Health and Social Care Committee

Inquiry into the Contribution of Community Pharmacy to Health Services in Wales

CP 43 – Community Pharmacy Scotland

Who are we?

Community Pharmacy Scotland is the organisation which represents community pharmacy contractor owners in almost every aspect of their working lives, and is the voice of these vital healthcare professionals as they deliver pharmaceutical care to the people of Scotland.

NHS Pharmaceutical Services Regulations 2009 state that Scottish Ministers must consult with a body representative of the general body of pharmacy contractors. Community Pharmacy Scotland is recognised as that body by Scottish Ministers. We currently represent the owners of 1234 pharmacies in Scotland. We negotiate on their behalf with the Scottish Government on all matters of terms of service and contractors' NHS service activity including remuneration and reimbursement for the provision of NHS pharmaceutical services.

Historical Background

The NHS in Scotland is operated under the NHS Scotland Act, first introduced in 1948. This recognises that NHS Boards must ensure adequate provision of pharmaceutical services. It also covers the arrangements for other independent contractors. Pharmacy contractors in Scotland since the inception of the NHS have negotiated with the civil service in Scotland directly. Post devolution the responsibility for Health moved from the Secretary of State to the Health Minister elected at Holyrood.

The first act of the new government was to produce *Our National Health: a plan for action, a plan for change.* This plan set out a new direction for health policy and delivery in Scotland. It was followed by the publication of *The Right Medicine: A strategy for Pharmaceutical Care in Scotland*. The Right Medicine was an agenda for the modernisation of pharmacy services.

The Right Medicine stated that the Government would work with the profession to develop a new system of remuneration which provides incentives to deliver a quality patient focused service. A set of principles was agreed in January 2003 to underpin the development of a new contract.

SG/Community Pharmacy Scotland Agreed Principles for new Community Pharmacy Contract

The new contract should:

- provide services that deliver pharmaceutical care in an efficient and effective way and in line with the proposals set out in *The Right Medicine*;
- support a rational network of pharmacies/pharmacists that provides equitable and convenient access for patients in terms of location and opening times;
- ensure that the provision of quality pharmaceutical care services, including the traditional dispensing function, is properly resourced;
- provide services in a way that ensures patients have better access to a full range of pharmaceutical care services;
- ensure that developments in pharmacy tie in with the priorities for healthcare in Scotland (e.g. Public Health, Chronic Disease Management);
- deliver a quality service throughout Scotland;
- provide opportunities for continuing professional development and the development of new skills for all staff within community pharmacy;
- provide opportunities to recruit, retain and motivate all staff within community pharmacy;
- encourage and support better partnerships between individual community pharmacies and with other members of the wider health and community care team, including pharmacists working out-with community pharmacy;
- ensure that patients throughout NHS Scotland benefit from the introduction of any new services, following due consultation and evaluation, which are resourced accordingly;
- ensure that pharmaceutical services are provided from premises fit for the purpose;
- ensure that a suitable infrastructure is in place including the provision of IT resource;
- ensure minimum financial turbulence for contractors who have demonstrated their commitment to NHS Scotland through their financial investment; and
- incorporate a 'high trust/low bureaucracy' approach.

Following the agreement of principles meetings were arranged between the two parties to agree further development. These meetings have two agenda sets - strategic and technical.

Our evidence on the questions posed follows.

1) **Funding of the Community Pharmacy Contract**

Funding for the provision of pharmaceutical services was traditionally made on the basis of a cost-plus contract. The cost of the service was established through surveys and an agreed level of profit calculated. This funding was known as the **global sum**.

The cost-plus arrangements were abolished many years ago and the global sum was subsequently updated through negotiation. When the new contracts were introduced, in 2005 in England & Wales and 2006 in Scotland, a new element was an agreement on the amount of reimbursement income which contractors would be allowed to keep. This was the **retained purchase profit element**.

The overall funding envelope for the provision of the core services therefore consists of: **Global Sum** + **Retained Purchase Profit**

Since 2006 the global sum has been updated through negotiation and the retained purchase profit arrangements have been modified to introduce an agreement that where the profits earned exceed a guaranteed amount then that surplus will be shared between pharmacy contractors and NHS Boards. The intention behind these new arrangements is to provide an incentive for contractors to purchase well.

A cost survey was held in to inform negotiations on the funding of the service and quarterly spot checks are held to confirm the level of purchase profit existing in the market place.

Funding for the provision of a number of services, the additional services, is negotiated between the pharmacy contractors and the NHS Boards. The NHS Boards have an allocation from central funds for these services but can chose to supplement that payment from other “funding pots”.

