Prescription for Excellence - Health and Sport Committee Session – 29 April 2014
Written submission from Community Pharmacy Scotland

- How the new role envisaged for pharmacists will work in practice across all settings, and what the implications will be for existing roles and services, with specific attention focused on how it will be taken forward in community pharmacies?

Since the publication of *The Right Medicine* patients and the public in Scotland have seen considerable changes in the nature of services provided by Scotland's network of community pharmacies. That development took place against a background of regular meetings, clearly defined aims and co-operative working.

Since 2011 the owners of these pharmacies have been faced with the uncertainties created by the Wilson-Barber review of pharmaceutical care for patients resident in the community, the publication in 2013 of the report from that review and very quickly thereafter the Government's response. That response appeared to bear very little resemblance to what had gone before and did nothing to foster the confidence needed to continue engagement with service development for patient and public benefit. There has also been a lack of meaningful engagement between Government officials and the owners of community pharmacies and at times a feeling that community pharmacy is being excluded from the new ideas. The recent letter from SG to NHS Boards about developing clinical capacity in NHS pharmaceutical care only served to increase confusion in the community sector and perhaps also within Boards.

Based on the above we find it difficult to see how the new role will work in practice. In order to get things moving we need more clarity in terms of what is expected of the teams working in community pharmacies. That would help to boost confidence and perhaps secure investment in development of staff and premises to ensure patients' needs are met. The rationale behind some of the service changes proposed needs to be spelled out. At the moment there is not enough sense of where we are heading to know what to do. Such a change programme requires more than "just do it".

The Wilson-Barber review stated the strength of a generalist pharmacist working in the community and the need to build on existing practice including further roll-out of the Chronic Medication Service. CPS strongly supports these aims and it seems sensible to us to use and develop resources which are already in place. There should be a focus on interaction with GP practices to accelerate full rollout of CMS. The Minor Ailment and Public Health services should be taken further as these initiatives help to build up patient confidence. Pathways to allow access to specialist advice would also be helpful.

Attempts to make patients access services at more than one point do not improve the patient journey. Attempts to introduce new service locations will incur additional costs.

Community Pharmacy teams (pharmacists and support staff) are often those with the most patient contact. The main factor in this lies in the patients accessing the pharmacy network for the supply of their medicines. Where the assembly of that supply occurs is a matter for further discussion and perhaps investment but without the interaction with the patient at the point of supply the best opportunity for care on a regular basis is lost. The interaction also acts as a point of triage to other services.

Prescription for Excellence states that patients should be registered with an individual pharmacist. That is not what happens elsewhere in NHS Scotland. Patients register with a general practice and are allocated a medical practitioner. Registration with a pharmacist would not provide continuity of care. A

great strength of community pharmacy is the open access to services and advice. Often this is at times out with normal working hours and weekends. It is impossible for an individual to provide continuity of care for all the contracted opening hours of a pharmacy. Registering with the pharmacy formalises a patient's relationship with the entire pharmacy team. Continuity is delivered by the whole team being involved in a patient's care.

The other factor is patient safety and avoidance of risk. The current pharmacy regulator is looking for the pharmacy to demonstrate safe and effective practice and to empower their teams. The presence of an NHS Board contracted pharmacist would add another layer of complexity to these procedures.

Community pharmacy contractors and their teams have found in recent years that the links between GPs and community pharmacies no longer work as well because the presence of NHS Board employed pharmacists. Attempts to introduce registration with a specific pharmacist would create a further barrier.

- What achievements have already been made in building collaborative working between GPs and pharmacists (i.e. through the joint initiative by RCGP Scotland and RPS Scotland) and what more will need to be done to bring about the changes envisaged in the strategy?

In a limited number of areas CMS has been fully rolled out to deliver care planning along with serial prescribing. This has delivered efficiencies for all stakeholders and allowed pharmacy teams to deliver more pharmaceutical care. The roll out needs to continue and accelerate to allow patients across Scotland to benefit from more opportunity for care and for community pharmacy teams to interact with the patient according to an agreed pathway.

In our response to Wilson-Barber we put forward proposals for how pharmacist prescribing could be developed, e.g. the pharmacy would be charged with providing care in line with set parameters and if these parameters were exceeded then a referral back would be made. We also called for access to appropriate medical records. Due to long lead times for IT development we have to begin scoping work soon on any changes needed to support new areas of work

We would like to see SG taking ideas forward in a more collaborative fashion.

Collaborative working between professional organisations is to be welcomed. In order to deliver the desired outcomes the contractor bodies must be engaged and supportive of the vision.

- What are the workforce planning implications of the strategy, and how will these be addressed?

Prescription for Excellence does not make clear what is required in terms of workforce planning because it doesn't make clear what the service model will be. For all scenarios NHS Education for Scotland would need to be adequately funded to deliver the appropriate training skills.

In 2013 a consultation on ensuring a sustainable supply of pharmacy graduates took place in England and that was looking at how the overall training programme should be provided. Changes to the method adopted by schools of pharmacy in England and Wales could impact upon students at the Scottish universities as currently there are more pharmacists graduating from Scottish Universities than there are pre- registration places available. At the moment most of these surplus graduates go to England for their pre-registration year. That option may be lost depending upon the agreed direction of travel. We expect a report from the consultation soon.

Support staff numbers are a commercial decision for contractors and it would be very difficult to produce a workforce plan. The statement from the pharmacy regulator that it will be looking at the scope of the pharmacy technician's role and the training requirements will also need to be taken into consideration.

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