

MODERNISING COMMUNITY PHARMACY IN SCOTLAND

I am extremely concerned that the publication of this consultation document coupled with the uncertainty of the new contract arrangements for community pharmacy has resulted in the loss of some of our most innovative and dynamic leaders from the network. Unless the Scottish Executive is able to act decisively to reassure contractors that change will be gradual and will be of benefit to the patient then I suggest that further loss will be incurred.

Community pharmacist contractors have upwards of £500,000 of working capital invested in the NHS through the infrastructure of premises, staff and NHS stock holding. I feel that this document does not take account of this investment.

Also, alluding to the loss of individual community pharmacy owners, I cannot see how the disintegration of the network into large conglomerations ultimately run by the shareholders of public companies can improve the pharmaceutical care of patients. Some areas already have a monopoly of one multiple group. Competition has always meant that community pharmacists, both independents and multiples, have strived to deliver a first class service to patients. Any research conducted on patients satisfaction with community pharmacy has always resulted in extremely high satisfaction results. That is not to say that change is not required it is the fact that the document raises a host of unanswered questions, coupled with lack of transparency on future funding of the service that requires an immediate response from the Scottish Executive.

I shall now respond to sections within the document:

Section 1: Legislative Background and General Overview.

No comment

Section 2: Introduction of New Community Pharmacy Contract

I am in agreement that remuneration models need to incentivise community pharmacy to deliver quality health care. 2.2

Clarification is required on how dispensing, as a key activity, is managed while greater emphasis is placed on the clinical management of an individual patient's condition. 2.5

If one of the core services is Acute Medication in 2.4 then presumably stock holding in community pharmacies would still have to be comprehensive even if e.g. the chronic medication service dispensing was somehow contracted out. Contractors will still have a significant investment in NHS stock.

In order to provide the level of pharmaceutical care envisaged in the Right Medicine it is essential that the community pharmacy remains at the centre of all activity. In other words, if it were decided that some dispensing could be done in a remote setting then all dispensed medication would be supplied to the patient via the community pharmacy of their choice.

2.8 Improvement in standards of premises, training of staff to required levels and general matters related to the infrastructure of pharmaceutical services will require significant resources.

The question you ask about additional powers to me is not the most pressing rather what additional investment is required in community pharmacy in order to meet the standards required in the future?

Section 3: Planning and Provision of Pharmaceutical Care Services

I agree with the policy intention statement in 3.1

- 3.4 I welcome consultation with stated representatives over the PCS but keeping plans 'under review' seems a disincentive to any investment that could potentially be made by a contractor.
- 3.9 The proposed 'holding PCSP' contract in areas of 'over provision' (definition required for this) I suggest is one of the reasons for this damaging loss of key community pharmacists from the network.
- 3.10 Any suggestion of contracts being available for one specific service will further fuel uncertainty in those contractors providing a full pharmaceutical service. Some of the comprehensive service to provide full pharmaceutical care to patients at present is provided at a loss to the contractor e.g. smoking cessation services.

You ask the question: are there alternative models for fulfilling the policy intention for patients?

In areas where for example a specific service is required to meet local need then a consortium model should be explored with the local contractors.

All PCS decisions must be able to be challenged at a further level e.g. National Appeal

Section 4: Pharmaceutical Lists

- 4.4. I agree with the principle that all registered pharmacists who are delivering pharmaceutical service in a Board area should be entered onto the pharmaceutical list for that area.
- 4.7 I understand from the proposal that those pharmacists on the Part A list will be the principal pharmacist i.e. the contractor
- 4.8 Locums and employees would be registered on Part B of the list.

Where I am in agreement with the above, I feel there may be emergency situations where a listed pharmacist falls ill. This situation is unlike most GP practices where clinics could be cancelled and other partners in the practice could cover for emergencies.

There therefore must be a contingency clause where e.g. a pharmacist registered in another board area was allowed to cover in an emergency.

Section 5: Persons Authorised to Provide Pharmaceutical Services

The question you ask, will the action proposed enable community pharmacists to devote more time to direct patient care, requires a great deal more detail.

I am in agreement that the 'direct supervision' model 5.4. could be modified to include technicians, both dispensing and checking e.g. certain repeat prescriptions under stringent Standard Operating Procedures. These procedures would of course be under the responsibility of the pharmacist. Where I would have difficulty would be the scenario where the pharmacist was attending a patient in the domiciliary setting or meeting other health care professionals in a GP practice to deliver pharmaceutical care and leaving the pharmacy without a pharmacist present.

If, as the thrust of the NHS service to patients is to improve access to health professionals then patients must be able to speak to the pharmacist in the pharmacy setting.

I am in agreement to moving towards a less stringent supervision of the dispensing process provided resources were given to the network to 1) train staff to the required levels and 2) to maintain salaries commensurate with added responsibilities.

Only then would pharmacists be able to spend more time with patients.

I am not in agreement with periods of time where the pharmacy would not have a pharmacist present.

Section 6: Cross Boundary and Distant Provision of Pharmaceutical Services

This section requires detailed discussions in order to avoid further destabilisation of the community pharmacy network since bodies out with the area could adversely affect core services and provision of services at a local level.

Section 7: Funding of Pharmaceutical Services

7.8 It is important for Boards to remunerate fully for core services under national agreements.

It is also imperative that core pharmacy budgets are ring-fenced.

Section 8: Partial Regulatory Impact Assessment

Unless the pharmacy market is stabilised then it will not attract sufficient investment to ensure the 'Right Medicine' is delivered with quality pharmaceutical input.



My response is not confidential.

