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Control of Entry Arrangements
Scottish Government Health Directorate
Pharmacy and Medicines Division
1East Rear
St. Andrew's House
Regent Road
Edinburgh
EH1 3DG

Dear Mr O'Donnell,

Response to Consultation on Control of Entry Arrangements

Thank you for the opportunity to respond to the Control of Entry Arrangements and Dispensing GP Practices consultation proposals.

This consultation is of particular importance to NHS Highland because the majority of Scottish dispensing practices are located in our Board area. In gathering views from across the organisation there were discussions and contributions from within the primary care operational units, from strategic discussions including pharmacy, public health and medicine and from NHS Highland Board members. However, due to the timing of Board meetings, the final response to this consultation has not yet been agreed and ratified by the NHS Highland Board.

NHS Highland identified a number of overarching principles for submission as part of this consultation. These are included below.

- NHS Highland agrees with the Scottish Government policy that, wherever possible, people across Scotland should have access to NHS pharmaceutical care services provided by a pharmacist. However, at this time patients and carers are not well informed about what NHS pharmaceutical services they are entitled to have provided by Boards.

- Where possible, it is preferable that NHS pharmaceutical services are provided by community pharmacists and their appropriately trained teams. However, NHS Highland acknowledges there will continue to be a need for dispensing practices, which play an essential role in the supply of medicines to patients in remote and rural locations. It is important that NHS pharmaceutical care services provided by pharmacists are now extended to these patients as described in the Scottish Government's Action Plan for NHS pharmaceutical care (*Prescription for Excellence 2013*).

- Patient safety requires that every prescription should have a clinical check, which should be independent of the prescriber and occur prior to dispensing. This presents

practical difficulties for some dispensing practices, especially those that are single-handed. Mechanisms to enable this to happen should be investigated.

- Pharmacists, as the experts in the safe and secure handling of medicines, should be involved in the governance of the NHS dispensing from dispensing practices. Every GP practice should have links with a pharmacist for advice however responsibility for governance of dispensing will remain with the GP practice.

- Currently there is separate funding for GP dispensing and the pharmaceutical services global sum. All medicines and pharmaceutical (including dispensing) services should be covered by a unified fund and Boards left to use appropriately.

- There should be a mechanism for providing financial incentive to recruit doctors to provide primary medical services in remote, rural and island locations but this should not be dispensing profit.

- Pharmacy Practices Committee (PPC) is outdated and no longer appropriate. Boards should be enabled to plan their delivery of primary care services (including contracted services) in line with identified health needs, in consultation with the public and protected from external changes that could destabilise local service provision, in line with the powers and functions defined in Part 3, Section 20 of the Smoking, Health and Social Care (Scotland) Act 2005. An enhanced role for Boards in this way, added to the "controlled" status that will be afforded to remote, rural and island communities, will defuse the professional tensions that have, on occasion, arisen due to uncertainties about future service provision. Freedom from unnecessary interprofessional competition will enable closer professional collaboration and accrue benefits for our patients.

We are happy to discuss any aspect of our response or the issues raised by the consultation proposals in more detail if this would be helpful.

Yours sincerely

Mary V Morton
Head of Community Pharmaceutical Services

Annex B

CONSULTATION RESPONSE FORM

Consultation Proposals - Part 1
Control of Entry (Pharmacy Applications) and Dispensing GP Practices

The stability of NHS services in remote and rural areas

Proposal 1:

The Scottish Government proposes amending legislation that will introduce the designation of *'controlled remote, rural and island localities'* for the purposes of considering pharmacy applications in these areas of Scotland and introducing a 'Prejudice Test' in addition to the test of 'necessary or desirable' (the adequacy test).

Do you agree with this proposal? **Yes** ☒ **No** ☐

Please tell us the reason for your answer in the box below

In this response NHS pharmaceutical services relates to National Health Service (Pharmaceutical Services)(Scotland) 2011.

If a prejudice test is introduced it should be for a *controlled locality* rather than a *controlled remote, rural and island locality.* In NHS Highland there are many pharmacies providing pharmaceutical services in localities which could be described as remote, rural and island. In addition there are remote, rural and island locations where there may be a need for a community pharmacy and where an application would not impact on other NHS provided services e.g. where there is no GP practice in a remote and rural area.

