

From:
Sent: 01 June 2004 13:19
To: pharmacyconsultation
Cc:
Subject: Modernising NHS Community Pharmacy

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1.6.04.

Dear Sirs,

Response to Consultation on "Modernising NHS Community Pharmacy"

I am writing to say that I broadly welcome your proposals as outlined in the above document. A planned distribution of community pharmacies should enable us all to deliver the objectives outlined in "The Right Medicine". A review of the supervision regulations is also to be welcomed although I still believe that the public wish to see their pharmacist as available in the pharmacy throughout the working day and without appointment. The cross-boundary proposals also have merit although I realise that this particular area requires further clarification.

I do have concerns about the creation and maintenance of a list of "approved" pharmacists who are permitted to work in Scotland as I fear that this will add to bureaucracy and may hinder provision of a pharmaceutical service to the public. Other concerns include provision of services by a named pharmacist rather than by a contractor as this may reduce the day to day operational flexibility of multiple pharmacies, and could hinder career progression for employee pharmacists. I am also disturbed that the proposals are to be cash neutral. Additional funding should be made available to ensure that the community pharmacy provision in Scotland is a first class community pharmacy service which is fit for the future.

I list below specific comments...

Section 2 - The New Pharmacy Contract

I seek clarification of how SEHD see other regulatory bodies fitting into the regulatory process (e.g. Royal Pharmaceutical Society of Great Britain, Local Authorities etc. Obviously there are a number of existing regulatory authorities with responsibility for professional, health and safety, environmental health and other matters. I would not want to see a duplication of effort or indeed of administrative workload placed upon community pharmacists.

2.10 The inclusion of dispensing error reporting to Scottish Ministers is in line with other professions. I was on a working party for SEHD to devise a mechanism for reporting of such incidents. That group agreed that patient and professional confidentiality was paramount and that any evidence gathering should be restricted to a statistical analysis which could not identify anyone responsible. I would hope that similar parameters apply under the new proposals.

Section 3 - Planning of Pharmaceutical Care Services

My two biggest concerns in the document are the principle of holding contracts, and the mechanism / consultation / appeal process for devising the PCSP's.

The principle of holding contracts has an implicit provision within it for premises improvements. (i.e. Boards could force contractors to improve premises in order to move from a holding contract to a permanent one). This is no bad thing in principle as we should all drive to improve standards. New services may well require the incorporation of a quiet area / consultation room. However many of Scotland's valued community pharmacies are in premises in which structural improvements are restricted or impossible. Relocation of the pharmacy into bigger premises would be costly and in some locations there may be no suitable alternative premises.

Pharmacy owners have invested large sums of money in their businesses over many years. Holding contracts would render their future viability in doubt as prospective purchasers would hold back from investing their own money in a contract that was not secure.

It is not clear how Boards will create a PCSP. Will there be guidance on how PCSP's should be developed and, if so, will there be a framework for design which includes a requirement for local community pharmacists to be represented in the process ?

No review cycle has been identified for PCSP's. Therefore a Board could review it's plan as frequently as it liked, and that means no stability whatsoever as anyone with a permanent contract could have it converted to a holding contract as the PCSP changes.

Whilst there is an unwritten implication that PCSP's will prevent new contracts for retail park pharmacies, there appears to be nothing to stop a Board including a contract for a new pharmacy at a retail park as part of its PCSP. This may result in a temporary overprovision in any given locality and an existing contractor might subsequently find themselves with a holding contract as a result.

Who decides what is overprovision ? A Board's PCSP might declare that only one community pharmacy is required in a small town where there are currently two or more successful and valued pharmacies providing a good service. How does this fit with customer choice ?

The document makes no reference to mechanisms for speculative contract applications in-between PCSP's. It is quite feasible that new housing developments will be built between PCSP's and as such would the Boards accept speculative applications for a new pharmacy contract ?

There is a need for uniformity of a standard PCSP process across Scotland. Also it would be fundamentally wrong to have people with no experience of community pharmacy drawing up the PCSP's in isolation.

Whatever protocols are established for PCSP's they must include an unambiguous, transparent and fair appeals procedure.

3.17 Strangely this point refers to direct supervision when Section 5 proposes to abolish direct supervision. Clarification is required.

Section 4 - Pharmaceutical Lists

Boards already keep lists of approved doctors and dentists. The proposal is to do the same for pharmacists. There is potential for there to be a national approved list so that pharmacists working across Board boundaries wouldn't have to be repeatedly vetted. This seems to be a practical solution which would avoid unnecessary bureaucracy at individual Board level.

