Health and Social Care Committee
Inquiry into the contribution of community pharmacy to health services in Wales

CP 30a – Alliance Boots – Supplementary note on Scottish model

Mark Drakeford AM
Chairman, Health and Social Care Committee
National Assembly for Wales
Cardiff Bay
Cardiff CF99 1NA

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Dear Mr Drakeford,

What Wales could learn from Scotland: the experiences of Boots UK

Boots UK operates operates over 2,000 community pharmacies across the UK, of which 99 are in Wales and around 280 are in Scotland. We thought it might be useful for the Committee to share with you some of our insights into the way in which the pharmacy contract operates in Scotland.

We have sought to draw out some key points that the Welsh Government would need to take into consideration if it wished to move closer to the Scottish model. After five years of the current pharmacy contract in Scotland, we believe that Wales is in a good position: it can adopt those measures that have been successful clinically, professionally and in boosting public health, while also being able to avoid some of the issues that naturally arise in the early days of any new arrangements, such as around IT systems.

We would also like to stress that there remains a great deal of commonality between the pharmacy systems across the UK. They are underpinned by the same body of UK and EU medicines legislation; the same professional codes of practice apply; and they all share the ethos of a publicly-funded, comprehensive NHS.

Core pharmacy services, including dispensing of prescriptions, sales of non-prescription medicines, the delivery of extended services and the provision of free advice to customers on medicines and healthy lifestyles, are largely the same in each country. Most differences relate to the systems for payment, the names of services or the IT systems underpinning them.

We do not envisage that Wales would have any great difficulty, in terms of the professional capability of its pharmacies, in adopting large parts of the Scottish model. Both Wales and Scotland also share an emphasis on “all-country” solutions, providing a comprehensive service to the whole population. This is of great benefit to Boots UK, as we seek to deliver a high quality service to all our customers.

Our comments are in note form for briefness, but we would be happy to talk these through in greater detail, including bringing in colleagues from Scotland if necessary.

Yours sincerely

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Boots UK

What Wales can learn from Scotland:
lessons from the Scottish pharmacy contract

What works in Scotland	What Wales would have to do
The pharmacy contract has a clear "high-level" vision and purpose, beyond simply delivering current services, with an aim to move towards rewarding clinical input rather than just volume of dispensing	Set out a clear vision (5-10 years) of direction of travel and milestones, with benefits for patients, NHS and pharmacy; get clear support from Government
The Scottish Government has been supportive in "words, deeds and cash", with supportive policy, legislation and funding being forthcoming. There is general cross-party support for pharmacy	Welsh Government would need to match words with "deeds and cash"; pump-priming funding for infrastructure and pilots would be needed; pharmacy needs to have influence within Government
There is a close and productive relationship between CPS (and RPS) and the Scottish Government in working towards the contract's higher aims	Ensure that both sides are well resourced and are willing to work towards solutions rather than just financial outcomes; set realistic timescales for achievement
There has been general buy-in from the profession, including professional bodies, academia and employers, ensuring smooth uptake of the new contract and its services	Ensure profession is involved in development of vision; ensure that pharmacists see words turning into "deeds and cash" to prevent disillusionment
There has been a lack of any significant opposition towards the aims of the contract, either from within pharmacy or from other professions. This may be due to a much lower incidence of dispensing by doctors in Scotland	Opposition from other professions needs to be taken on or neutralised with political support; public support needs to be nurtured and made vocal
There has been general positive coverage in the national media and trade press	Media needs to be kept on side with positive things to report
AMS: Builds on existing pharmacy practice; eAMS not over-specified (ie, no smartcards); smaller range of IT systems (especially for GPs) to be connected; incentive and infrastructure payments; service was piloted before roll out	Translate "essential" into AMS using 2D barcode technology; incentivise uptake; ensure system is robust and quick
CMS: Builds on previous work (care plans); piloted and gradually extended; training and support for pharmacists through NES; incentive payments for uptake; clear fit with overall vision for contract and profession	Set out clear and long-term plan (building on Scottish experience) with proper piloting; ensure GP buy-in and support through incentives; make sure service aims to "walk before it can run"

MAS: Builds on traditional role for pharmacies; solved a problem for NHS and patients (around prescription exemptions); eMAS has central database for eligibility and was not over-specified; "radio-button" registration (in-out); reasonable range in formulary; CP2 form has other uses; easily understood by patients and politicians	Establish a single MAS service for Wales; set up single database for eligibility; introduce pharmacist prescribing form; address issue of eligibility following introduction of free prescriptions
PHS: Builds on previous pharmacy services; single specification for service, payment and training; compulsory for all pharmacies; easily understood by patients and provides easy access; lack of opposition (by GPs or media)	Set out a single suite of services (beyond those in Scotland); avoid duplication of effort and accreditation issues; have national advertising to promote uptake and avoid restrictions on what pharmacies can say and do in terms of promotions
Finances: Transition has been gradual; single monthly payments give stability; use of e-systems incentivised; uplifts in purchase profits and benefit-sharing with NHS; Cat R solution to branded generics; ringfenced funding; NHS investment in pharmacy IT and premises; no dilution as control of entry unchanged	State the aim of transition to capitation-based payments in long term; make long-term plans; introduce monthly payments; make use of Cat R and benefit-sharing; have robust IT systems
Comms: Use of pilots has generally avoided last-minute scramble to make new services work; communications have been clear and timely; good summary workbooks available for pharmacies	Ensure realistic timetables for service introduction with timely comms to pharmacies, NHS and public; provide good support for pharmacies once started
Incentives: Scotland has favoured "carrots before sticks" in terms of incentivising uptake of services by pharmacies; there has been "a large bag of carrots, generously shared"	Use incentives to ensure prompt and comprehensive uptake of services and underpinning IT systems
Data: There has been comprehensive collection of data; NHS bodies have issued good summaries of progress and implications using this data	Collect meaningful data on national basis; analyse data for evidence of outcomes and impacts; publish summaries widely