The "controlled locality" should not be defined solely according to the eight fold rural urban classification in introducing a prejudice test. The eight fold rural urban classification does not always describe local populations as expected for example an application for a location on the outskirts of the city of Inverness was classified as Accessible Rural. The presence of one or more dispensing practice or branch surgery in the "controlled locality" will be a more valuable determinant.

Boards should identify their "controlled localities" in relation to spread of the population, geography, access to services, sustainability of a community pharmacy in that area and not just in relation to whether they are remote, rural or island localities.

Designating "controlled localities" would assist Boards in the planning of services and helping to provide stability for isolated rural practices. It would also provide dispensing practices with longer-term security which is helpful for vulnerable practices.

The NHS Board should be responsible for deciding which areas they define as "controlled localities". These areas should be identified in the NHS Boards

Pharmaceutical Care Service Plan.

Boards should be enabled to use Pharmaceutical Care Services Plans based on population needs which include public health and health inequalities to identify needs and gaps in the provision of pharmaceutical care.

Boards should be enabled to identify pharmaceutical care needs, invite applications to meet these needs and chose the best option for delivering them.

It was not clear whether the prejudice test would be based on business or on patient care considerations when considering the impact that the opening of a new pharmacy might have on existing NHS services. It would be preferable for the prejudice test to be based on considerations of patient care.

The suggested prejudice test could curtail people's right to NHS pharmaceutical services if it prevents a pharmacy application being successful in an area where pharmaceutical services are inadequate. However if patients in these cases were enabled to access NHS pharmaceutical services from community pharmacies via telehealth and other means as well as having access to a pharmacist linked to the practice this would overcome this.

A prejudice test should not stifle innovative models of service delivery nor protect and maintain an outdated model of healthcare delivery. Boards should be enabled to consider and implement innovative solutions to the provision of healthcare in remote and rural areas.

There should be a set period that the proposed temporary prejudice clause would span to ensure that the temporary solution does not become a permanent one.

If a prejudice test is introduced there should be an equitable approach to all contractor groups particularly other pharmacies (i.e. an application which might prejudice the provision of health services from another pharmacy) in the controlled locality.

A mechanism is required to protect services which have been identified as addressing an identified healthcare need. This mechanism should address inequality issues.

We are moving to integration of NHS and councils across Scotland so we have to start by making sure that our own primary care health services, including medical services, are enabled to be planned at Board level and delivered in an integrated manner by removing barriers.

NHS pharmaceutical and dispensing services should be governed within a quality framework wherever possible meeting the same standards and in areas where this is not possible alternative standards should be in place.

The level of pharmaceutical care services expected to be delivered by dispensing practices should be embedded in contracts.

Whilst the income GP practices receive for dispensing is not intended to subsidise the delivery of primary medical services, in reality it has been seen as part of the overall funding for the GP practice and the income may have been used to fund services.

The recruitment and retention of rural GPs will become increasingly difficult if there are less dispensing Practices in rural areas. The loss to Practices of dispensing income makes it even less likely that GPs will remain there in future, which will be damaging to the health and wellbeing of these communities.

NHS Highland has seen several examples of the stability of practices being affected by the cessation of dispensing and difficulties in recruitment of GPs to these practices. The formulas used to calculate funding needs to be reviewed to ensure small practices are adequately funded to provide primary medical services and should include a factor for the influx of visitors into rural areas in the summer i.e. the population in some areas triples in the summer months.

Introducing a prejudice test is useful in principle but further details are required about how prejudice is defined and how it could be demonstrated. For example, in what circumstances could a dispensing practice claim prejudice and how would it be able to prove that withdrawing dispensing services would result in it having to cease providing other services?

Allowing the PPC to consider if the other NHS services would be affected by a pharmacy contract being granted would be useful within the "controlled localities". However more detail is required on how this would be done. There would need to be an agreed definition of the test and format for demonstrating the impact on the practice if a pharmacy opened.

There is a need to consider the proposed changes in the context of the development of the Board's Pharmaceutical Care Services Plan and its wider clinical and care strategy, particularly work ongoing on remote and rural sustainability.

The proposals are set in the context of current models of primary health care provision and there is a need to ensure that they do not cut across new models that may emerge.