Distribution of the Financial Envelope

Prior to the introduction of the revised contractual arrangements in 2006 detailed discussions took place on the make up of the financial envelope, including the transfer of money (£30m) from reimbursement into remuneration when the Category M pricing arrangements were introduced, the way the money should be allocated to each of the new services, and the actual method of distribution for each of the service areas. For obvious

reasons both pharmacy contractors and the NHS Boards were keen to see that this transfer of money worked accurately. A full series of booklets is available on the Community Pharmacy Scotland to outline funding since 2006 for further perusal.

Method of Distribution

A. Remuneration

Minor Ailment Service (MAS)

Funding for this service is made on a **banded capitation basis**. Information on the number of patient registrations per pharmacy is held centrally and payment is made on the number of registrations on the system at the end of the month. Reimbursement is also made for any product supplied. No fees are paid.

Public Health Service (PHS)

Funding for this service was initially made as a **fixed amount** per pharmacy. As the new patient -centred PHS services were introduced the fixed payment element has been reduced and **payment per intervention** has been introduced.

Acute and Chronic Medication Service (AMS/CMS)

A unique feature of the Scottish contract was the decision taken in 2004 to move away from the payment of individual fees and allowances and to enter into a **transitional payment system.** The idea then was to provide stability over a period of time while the new services were introduced. For each contractor where sufficient information was available a fixed monthly payment was introduced. In subsequent years the monthly payment was adjusted to reflect growth within the system and negotiations on the overall sums available. In October 2011 the first steps have been taken to move away from the fixed payments and start to allocate money for the provision of the Chronic Medication Service. It has always been the stated intention that payment for CMS will be made on a **capitation basis**, weighted as appropriate.

Miscellaneous

A number of other fixed payments are also made, e.g. for participating in the Urgent Supply arrangements, for the provision of flu vaccines on stock orders, and towards IT requirements.

A. Reimbursement

The arrangements for the pricing of products supplied are set out in the Drug Tariff. The amount of profit within the system is modulated through the application of both generic and proprietary discount clew back rates.

2) Arrangements for Sharing Information

An electronic infrastructure has been created to allow transmission of prescription information from GPs to CPs. More detailed information may be accessed at Scottish Health on the Web Community Pharmacy.

Currently two services support the sharing of information electronically. The first is the Acute Medication Service (see annex A for further information). This shares GP prescription information using barcode technology to support ongoing remuneration and reimbursement.

The use of barcodes on prescriptions also supports improvements in patient safety. Downloading the electronic message directly minimises the risk of transcription error from a handwritten or non e-enabled prescription. The barcode also prevents the dispensing of an out of date prescription previously this relied on human intervention and this could be missed.

The second core service which shares information electronically with GPs is the Chronic Medication Service (see Annex A for further information).Two sorts of information are shared. Firstly, dates of dispensing for CMS serial prescriptions will be automatically sent to GPs for information. Secondly once CMS is fully established it will also be possible for CPs to provide end of treatment reports to GPs. The information shared will support GPs to ensure appropriate monitoring and feedback on patients is shared to support the release of a further serial prescription or QOF (quality and outcomes framework) review.

In terms of access to information community pharmacists are currently very restricted in terms of what they can see. CPS continues to lobby for access to the electronic record information. We believe the following information would be useful for pharmacy contractors:

- **Cholesterol results**

Cholesterol results for patients who are taking cholesterol lowering medicines (statins) if the patient is not reaching target levels and previously was, the intervention of a pharmacist could support improved adherence along with lifestyle advice without requiring increased doses (and therefore cost) of medicines.

- **Warfarin blood results**

Warfarin requires careful monitoring and patients must achieve a certain target level (INR). This level is maintained in a dose response relationship and it would be helpful for pharmacists to have sight of an e-copy of the required dose and current level. Patients are currently expected to provide their Warfarin Book but routinely forget to bring it.

- **Chemotherapy prescribing by secondary care**

Community Pharmacy currently has no visibility on prescribing in secondary care. This would be helpful in this instance if a patient presented feeling unwell in the unscheduled care period. There is a risk if a patient does not inform the pharmacist they are undertaking chemotherapy that infection which is more severe in immunocompromised patients is not escalated appropriately.

3) **Integration into Wider Health Services**

The focus within NHS Scotland is to use Community Pharmacies where appropriate to make services accessible to patients and to reduce pressures on other parts of NHS Scotland. Examples of how this is being achieved are:

- The Minor Ailment service – 790,059 patients were registered at the end of March 2011 and 1.7m items were prescribed.
- The Public Health Service – NRT and EHC – Over 80% of EHC consultations in Scotland are now delivered through the community pharmacy network and in the past two years a reduction has been seen in the abortion rate and in the birth rate.
- Provision of services in the GP out of hours' period – NHS24 uses community pharmacy as a major line of referral.
- CPUS Service – where a patient who is receiving treatment for a chronic condition has been unable to access the GP practice that patient will be able to receive a full cycle of his/her medication from a pharmacy through the “urgent supply” arrangements. The pharmacist has the facility to write a prescription for a full cycle and the service is underpinned by a national PGD hosted by NHS 24.

