Boards. Financial provision already exists for the development of e-pharmacy initiatives, which would cover the development of e-payment systems for community pharmacy, and the expectation is that any such development would result in revenue savings.

Planning & Provision of Services (Section 3) & Cross-boundary and Distant Dispensing (Section 6)

Policy Costs

8.17 Pharmacy contractors who secure a 'new' Pharmaceutical Care Services Plan (PCSP) contract would, as now, be remunerated in accordance with both nationally and locally negotiated fees and allowances. Pharmacies with a 'holding' PCSP contract, which implies that their services are in excess to NHS needs would for a set period of time, continue to be remunerated at the nationally/locally agreed rates. During that period of time their Board would, where possible, offer the pharmacy contractor a service contract elsewhere in the Board's area, or facilitate possible partnership working with other local pharmacy contractors.

8.18 Expenditure by Boards on providing incentives for service change would be an additional call on their resources but, where over provision exists initially, there should be savings in the longer term as services are reconfigured in line with the lower level of need. At this stage, where the correlation between current service requirements and provision is not known, it is not possible to estimate the financial implications of this policy.

8.19 Boards will incur additional expenditure where there is an under provision of services and they are gradually expanded to meet required need. Similar to above, it is not possible to put a cost estimate to this consequence. However, as explained at Section 7, it is proposed that the way in which Boards are funded for the provision of community pharmacy services will in future more accurately reflect needs at an individual Board level.

Implementation Costs

8.20 It is estimated that the cost of administering the current control of entry arrangements in Scotland are just under £1.3m²³ per annum as follows:

Admin costs to business	£ 500,000
Appeal costs to business	£ 105,000
Total business cost	£ 605,000
Board costs	£, 600,000
Appeal Panel costs	£ 85,000
Total NHS costs	£1,290,000

8.21 Under the proposed new planning arrangements Boards will have a new responsibility in the shape of producing a pharmaceutical care services needs plan for their area and thereafter ensuring that, over a period of time, service provision on the ground aligns to those needs. However, this will effectively replace their existing responsibilities and, therefore, is not expected to add to the costs identified above. The proposals at Section 6 (Distant Dispensing) extend the options for Boards to secure required service provision and, therefore, should not result in additional administrative costs.

8.22 Businesses wishing to apply to provide services in identified areas of need would continue to have associated administrative costs but these would probably be in the same order as those under the present arrangements. It is envisaged that there will be less need for appeals under the new arrangements but, in any event, the cost implications for business and the NHS overall would remain relatively insignificant.

Listing (Section 4)

Policy Costs

8.23 The policy will require existing 'principal' contractors to provide additional information to support their pharmaceutical list entry, and introduce a new requirement on 'non principals' to meet the same information requirements as principal contractors. No costs attach to this policy proposal.

Implementation Costs

8.24 Boards, and possibly the Common Services Agency (CSA), would incur limited additional costs as the new listing arrangements are put in place but once established the administrative costs should differ little to those at present.

Supervision of Pharmaceutical Services (Section 5)

8.25 None

Community Pharmacy Funding (Section 7)

8.26 Nationally the proposals would be cash neutral. Payments would still be measured and managed against the set 'global sum' and contractors would continue to be remunerated in accordance with nationally agreed or set rates.

8.27 On the other hand, the proposals would see funds currently managed centrally being passed to Boards in a way that may not match current payment patterns for community

²³ Based on OFT costings (Appendix B to 2003 report on pharmacy services in UK) and Scottish activity levels

pharmacy. The allocation formula has yet to be developed so there is currently no indication of the financial variations that might result. However, the intention would be to phase in the allocation process over a period of time that will allow Boards to manage the change accordingly.

Business sectors affected

8.28 There are approximately 1150 community pharmacies and 14 appliance suppliers providing NHS pharmaceutical services in Scotland. The large chain, small chain and independent sectors account for 30%, 11% and 57% of numbers respectively. Supermarkets account for the remaining 2%. Typically, for the small chain and independent community pharmacy contractors the NHS pharmacy business accounts for approximately 80% of their total business turnover.

Compliance Costs for a typical business

8.29 As the above paragraph indicates, the businesses fall broadly into 4 categories. To varying degrees within each band there will be a considerable variation in the size of the NHS business governed, in the main, by the 'catchment' area in which the business is located. This is because, under the current remuneration structure for community pharmacists, payments are driven largely by prescription volume, i.e. through the dispensing fee. And the greater the number of prescriptions dispensed, the greater the turnover for the reimbursement of drug costs.