There is a need to ensure that flexibility is kept in terms of skill mix to deliver pharmaceutical care in the future. Community pharmacy teams can provide a range of health care and improvement interventions complementary to general practice and this needs to be factored in to plans for a geographical area in terms of ensuring quality and value for money.

It is not clear whether the prejudice test would have primacy over the original legal test.

Proposal 2:

The Scottish Government proposes that the designation of an area as a *'controlled remote, rural and island locality'* should be reviewed periodically by NHS Boards so that NHS provided or contracted services are responsive to population changes, and changing healthcare needs and priorities both locally and nationally. It is proposed that the review should be carried out at a minimum of every three years.

Do you agree with this proposal? **Yes** ☒ **No** ☐

Please tell us the reason for your answer in the box below

The addition of a prejudice test would be beneficial. If a prejudice test is introduced it should be for a *controlled locality* rather than a *controlled remote, rural and island locality.* If a prejudice was introduced it would need to be responsive to changes in need. Review of controlled localities would be required periodically to reflect the changing nature of the population, access, provision of NHS services, advances in technologies used to provide pharmaceutical services, etc. Initially a three year minimum appears appropriate but this should be adjusted in line with experience gained but should also allow for a review sooner if there is a significant change in the needs of the population. Regular review is essential. Boards should be enabled to both carry out this review and determine the frequency of review. It would be beneficial to align review of the controlled localities with when Boards are required to review their Pharmaceutical Care Services Plan.

Proposal 3:

The Scottish Government is of the view that people living in remote, rural and island areas should have access to NHS pharmaceutical services and NHS primary medical services that are no less adequate than would be the case in other parts of Scotland.

Where the dispensing by a GP practice is necessary, it should be supplemented with pharmaceutical care provided by a qualified clinical pharmacist sourced by the NHS Board to ensure the person-centred, safe and effective use of the medicines. NHS Boards would be required to develop local plans sensitive to local circumstances to achieve this.

Do you agree with this proposal? **Yes** ☒ **No** ☐

Please tell us the reason for your answer in the box below

Providing people living in remote, rural and island areas with access to NHS pharmaceutical services and NHS primary medical services that are no less adequate than would be the case in other parts of Scotland is a very ambitious and potentially expensive aspiration which could lead to an inefficient use of NHS resources. Supplementary implies additional but since there is a need for clinical pharmacist resource this is complementary rather than supplementary. The approach of this

type of partnership or multi-professional team in primary care is good and should give Boards some flexibility about engaging with independent pharmacy providers rather than setting up their own pharmacy.

Where there is a dispensing service this should be supported with pharmaceutical care in line with risk assessment of patients needs.

There should also be pharmacist input into the governance arrangements for the safe and secure handling of medicines in dispensing practices.

The implementation of a prejudice test might exclude access to a local community pharmacy and the core contract pharmaceutical services but Boards could provide some access to either a pharmacist locally or some as yet undefined pharmaceutical services by remote means using new service models and technologies. One model might be for a group of community pharmacy contractors to support a group of dispensing practices by providing pharmaceutical care services to their patients.

There needs to be a clear definition of a qualified clinical pharmacist which enables the use of different models involving community pharmacists, primary care pharmacists, hospital pharmacists and specialist pharmacists. For example a community pharmacist could be a suitably qualified clinical pharmacist to provide this service as this would be in line with the provision of the Chronic Medication Service. It could be appropriate to provide this remotely from a community pharmacy in another location by using communication technology (e.g. FaceTime or Skype style technology).

Pharmaceutical care should be available to all patients in Scotland. The "Prescription for Excellence" document outlines the role of the clinical pharmacist in providing pharmaceutical care. However this presents significant challenges in the remote, rural and island locations across Highland. Funding is required to enable Boards to provide pharmaceutical care for patients in remote areas and investment is required to develop the use of technology.

