Community Pharmacy Scotland response to the Department of Health Consultation

Amendments to the Human Medicines Regulations 2012: Hub and Spoke dispensing, prices of medicines on dispensing labels, labelling requirements and pharmacists' exemption

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Who we are

Community Pharmacy Scotland (CPS) is the body recognised to represent the pharmacy contractors who own Scotland's 1255 community pharmacies in negotiations with the Scottish Government on remuneration and terms of service relating to the provision of NHS pharmaceutical care services. Within our membership we represent all types of pharmacy, multiple and independent, rural and urban, situated throughout Scotland.

Scottish Pharmacy contractors dispense just under 100 million prescriptions per year. In addition, we offer a range of services including Minor Ailment Service (MAS), Public Health Services Smoking Cessation and Emergency Hormonal Contraception and the Chronic Medication Service for patients with long term conditions. The pharmacy contract in Scotland has been developed and is remunerated to meet the needs of NHS Scotland.

CPS is pleased to respond and contribute to the consultation.
The consultation has been approved by our Board, each member of which is an elected member of the contractor network in Scotland.

In formulating our response, we draw attention to the legislative differences between Scotland and the other home countries, which have a bearing on our replies.
We also highlight that, for all responses, it is essential that all Spokes and Hubs are registered premises.

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Question 1: Do you agree that we should remove the impediment in medicines legislation that prevents the operation of 'hub and spoke' dispensing models across different legal entities?
Yes.

In formulating our response, we consider it essential that both the Spoke and Hub are registered pharmacies.
We have assumed the amendment relates to the full dispensing operations and have taken the term assembly to be as per Medicines, Ethics and Practice.

Question 2: Do you agree that in the Human Medicines Regulations we should not impose any restrictions as to which 'hub and spoke' models can be operated?
No

CPS is supportive of the Hub-to -Spoke-to-Patient route, where both Spoke and Hub are registered pharmacies.
It is vital that the relationship between the patient and their community pharmacist remains strong. This will ensure the patient care and advice is provided in the pharmacy.
If the option to deliver direct to the patient is implemented, the vital counselling may not take place, which would have a detrimental effect on the care provided.
We do not want to see the supply and service completely separated. Otherwise, all we have is internet pharmacy and a commoditisation of the dispensing service.

Prescription for Excellence has a Workforce and Technology Group collating and analysing evidence on this type of work.

Question 3: Do you agree that 'hubs' should continue to be registered pharmacies?
Yes.
This is essential to meet the GPhC Premises Standards.

Question 4: Do you think 'hub and spoke' dispensing raises issues in respect to the regulation of pharmacies? If so, please give details.
Yes.
Accountability and responsibility for adverse incidents needs to be defined, and any amendments made to the Human Medicines Regulations.
Consideration needs to be given to the Falsified Medicines Directive due for implementation in 2019.

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Question 5: Do you have any comments on the assumptions for our Impact Assessment (Annex C) for the proposal to make 'hub and spoke' dispensing possible across legal entities?

Assumption 1
10% reduction on pharmacist labour costs at spoke pharmacies.
This must assume the pharmacist is involved in the dispensing process, since this is where the potential saving is made.
The absolute role of the pharmacist at the spoke is largely unchanged; the clinical check and patient counselling still take place there. We do not anticipate any change to the pharmacist workload in the dispensing process at the spoke.

25% reduction in pharmacy technician labour costs at spoke pharmacies.
This is only relevant where the resource is removed, as opposed to being diverted elsewhere to provide other services to the patients. It could, however, limit the participation for some pharmacies in the Hub & Spoke Operation, as there needs to be a minimum number of people (at least three) in the pharmacy for security purposes.
There is no specific evidence to quantify the figures quoted.

2.5-5 % increase in Pharmacist Labour Costs at hub pharmacy.
This is difficult to quantify; the pharmacist at the hub will mainly have the role of the Responsible Pharmacist. Accuracy checking will be undertaken by an Accuracy Checking Technician.
There is no specific evidence to quantify the figures quoted.

6.25-12.5% increase in pharmacy technician labour costs at hub pharmacies.
Anticipate this is likely to be closer to the 12.5%.
There is no specific evidence to quantify the figures quoted.

Estimate 45% of medicines will be dispensed through H&S Dispensaries.
There is no specific evidence to quantify the figures quoted.

Assumption 2
Labour saving for other staff.
We do not anticipate any here; the sortation and handout still has to happen in the pharmacy. The tasks and patient care provided by the rest of the team are unchanged.

Assumption3
Potential labour saving for independent, small multiple and large multiples are the same.
The rate limiting factor is the volume of prescriptions available to go to the hub; immediate supplies need to be filled in the pharmacy, and collection items require a reasonable time window.

Assumption 4
25-50% of independent pharmacies and 25-50% of small multiples will use Hub and Spoke pharmacies.
There is no specific evidence to quantify the figures quoted.