8.30 As previously stated, the New Contract is expected to include a revised remuneration structure, the financial envelope for which has still to be discussed. It is, therefore, not possible at this stage to provide a meaningful illustration of the overall compliance cost of the proposals listed in this document, which are essentially about ensuring that the legislative framework can support the agreed changes to service practice and delivery. However, it has been agreed between SEHD and SPGC that any new fees/allowances 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.

LIST OF ORGANISATIONS / INDIVIDUALS TO WHO THIS CONSULTATION DOCUMENT HAS BEEN SENT

All registered pharmacists in Scotland
All Community Pharmacies
Scottish Pharmaceutical General Council
Royal Pharmaceutical Society in Scotland
Scottish Association of Trust Chief Pharmacists
Scottish Prescribing Advisors Association
Scottish Pharmaceutical Federation
Association of Independent Multiples Scotland
Company Chemist Association
Guild of Healthcare Pharmacists in Scotland
British Medical Association – Scottish General Practitioners' Committee
Royal College of General Practitioners
British Dental Association
Royal College of Nursing

All NHS Boards
The Health Service Commissioner for Scotland
Common Services Agency
NHS Health Scotland
NHS Quality Improvement Scotland
NHS Education for Scotland
NHS Scotland Counter Fraud Services
NHS Confederation
Scottish Association of Health Councils
LHC's
LHCC's
The Patients' Association
Scottish Consumer Council
Consumers Association

The Scottish Parliament SPICE
Clerk of the Health and Community Care Committee
Scottish Youth Parliament
Local Authorities in Scotland
COSLA
Equal Opportunities Commission – Scotland
Woman's National Commission
Commission for Racial Equality – Scotland
The Disability Rights Commission
Age Concern Scotland
Help the Aged
Scottish Council of Voluntary Organisations Scottish Consumer Council
Scottish Trade Union Congress
Unison

THE SCOTTISH EXECUTIVE CONSULTATION PROCESS

Consultation is an essential and important aspect of Scottish Executive working methods. Given the wide-ranging areas of work of the Scottish Executive, there are many varied types of consultation. However, in general Scottish Executive consultation exercises aim to provide opportunities for all those who wish to express their opinions on a proposed area of work to do so in ways which will inform and enhance that work.

While details of particular circumstances described in a response to a consultation exercise may usefully inform the policy process, consultation exercises cannot address individual concerns and comments, which should be directed to the relevant public body. Consultation exercises may involve seeking views in a number of different ways, such as public meetings, focus groups or questionnaire exercises.

Typically, Scottish Executive consultations involve a written paper inviting answers to specific questions or more general views about the material presented. Written papers are distributed to organisations and individuals with an interest in the area of consultation, and they are also placed on the Scottish Executive web site enabling a wider audience to access the paper and submit their responses²⁴. Copies of all the responses received to consultation exercises (except those where the individual or organisation requested confidentiality) are placed in the Scottish Executive library at Saughton House, Edinburgh (K Spur, Saughton House, Broomhouse Drive, Edinburgh, EH11 3XD, telephone 0131 244 4552).

The views and suggestions detailed in consultation responses are analysed and used as part of the decision making process. Depending on the nature of the consultation exercise the responses received may:

- indicate the need for policy development or review
- inform the development of a particular policy
- help decisions to be made between alternative policy proposals
- be used to finalise legislation before it is implemented

If you have any comment about how this consultation exercise has been conducted, please send them to:

Name: Anne MacLeod
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Regent Road
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E-mail: Anne.MacLeod@scotland.gsi.gov.uk

²⁴ www.scotland.gov.uk

RESPONDEE INFORMATION FORM

Please complete the details below and attach it with your response. This will help ensure we handle your response appropriately:

Name:

Postal Address:

Consultation title: **MODERNISING NHS COMMUNITY PHARMACY**

1. Are you responding as: (please tick one box)

- an individual (go to 2a/b)
on behalf of a group or organisation (go to 2c)

2a. INDIVIDUALS:

Do you agree to your response being made available to the public (in SE library and/or on SE website)?

- Yes (go to 2b below)
No, not at all

2b. **Where confidentiality is not requested**, we will make your response available to the public on the following basis (**please tick one** of the following boxes)

- Yes, make my response, name and address all available
Yes, make my response available, but not my name or address
Yes, make my response and name available, but not my address

2c ON BEHALF OF GROUPS OR ORGANISATIONS:

Your name and address as respondents **will be** made available to the public (in the SE library and/or on SE website). Are you content for your response to be made available also?

- Yes
No

3. We will share your response internally with other SE policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for the Scottish Executive to contact you again in the future for consultation or research purposes?

- Yes
No

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