Introducing a clinical pharmacist to provide pharmaceutical care will improve the pharmaceutical care of patients of dispensing practices. This role is clearly supported within "Prescription for Excellence". However, a number of points about how this role will be achieved need to be considered:

- The consultation does not describe how these clinical pharmacists will be funded. Will there be additional central funding to enable Boards to employ such pharmacists? Most dispensing practices are located in Boards with small pharmacy teams that would be unable provide this additional pharmacist role from within the existing team. This is definitely the case for NHS Highland where there is no spare capacity within the pharmacy team.
- Clearly defined standards are needed both for the proposed pharmacist-provided pharmaceutical care service and also for the dispensing service provided by practices. These standards should define the roles and responsibilities of all involved, and how the two services work together. This also provides a good opportunity to define wider standards for dispensing in dispensing practices, such as the training requirements for staff and safe dispensing procedures. NHS Highland already provides advice to practices on an ad hoc basis but national standards would be preferable.
- Using technology to improve access to pharmaceutical advice and access to

medicines should be explored. For example, using telemedicine to link a dispensing practice with a community pharmacy could allow the pharmacist to remotely supervise the sale of over the counter medicines that would be supplied by trained dispensary practice staff. The same mechanism could also be used for the supply of medicines via the minor ailment service (MAS), with the support of accredited checking dispensers in the dispensing practice to supply medicines via a pharmacist-written MAS prescription. Other services currently within the community pharmacy contract could also be provided in this way, e.g. smoking cessation, access to emergency hormonal contraception.

- In 2007, a pilot of a community pharmacist prescriber visiting a dispensing practice once a week to carry out medication reviews and implement any necessary changes was carried out in NHS Highland. Although the pilot was small, it demonstrated a need for this service and was well received by both the practice and patients involved. This pilot appears to support the proposal to introduce a clinical pharmacist role in dispensing practices.

Consultation Proposals - Part 2

Wider Pharmacy Application Processes

The proposals discussed in Part 2 apply to all applications to open a community pharmacy whether in a remote, rural or island area, or in other parts of Scotland.

Public consultation and the community voice

Proposal 4:

The Scottish Government proposes that the regulatory framework going forward will look to include a community representative among those who should be notified, as an 'interested party or persons', of any application to open a community pharmacy in the locality. The community would therefore in statute be considered as a body or party whose interests may be significantly affected by the pharmacy application.

This would be a nominated representative from, for example, the local Community Council or the local Residents Association or another appropriate local community representative body recognised by the NHS Board.

As an 'interested party' the community representative would be entitled to make written representations about the application to the Board to which the application is made within 30 days of receipt of the Board's notification of the application.

In addition, where the NHS Board PPC decides to hear oral representations, the community representative will be entitled to take part, together with the applicant and the other interested parties, and would be given reasonable notice of the meeting where those oral representations are to be heard. Once each interested party, including the community representative, has presented their evidence in turn they would then leave the hearing leaving the PPC to consider all the evidence presented.

As an 'interested party' the community representative will also have a right of appeal against the decision of the NHS Board PPC to represent the views of the local community.

Do you agree with this proposal? **Yes** ☒ **No** ☐
Please tell us the reason for your answer in the box below

Including an interested party to represent the community at the oral hearing would be welcomed but we consider that this might be more appropriate to be a local councillor. In our experience we have found that in our discussions with local councillors they have been more able to understand the legal test and how the PPC must apply this than members of community councils.

In some of our remote and rural areas we have had as many as eight community councils involved in our public consultation. If these were all invited to speak for as long as they wish, there would be potential for hearings to last many days.
It would be difficult for one community council to represent the views of all in these types of cases.

In some cases communities have been influenced by those with a financial interest in the outcome of the decision, creating a potential biased community view.

It was also suggested that the dispensing GP should be included as an interested party in their own right instead of only via Area Medical Committee representation as is currently the case.

The community should be included as an interested part and they should be represented by a spokesperson nominated by the community. They must present a balanced view and be able to evidence the consultation undertaken with the whole population. The community should not be able to nominate, someone acting in the capacity of counsel, solicitor, or paid advocate or an employee of any of the other interested parties to represent them.

No reasonable person or body can object to community involvement in discussions of the health services in an area but such representation must be balanced and appropriate. The community representative must be able to demonstrate the breadth and quality of his or her own consultation, and what evidence has been considered to reach his or her conclusions.

It would not be appropriate for Boards to have to make a decision between different communities in the area as to which represents them. There may have to be discretion to allow more than one community interested party.

Proposal 5:

The Scottish Government is of the view that in the future PPC hearings should be handled in such a way so that no one person or organisation is able to dominate the entire hearing. This might include options such as limiting the time allocated to give oral representations or the issuing of guidance to PPCs. The Scottish Government thinks that all PPC meetings in future should follow a standard process in the management of PPC Hearings.