The Royal Pharmaceutical Society of Great Britain already keeps a register of pharmacists allowed to practice in the UK. Logically, what makes a Board's approved list any better than the RPSGB register ? A pharmacist could be approved on a Board's list today and then commit malpractice tomorrow. The Board's review processes would have to be capable of instant delisting in order to protect patients. This is an unlikely eventuality. Would the Board be required to inform other pharmacists that someone had been delisted ? If not, a previously approved pharmacist who had been regularly employed as a locum could continue to be employed against the wishes of the Board.

4.3 Stresses that currently Principals (i.e. contractors / superintendent pharmacists) are responsible for the Non-Principals (employees pharmacists) they employ. Therefore there is clearly already a professional obligation on Principals to ensure that the pharmacists they employ are fit for purpose and I fail to see why the Boards cannot maintain quality of pharmacist working in their area via this mechanism, rather than through additional paperwork.

Recently, due to the shortage of pharmacist in Scotland, community pharmacies have had to employ locums from England and Wales. What mechanism would there be to register such locums with any given Health Board ? What happens in an emergency ? Would the Board expect to keep a pharmacy closed because the only available pharmacist was not included in its approved list ? After all that pharmacist would still be on the RPSGB register. Is the public better serviced by having no access to pharmaceutical services under such circumstances, or is it better to have the pharmacy open with an unapproved but perfectly capable pharmacist ?

On a separate point, if Boards do insist upon the clinical component of care service being on a named pharmacist basis, employees of multiples could hold their employers to ransom. ("I won't do this unless you offer me that"). It also doesn't allow for what happens during days off or sickness and holidays. It must be far better to leave the clinical component with the contractors in order not to restrict services nor overly complicate matters.

Section 5 - Persons authorised to provide pharmaceutical services

This section is entirely taken up with amending the Medicines Act 1978 to remove the requirement for "direct" supervision. There is some sense in it, as it could free up pharmacists for domiciliary visits etc. However will the public accept pharmacists being absent from the premises for extended periods ? Don't the public want to "Ask their pharmacist ?".

Taken alongside an article in the Pharmaceutical Journal about remote supervision (27.3.2004) this proposal could allow one pharmacist to remotely supervise as many pharmacies as he saw fit. That would in my mind be wholly unacceptable and contrary to the spirit of your proposals.

Section 6 - Cross boundary and distant provision of pharmaceutical services

6.10 I seek clarification on this clause that appears to prevent anyone outside Scotland (with the possible exception of Northern Ireland) providing remote dispensing / e:pharmacy / web dispensing. The clause specifies that anyone providing such services must have a full pharmaceutical care contract with a Board. (Terminology only applicable to Scotland and Northern Ireland Is this infact SEHD's intention ?

6.11 This clause seems to be a loophole to gaining a contract. Once a contract is granted, what is to stop the contractor from subsequently reducing the services on offer ?

6.13 This clause excludes the provision of controlled drugs across Board borders. It seems illogical to exclude any category of medication from the proposals. Is this because CD legislation remains a matter for Westminster ?

This clause also identifies that records of cross-boundary services will need to be kept. SEHD must ensure that these don't put an intolerable burden on contractors.

Section 7 - Funding

If SEHD devolve funds to Boards for them to spend, the provision must be fairly apportioned. Local funds won't necessarily be ring-fenced for pharmacy. Also if the cross-boundary proposals in Section 6 are implemented then there will be considerable movement of patients. (e.g. methadone / EHC patients in Kilsyth (Lanarkshire) may well prefer to access these services where nobody knows them in Kirkintilloch (Greater Glasgow). How will the funds be calculated and divided to ensure parity with pharmaceutical care provided ? Could we see cash-strapped Boards encouraging patients accessing services outside their boundaries ?

Section 8 - Partial regulatory impact assessment

The thing to note here is 8.26 which states that "nationally the proposals would be cash neutral". But the overall proposals would involve significant additional investments for contractors and increased costs of administration for the Boards. I therefore fail to see how the proposals can be cash neutral

Yours sincerely,

RESPONDEE INFORMATION FORM

Name:

Postal Address:

Consultation Title: MODERNISING NHS COMMUNITY PHARMACY

1. Are you responding as:

an individual YES

on behalf of a group or organisation NO

2a. INDIVIDUALS

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

2b.

Where confidentiality is not requested we will make your response available to the public on the following basis

YES, make my response available but not my name and address

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