MODERNISING NHS COMMUNITY PHARMACY

There is a definite need for a new contract which is not just based on script numbers. It has long been stated that pharmacists can offer greater care to the community if their skills are utilised more fully.

Section 2

The core services to be provided in 2.4 provide a good basis on which pharmacist should be remunerated and it is also important to recognise that dispensing is still a key element to the service and it must be remembered that every script dispensed under the current regulations will also have a "clinical check" carried out on it when the pharmacist either produces the label or gives the script the final check. It may take some time till the skills of support staff are up to carrying out this check with confidence.

Time and resource will need to be provided to assist pharmacists to go through the transition from the old contract to the new contract. It would be important that pharmacists do not find themselves being bogged down with paperwork and so it is important that IT solutions are found to assist pharmacists in order for them to provide better patient care without any adverse affect on their already heavy workload.

Although diagnostic testing is welcomed I feel this should be carried out under local arrangements with GPs and that clear paths of follow up are used for patients who have suspect results.

Section 3

I would agree in principal in moving from a reactive process to a proactive process provided this does not destabilise the excellent provision that is already available. The process of planning PCS would have to be consistent throughout Health Boards and decisions on planning should be transparent and reviewed regularly.
Although a change is required the market forces that have been in place since the limitation of contracts came in, in 1987, have worked well and it must be said there cannot be many instances of over or under provision. If there is under provision then I feel that this may be due to there being a lack of pharmacists in each pharmacy not the number of pharmacies, this would require an increase in resource to correct any shortfall. Where there may be a shortfall in outlying areas this is taken are of with ESP scheme. Other instances of shortfall could be made up with an official delivery service. The building of a new housing area does not automatically create a shortfall in pharmaceutical care, it may take many years for a drift in population to show up any lack of provision, a knee jerk reaction to create pharmacies in these areas will result in overprovision while creating under provision elsewhere.

There cannot be many cases of overprovision and I am sure that the new core services will take any that do exist out of this category.
Creating holding contracts will destabilise the system and prevent reinvestment in businesses. In the current climate of uncertainty the creation of holding contracts would undermine confidence in the profession. It is extremely important that all contractors feel that they are able to embrace the new contract with confidence as in all cases I am sure the need to provide better health care for patients is paramount.
I feel that by making minor changes to current legislation is the best way forward. The changes that do occur must minimise the risk of legal challenge and have appropriate contractor representation.

Section 4

The Principal to have all pharmacists accountable for the services they provide is to be welcomed, but in practice is difficult to administer. There may also be problem when a pharmacist locum is not registered to offer certain services. It would be better that the contract stays with the contractor and perhaps some sort of log book is used to identify pharmacist on duty that day. This log book could be sent into health board on a weekly/monthly basis. The contractor would be responsible to make sure all aspects of service are provided. This would make sure that consistent service is offered across the organisation and ensures both access and continuity of care.

Section 5

A very important step is to redefine what constitutes SUPERVISION. Under current regulations pharmacists do not have time to implement new items of the core services. In order for this to happen there will need to be an increase in the technician workforce to a standard where pharmacists feel confident for these technicians to work on there own. It must be also stated that although certain parts of the dispensing of a script are mechanical the importance of a pharmacists clinical impute must not be overlooked. There will only be a certain percentage of scripts that fall into the category of the “chronic medication service,” and these scripts may be able to be left to qualified technicians. It is difficult to see how pharmacists can divorce themselves from the dispensing process of all other scripts. I also believe that GPs value our expertise when writing acute scripts and rely on our double check of their prescribing. There will need to be training standards agreed for technicians with potentially NES providing support.

Section 6

It is important for a patient to access ALL components of the core services from a CP. It would be poor patient care if contractors only dealt with selective aspects of the new contract. However it seems reasonable to allow a CP to enter into agreement with a distant provider as long as full services are still offered with this script. In simple terms I see it working in practice that repeat scripts come to a CP this is then sent to a central source for dispensing and then returned to pharmacy for the patient to collect. This keeps the patient

in contact with a pharmacist to discuss any aspects of this medication the patient or pharmacist wish to discuss further.
Clarification is required on other aspects of the wording here. Do patients need to register with more than one Health Board? Do all pharmacies need to register their list of services with all Health Boards? This needs to be kept simple.

Section 7

Where there is a need to address public health issues in a certain health board then funds should be found to fund this, but not at the detriment of funds to other health boards. It may be that monies should be found from sources other than the global sum.

Section 8

New legislation will be required to allow full implementation of the policy proposals. It is important that all costs needed for this process are taken into account and that CP should not be disadvantaged financially while this process is taking place. The costs of running a pharmacy contract are I am sure higher than the SE would imagine. The costs of proving this new service will be substantially higher and must be taken into account fully. If not it will destabilise and demoralise current system leading to poorer patient care.