Do you agree with this proposal? **Yes** ☒ **No** ☐

Please tell us the reason for your answer in the box below

All interested parties have to be given what they consider to be a fair hearing when PPCs hear oral representations. There was some concern that a time limit could negate that. In NHS Highland we have had a PPC decision overturned by the NAP, granting an appeal on the grounds that the applicant was time limited. However if there was a time limit for each interested party when this application was heard there should therefore not have been grounds for appeal.

Currently all parties have an equal opportunity to make their case. One party dominating the hearing is liable to produce a negative effect if they continue for too long. Managing the hearing is currently in the hands of the PPC Chair and there has been no feedback to suggest that domination by an individual has been a problem here.

A standardised process is already being applied and PPC administrators are working together to improve this across Scotland but this still allows for individual Board needs to be accommodated e.g. visit to UHI Development for an Inverness application where the applicant's case relied heavily on the change that this development would make to the healthcare needs of the neighbourhood.

There is currently guidance to PPCs outlining a standard process, it is the function of the Chair to apply this and our experience is that this has worked well here.

A standard process should be appropriate to ensure all hearings are conducted in the same way to the same standard and no one party can dominate the hearing.

Introducing a standard process would reflect general good working practice.

Proposal 6:

The Scottish Government proposes that going forward those assisting in oral representations by the applicant, the community and other interested parties in attendance are able to speak on behalf of those they are assisting.

Do you agree with this proposal? **Yes** ☒ **No** ☐

Please tell us the reason for your answer in the box below

The current restriction produces an artificial barrier to communication in the oral hearing this change should facilitate a smoother flow of responses from the interested party and their assistant.

There would have to remain a distinction as to who was the interested party (main participant) in case there was a difference of opinion between them and their support assistant.

This proposal should improve the oral hearing process for everyone involved.

How this is to be conducted should be included in the standard process.

The proviso in the 2009 regulations should remain that a person who assists cannot appear in a capacity of counsel, solicitor or paid advocate.

Making the hearing open and transparent is to be welcomed. However, it would be detrimental if hearings became dominated by representatives of professional bodies who did not have a local interest in the application, or if significant inequality was introduced by the involvement of legal advisors on one or other side.

Proposal 7:

The Scottish Government proposes that going forward those applying to open a pharmacy, for the purpose of providing NHS pharmaceutical services, should first enter into a pre-application stage with the NHS Board to determine whether there is an identified unmet need in the provision of NHS pharmaceutical services.

This would assist NHS Boards in determining the urgency of the demand for NHS pharmaceutical services identified by the applicant. NHS Boards Pharmaceutical Care Services Plans would need to reflect an assessment of service gaps and where need is most urgent.

Where an application proceeds, the applicant must be able to provide evidence to the NHS Board and the affected communities that every effort has been made to publicise the intention to open a community pharmacy and to consult and obtain responses from residents in the associated neighbourhood. Also, the notice must be advertised in a newspaper and all circulating local news free-sheets and newsletters in the neighbourhood in order to reach the vast majority of residents.

NHS Boards will also be required to do the same level of advertising in relation to its consultation activities.

Do you agree with this proposal? **Yes** ☐ **No** ☒

Please tell us the reason for your answer in the box below

There should be a pre-application stage where the applicant engages with the Board to help the applicant to understand what is required of them by the regulations, NHS Highland already has an informal process for this. Applicants should consult the PCS plan or the Board could seek applications for areas with the greatest unmet need. This would remove the need for a pre-application stage to determine if there is an unmet need.

It would be preferable to require an applicant to consult a Board's Pharmaceutical Care Services Plan before making an application to open a pharmacy. The plan should identify areas of unmet need in the provision of NHS pharmaceutical services as well as defining the proposed controlled localities. Applicants should be advised that Boards would welcome applications in areas of unmet need and that applications for other areas would be considered less urgent. If an applicant has consulted the Board's Plan then there should be no requirement on the Board to enter any pre-application discussions with the applicant to determine if the application addressed unmet need.