4) **Key Drivers of an Enhanced Role**

The key drivers behind an enhanced role for community pharmacy are:

1. Deliver Pharmaceutical Care for Patients in Scotland to ensure they get the most from their medicines.

2. Efficient use of monies for Prescribing Budgets through reduction of waste
3. The availability of access to a healthcare professional
4. The need to make best use of all health professionals
5. The challenges posed by the forthcoming demographic changes. We need to ensure ongoing review and reshaping of care provided to prevent unnecessary admissions to hospital.

5) What pharmaceutical care services do we provide?

Pharmacy contractors in Scotland are expected to provide all four core pharmacy services in the contract framework. The four core services (detailed description in Annex A) are:

- Chronic Medication Service
- Minor Ailment Service
- Public Health Service
- Acute Medication Service

Pharmacy contractors will also provide locally negotiated (additional) services in agreement with their local health board. Such services include needle exchange schemes and the dispensing and supervision of consumption for methadone prescriptions.

6) How was the contract developed?

The contract evolved through a series of discussions between us and the Scottish Government. The key components of these discussions focussed around:

- Who was the contract for?
- What did we want it to do?
- What services would be provided?
- How would we get paid?
- What infrastructure would be required?

The objectives of the service redesign were to ensure:

- Ready access to the Community Pharmacy network for supply and care
- Deliver Quality services for patients, users and carers
- An Improvement in the public's health
- Position the pharmacy profession as key provider of Healthcare.

It must be recognised that the development of the contract would not have been possible without the underpinning of the ePharmacy programme. Every pharmacy has been provided with an N3 connection.

Money has also been provided for other infrastructure requirements such as the training of staff, for premises improvements, for the availability of Pharmacy Champions and Pharmacy IM& T facilitators.

Training material for the new services has been made available by NHS National Education Scotland.

7) Strengths and Weaknesses of the Scottish Pharmacy contract

Strengths – The first recognisable strength of the contract is close collaboration between the Scottish Government and Pharmacy contractors to realise a joint aim. The second strength was a vision was clearly laid out for all to see at the beginning of the process. A further strength was the Scottish Government and CPS being bold enough to ensure ongoing contractor financial stability during the development of the contract including novel ways of funding such as capitation and a move away from what was seen to be a perverse incentive.

The use of pilots prior to full service rollout was also useful as these highlighted potential issues in service delivery. There was also recognition of the need to build capacity in IT, staff and premises which has resulted in a improved pharmacy network better able to deliver the new services

Weaknesses – The introduction of GP QOF has resulted in inexorable increases in prescription volume. Whilst this has improved the management of long term conditions the pace of dispensing and supply required in pharmacy to service this reduces time available for new services. Community Pharmacy Scotland is aware this needs to be tackled to support ongoing service delivery.

The fact that IT system suppliers are required to deliver different solutions for other home nations has slowed development at times. We now have operational underpinning for all services as required but system upgrades are required to improve service delivery and these are only now coming on stream.

The protracted roll out of CMS has resulted in GPs being less engaged than would be desirable. Hopefully this will improve in time as co-delivery of care ramps up.

A further weakness for the Scottish contract was the effect of the implementation of Category M changes agreed in England and Wales. Due to

this steps were undertaken this financial year to distance ourselves from the link to Category M.

8) Translation across to Wales

In terms of service development which could be transferred across to Wales we see potential for adopting elements of MAS and CMS. The software packages have already been developed for contractors and it would be worth exploring to see how they could be integrated into the existing pharmacy systems. It would of course also be necessary to look at the NHS IT systems, particularly in terms of setting up registration systems, and we do not know whether this is something NHS Wales has already looked at.

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Annex A

Core Services Description

The Minor Ailment Service

This service was introduced in 2006 and evolved out of successful pilot schemes run in 2 Health Board areas.

Initially patients who were exempt from prescription charges could register with the community pharmacy of their choice and use that pharmacy as the first port of call for the consultation and treatment of common illnesses. The pharmacist advises treats or refers the patient according to their needs. The service is underpinned by an electronic infrastructure. A module has been developed within the pharmacy PMR which allows:

- registration information to flow to and from a central registration store maintained by a support division within NHS Scotland
- the pharmacist to generate a prescription form for signature by the patient

Payment for the service is made on a banded capitation basis and through reimbursement for any item provided. No fees per item are paid.