Issues seen in Scotland	Possible Welsh solutions
Pace: Roll-out of services (especially CMS) has been behind initial forecasts; uptake of CMS remains slow	Set realistic timetable for piloting and roll-out (avoiding artificial timescales such as elections); learn from Scottish experiences
Uptake: Lack of national advertising and restrictions on what pharmacies can say mean that uptake of services is lower than it could be (eg, only 14% registered for MAS)	Play to pharmacy's strengths in marketing backed by national awareness campaigns for patients and NHS
The Scottish contract has not addressed underlying matters such as rising volumes and supply chain issues	These need to be addressed at a UK level by all stakeholders, including pharmacy and Governments
Variability: There is still variability introduced by Health Boards, such as use of pharmacy for smoking cessation; impact of pharmacy services is much less in remote and Island settings due to low pharmacy numbers	Have a single suite of services; don't introduce bureaucratic complexity ("simple for stores"); address rural issues through innovative solutions for remote delivery of services
Progress: There has been a lack of new services for PHS and a sense that the current contract might be "running out of steam", hence the Review of Pharmacy Services; little progress with stated aims of innovative use of IT or robots in dispensing; issue of eligibility for MAS now prescriptions are free for all	Learn from Scottish experiences and Review once published; consider how innovation can be maintained in the system
Threats: Scottish Government pharmacy advisors have sought to have greater control over private providers, including through premises standards, performers' lists or individual contracts; influence of dispensing doctors	Resist the desire to interfere with the operation of the highly successful pharmacy market

Glossary:

AMS: Acute Medication Service – core service within the Scottish community pharmacy contractual framework covering the dispensing of all NHS prescriptions (except those in CMS) and the provision of relevant pharmaceutical advice to patients. Also includes the use of electronic prescriptions for dispensing and electronic processing of pharmacy payments

MAS: Minor Ailments Service – core service covering the provision of non-prescription medicines to registered patients who meet the previous criteria for exemption from NHS prescription charges (on grounds of age or income).

PHS: Public Health Service – core service covering the provision of selected public health services to patients through community pharmacies. Current services include smoking cessation, provision of emergency hormonal contraception and test-and-treat for Chlamydia infection. These services are provided under national PGDs. Also includes participation in public health campaigns and the display of window posters to support these.

CMS: Chronic Medication Service – a service through which community pharmacists assume responsibility for the pharmaceutical care of selected, registered patients with long-term medical conditions. Includes the preparation of a pharmaceutical care plan (agreed between pharmacist, patient and prescriber) and the dispensing of serial prescriptions. Pharmacists are able to make alterations to the prescribed medication, as set out within the care plan, as necessary. The dispensing of serial prescriptions is currently in "early adoptor" stage at small number of pharmacies in Scotland.

Core service: Service required to be provided by all community pharmacies in Scotland as part of the community pharmacy contract. Currently, AMS, MAS and PHS. CMS is a core service but has only recently started full registration of patients and is not yet fully rolled out.

ePharmacy: electronic systems to support AMS, MAS, PHS, CMS. Required to be used by all community pharmacies. Normally provided to pharmacies by IT suppliers as add-ons to existing pharmacy management systems. Underpinned by NHS Scotland systems, including patient demographic database used to confirm eligibility for MAS.

Category M: System used across the UK to set prices of common generic medicines in order to deliver agreed levels of retained purchase profits to community pharmacies. Prices are set by Department of Health and published in Drug Tariff. They are normally readjusted twice a year.

Category R: System used in Scotland on top of Category M to adjust the prices of proprietary medicines in relation to generic prices in order to maximise generic prescribing.

CP2 form: Prescription form used in Scotland to authorise the provision of products through MAS and PHS. Also used to make supplies to patients in emergencies under the "Community Pharmacy Urgent Supply" (CPUS) scheme, which runs under a national PGD.

PGD: Patient Group Direction – a written protocol, drawn up and signed by a doctor and a pharmacist, that allows the provision of prescription only medicines (POMs) to pre-defined groups of patients who meet eligibility criteria in certain circumstances. This avoids the need for each patient to have an individual consultation with a registered prescriber. Widely used by NHS and private healthcare bodies. Supplies made through PHS and CPUS are made under NHS PGDs.

NES: NHS Education Scotland – provider of postgraduate education and training to NHS employees in Scotland, including pharmacists. Similar role in Wales is undertaken by Welsh Centre for Postgraduate Pharmacy Education (WCPPE).