It was not clear whether the intention was to allow Boards to be able to refuse the application if they determine that there is not an unmet need. If the unmet need identified by the applicant has not been identified in the Pharmaceutical Care Services Plan the application currently would still have to be processed by the Board. For this to change there would need to be a process for the Board to decide whether the application has identified an unmet need and to allow the applicant to progress with their application or the identified unmet need could be considered for inclusion in a future Pharmaceutical Care Services Plan with some indication of urgency of the demand.

The NHS Boards pharmaceutical care plan should identify areas of unmet need and prioritise the areas where the need is greatest as well as the "controlled localities". There would need to be a consistent method used across Boards to assess where need is most urgent and the criteria used to decide where these areas are.

Extending the advertising as suggested would be an enormous cost to applicants and Boards both financially and in terms of workload. This suggestion does not reflect the current use of social media resources e.g. Facebook and Twitter. For our NHS Highland public consultation we have found that using the latest news section of the NHS website, Twitter, Facebook; local leaders via the community councils, local councillors, MPs, MSPs and the business community via the Chamber of Commerce and Federation of Small Businesses; has been an effective method of consulting with the community. We also directly contact any community groups identified in the applicant's consultation.

The applicant should have to convince the PPC that they have taken sufficient appropriate steps to gauge public opinion e.g. a representative public survey (not "likes" on Facebook) in addition to the advertisement as currently required. This should be tailored to the community in question and not restricted by regulation.

We have found that public opinion can be easily swayed by those with a financial interest in the outcome of the PPC decision.

It is clearly difficult for the public to understand what pharmaceutical services are and what value they might have for them. Uninformed and biased opinions can be firmly held.

The level of public consultation for this function should be the same as that required by Boards in relation to other consultations in order to be equitable.

Wide public consultation is essential but the process suggested is too burdensome and would require considerable resources. Identifying all publication in an area would be difficult. The proposal does not take into account the use of other types of media such as face book etc

The proposed process to publicise applications is too onerous. Although advertising the intention to open a pharmacy through local newspapers is appropriate and welcomed, it should not be necessary to advertise in "all" free sheets. By making this a requirement, it suggests that if the Board or an applicant missed one free sheet, it could result in an application being refused. It would be preferable to require advertising in at least one local newspaper and a demonstration of effort to advertise in other media too.

It should also be noted that if Boards produce Pharmaceutical Care Services Plans that clearly state areas of unmet need, then this informs communities in advance of the potential for pharmacy applications.

Proposal 8:

The Scottish Government proposes that going forward NHS Boards specify to what extent the views of the community have or have not been taken into account in their published decisions on the outcome of a pharmacy application.

Do you agree with this proposal? **Yes** ☒ **No** ☐

Please tell us the reason for your answer in the box below

We do this already in the note of the PPC meeting. We also record that the decision can only be based on the legal test and this does not currently take account of whether the public want a pharmacy or not but only the adequacy or otherwise of access to the pharmaceutical services for the public of the neighbourhood.

If there is any change to the regulations to allow public opinion to influence the PPC decision then where public opinion has been influenced this needs to be able to be taken into consideration.

It is important the process is transparent and the views of the community are heard and can be taken into account when planning services.

Securing NHS pharmaceutical services

Proposal 9:

The Scottish Government considers that NHS Boards should be able to take into account how NHS pharmaceutical services would be delivered in practice

in the long term after an application has been received. This includes taking into account the financial viability of the pharmacy business proposed. This is an important factor in securing these services in the long term.

Do you agree with this proposal? **Yes** ☐ **No** ☒

Please tell us the reason for your answer in the box below

There were different views expressed in NHS Highland in relation to this question. Most of the responses related to new services in remote, rural and island locations.

The PPC has in the past stated that they would welcome evidence of the long term sustainability of pharmaceutical services to be provided by the applicant e.g. a business plan. There is a distinction between viability of the business (particularly those related to non NHS elements of the pharmacy business) and the sustainability of NHS patient care. Boards should be more concerned with sustainability of NHS service. When we get to the stage of having controlled localities and the prejudice test or later fully implementing pharmaceutical care service planning then we would be commissioning services based on need and we would be able to understand better how a service would be sustained (by using our population data etc.). NHS Highland therefore considers the solution to be the implementation of PSC Planning rather than introducing assessment of financial viability by the PPCs.