The pharmacist can provide any P or GSL item that is not blacklisted, dressings and appliances from Part 2 of the Drug Tariff, selected appliances from Part 3 such as bug busting kits and any prescription only medicines agreed suitable and underpinned by a Patient Group Directive (PGD).

Pharmacists are expected to prescribe in line with local and national formularies. A separate budget line has been created for MAS prescribing costs.

A recent research paper concluded that the banded capitation payment system was one of the strengths of the service.

The current position is that the service remains available only to those patients who were previously exempt from prescription charges. CPS has proposed that all patients should be allowed to register for the service but that the contents of the formulary should become more restricted.

Public Health Service

This service was first introduced in 2006 and has been developed over the succeeding years.

Initially the service specification covered the promotion of self care, the display of public health posters and leaflets and the provision of opportunistic interventions for advice and support on self care, health protection and health improvement. Subsequently new initiatives saw the delivery of a smoking cessation support service and a sexual health service. Initially the sexual health service covered both the provision of Emergency Hormonal Contraception and HC and a Chlamydia testing service but the chlamydia element has now been withdrawn.

Contractors are required to return information to the NHS board in the form of a minimum dataset for the smoking cessation service. The Boards are charged with meeting HEAT targets for smoking cessation.

Payment for the service is made through a combination of a fixed rate payment plus a fee per intervention for the patient centred services.

eAMS – Electronic Transmission of Prescriptions

In essence this element of the contract covers the traditional dispensing and supply role. An electronic infrastructure has been developed to support electronic transmission of prescription information (ETP)

The overall aim of ETP is to enable the electronic generation, transmission, dispensing and
processing of prescriptions.

ETP allows a GP to produce a bar-coded paper prescription and an associated electronic message. This message is an electronic version of all the details that are printed on the prescription form. The message is sent by the GP system to the ePharmacy Message Store (ePMS) where it sits until the patient presents the prescription in a pharmacy.

Pharmacists or their staff are able to retrieve the message by scanning the bar code on the prescription form. The pharmacy PMR (Patient Medication Record) system can then use most of the information in the message to process the prescription, whilst still allowing referral to the paper form where necessary. Once the prescription is dispensed, contractors send an electronic claim message to the message store. This claim is later retrieved by Practitioner Services Division (PSD) at NHS National Service Scotland (NHS NSS). This electronic claim information is used where possible and supported by a set of pricing business rules for remuneration, reimbursement and

information gathering purposes. This forms the basis of the 'ePay' element of the ePharmacy Programme.

ETP has initially covered all acute and repeat GP prescriptions. ETP will also be extended to cover serial dispensing, other prescribers and Out of Hours prescriptions.

The electronic transfer of prescriptions was initially piloted in NHS Ayrshire & Arran, where in excess of one million ETP prescriptions were successfully issued by a number of GP practices prior to National Role Out.

CMS – Pharmaceutical Care Support for Long Term Conditions

Chronic Medication Service (CMS) provides an ideal opportunity to:

- build on and strengthen existing good pharmacy practice
- encourage joint working between GPs and community pharmacists
- further improve patient care

The purpose of CMS is to further develop the contribution of community pharmacists in the management of individual patients with long-term conditions by improving their understanding of their medicines and working in partnership with them and other healthcare practitioners to maximise the clinical outcomes from their therapy.

By applying a systematic approach pharmacists will help patients manage their long-term conditions in order to:

- identify and prioritise risk
- minimise adverse drug reactions
- address existing and prevent potential problems with medicines
- provide structured follow-up with referral interventions where necessary.

CMS is underpinned by a generic framework for pharmaceutical care planning based on the Clinical Resource and Audit Group (CRAG) Framework document, *Clinical Pharmacy Practice in Primary Care*. It is described in more detail in *Establishing Effective Therapeutic Partnerships*, the CMS Advisory Group report commissioned by the Chief Pharmaceutical Officer and produced under the chairmanship of Professor Lewis Ritchie.

CMS outline

CMS is a service which requires patients to opt in before participation. There are three specific stages in the Community Pharmacy CMS process each of which is underpinned by the ePharmacy Programme.

- **Stage 1** involves the **registration** of patients for CMS.
- **Stage 2** introduces a generic framework for **pharmaceutical care planning.**
- **Stage 3** establishes **the shared care** element which allows a patient's general practitioner (GP) to produce a **serial prescription** for up to 48 weeks (generally 24 or 48 weeks) and which is dispensed at appropriate time intervals determined by the patient's GP.

This stage will be supported by disease specific protocols for a number of pertinent disease conditions which outline common potential pharmaceutical care issues, referral criteria and reporting requirements.

Current tools being developed support safe use of Methotrexate, Lithium and initiation of new medicines. It is anticipated other high risk medicines such as Warfarin will also be supported.