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Assumption 5
30-60% of medicines dispensed will make use of Hub & Spoke dispensing.
This is affected by many variables, as per above;
Volume of collected scripts
Number of staff in the pharmacy – minimum of three people needed in the pharmacy for Safety and Security.
There is no specific evidence to quantify the figures quoted.

Assumption 6
Some hub capacity will be provided by large, automated hubs and some by smaller pharmacies collaborating to provide their own hubs.
There is insufficient data at this stage to predict the relative proportions.

Assumption 7
A hub with capacity for 250 spoke pharmacies costing £5 million and one of 1500 capacity at £120 million.
There is no specific evidence to quantify the figures quoted.

Assumption 8
There is no assumption 8 in the paper

Assumption 9
Assumptions based on £36441 pharmacist and £19462 for technicians.
The pharmacist saving is negligible; potential savings all come from the operation by the dispensing team, and are only relevant where the resource is removed and not diverted to other services for patients.
Potential for increased income if pharmacists are able to deliver more services in this time window.

Assumption 10
30% of dispensing activity is performed by independent pharmacies (fewer than 5), 20% by small multiples (between 5 and 99) and 50% by large multiples.
There is no specific evidence to quantify the figures quoted.

Assumption 11
What level of stockholding reduction is realistic?
Stockholding reduction will depend on the timing of the patient collection, and previous stockholding in pharmacies.
There is no specific data on actual stock reduction.

Assumption 12
Hub pharmacies supplying directly to patients.
We are not in support of this for the reasons detailed above. Both Spoke and Hub must be registered pharmacies, and the provision of patient care by the pharmacy at the point of hand out/collection is critical.

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Question 6: Are you aware of or able to provide evidence that 'hub and spoke' dispensing is more efficient and cost-saving, including according to the scale of the 'hub' operation?
This information may be available from some CCA pharmacies already operating these, however, these figures are business sensitive and not available to CPS.

Question 7: Are you aware of or able to provide evidence that 'hub and spoke' dispensing is safer, including according to the scale of the 'hub' operation?
There is no specific data available.

Price of Medicines on dispensing labels

Question 8 Before changes can be made for the prices to be displayed on NHS dispensed medicines, enabling amendments need to be made to the Human Medicines Regulation 2012. Do you agree with these amendments to the Human Medicines Regulations 2012?

No.

There is no evidence of the benefit of this, and there will be a significant cost to deliver. In addition, there is a Patient Safety Risk that some patients may stop taking their medicines out of concern for the cost burden to the tax payer/Scottish Government. CPS do not support this proposal.
It does not represent current Scottish Government policy.

Question 9: Are you aware of any other evidence that supports the impact of patients' understanding of the prices of health services on their behaviour, including from local initiatives? If so, please give details?
As per above, potential Patient Care and Safety risk.

Question 10: Do you have any views on the proposed implementation in the NHS in England? If so, please give details?
None available.

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Labelling of medicines supplied under patient group directions and monitored dosage systems

Question 11: Do you agree with the set of information that is proposed to appear on the dispensing labels for MDS?
Yes
This supports best practice already in place, ensuring the meds supplied on PGD and MDS are labelled and given the same information as for supply of meds on prescription. Consideration may need to be made for bespoke dosette labelling to support specific patient needs. This will be explored further directly with the DoH.
It helps underpin the Universal Claim Framework which is being developed within NHS Scotland. In order that messages are created and sent, the information must be captured on the PMR

Question 12: Are there practical issues with what is proposed that would make application difficult in practice? If so, please give details.
Labelling regs may need some amends to the PMR/MDS Systems which may result in a cost implication for Community Pharmacy.

Question 13: Do you have views on the proposed flexibility for the information to appear on a combination of both the outer and immediate packaging?
No issues.

Question 14: Do you think pharmacies that supply medicines to other healthcare settings, e.g. 'hub' pharmacies and some hospital pharmacies, will need to part prepare some pharmacopoeia and other preparations in advance of the prescription being received? If so, please provide examples of the sorts of part preparation that are necessary.
No.

Question 15: Do you think that pharmacists in a registered pharmacy should continue to be allowed to prepare 'Chemist's Nostrums'? If so, could you provide us with examples of 'Chemist's Nostrums' that are being prepared?
Yes
While they are not used very often, Chemist's Nostrums are of value for some patients and the current exemption must remain in place.

Question 16: Is there anything else you would like to raise with regards to the proposals for restructuring the pharmacists' exemption?
Would have no adverse implications for pharmaceutical care or pharmacists in Scotland.

Question 17: Do you have any comments on the initial equality assessment or evidence that we should consider in the development of final equality assessment?
None

Questions 18: Do you have any comments on the draft Human Medicines (Amendment) (No. 2) Regulations 2016?
CPS has no further comment

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