It is very important that new services particularly in remote, rural and island locations are sustainable and reliable, so it is essential that pharmacy businesses are financially viable in the long term. It would be detrimental to patient care for a pharmacy business to be established only to close some months later because it was not financially viable. In addition, the closure of a pharmacy in a remote, rural or island location would result in significant upheaval for the local GP practice which would almost certainly be required to start dispensing medicines again and also for the Board in terms of organising service delivery. There have been no instances of this happening in Highland. (The only recent pharmacy closure was in the centre of Inverness where the patients moved to using other pharmacies in the city centre.)

Boards should only be concerned with NHS business and are not in a position to evaluate community pharmacy business plans.

Boards should be more concerned with the efficiency with which we use the global sum, that is the cost effectiveness of pharmacies (i.e. what is the board getting in terms of patient care for the money spent).

Timeframes for reaching decisions

Proposal 10:

The Scottish Government proposes that going forward the regulatory framework would require NHS Board PPCs to make a decision within 6 weeks of the end of the public consultation process and the NAP to make a decision within 3 months upon receipt of an appeal (or appeals) being lodged.

In more complex cases the timeframe would be made extendable where there is a good cause for delay.

Do you agree with this proposal? **Yes** ☒ **No** ☐

Please tell us the reason for your answer in the box below

Boards can on occasion have difficulty in identifying dates when sufficient members of the PPC are available for oral hearings and therefore they should be allowed longer than 6 weeks from the end of the consultation period to make a decision. We have had particular difficulties scheduling a hearing where repeat applications had to be heard by different PPC members and since all of ours had already been used we needed to borrow members from other Boards which provided additional problems due to long distance travel requirements.

In the past we have had to wait up to 6 months for a ruling on an appeal from NAP. Our understanding is that this was due to pressure of work for NAP so setting a shorter timescale will not be achievable within current resources.

There should be established time frames that all parties are aware of and work to and a process to take account of exceptional complex cases.

Expert advice and support to PPCs during deliberations

Proposal 11:

The Scottish Government proposes that going forward the regulatory framework would make provisions for the appropriate role of an independent legal assessor acting in a supporting and advisory capacity, including providing advice and guidance on technical and legal aspects of the application process during PPC deliberations.

Do you agree with this proposal? **Yes** ☐ **No** ☒

Please tell us the reason for your answer in the box below

Since the introduction of the new regulations we have not had any appeals where we had to rehear the application so fundamentally we see no need for an independent legal assessor.

We believe that Board officials successfully provided this function during the private deliberations for many years on the understanding that they only responded to requests for advice and guidance on technical and legal aspects. The Board officials now only provide the supporting and advisory function to the non private sections of the hearing. This extends the time for the oral hearing to be completed as the PPC have to repeat all of their reasons to the Board officials after the decision has been reached in order for them to be recorded.

The inclusion of an independent legal assessor to provide technical support and guidance to PPCs in the course of their private deliberations would make it even more difficult to set a suitable date for a hearing which could lead to a longer delay

in hearings being carried out.

The independent legal assessor would not necessarily have any better understanding of the regulations than the Board officials currently supporting the PPC have.

Including an independent legal assessor would increase the cost to Boards of holding oral hearings.

There are different ways that the supporting and advisory function could be achieved, for example, additional training could be provided to enable the Chair to take on this role, or a PPC chair from a different Board, or a Board official from a different Board.

We would prefer to be spending money from the public purse on the delivery of services rather than on the expenses involved in running PPCs. Any suggestions which increase the costs of PPC need to be weighed against the opportunity costs.

Essential to ensure the legal test is considered and appropriately documented, especially if the proposed prejudice test is introduced as PPC may hear this types of applications infrequently.

Advice of an independent legal assessor, as well as the introduction of standard processes in proposal 5, would improve the consistency and appropriateness of decision making by PPCs.

Additional Comments

It has been quite some time since the last national training for PPC members.

Regular national training would promote consistency across all Boards.

PPC lay members will be discouraged from engaging if the process becomes too adversarial or lengthy. They volunteer to assist Boards in processing applications.

Representatives from dispensing practices are able to be represented by the Area Medical Committee at the oral hearing but it is our opinion that they, like the affected community pharmacy contractors, should be included as interested parties and be enabled to speak on their own behalf.