**Summary of Consultation Feedback – Community Pharmacy Contracting Policy**

**November 2019**

We appreciate the time people took to consider this consultation on implementing a Hutt Valley DHB policy for contracting for pharmacist services and acknowledge the time people took to respond. The responses received will be considered in their entirety when recommendations on a final policy are made to the Board of Hutt Valley DHB.

A summary of the feedback follows from the 10 submissions. Four of the submissions were provided by pharmacy owners, four were provided by pharmacy provider representatives and two by other organisations. Of the 10 submissions, seven were generally supportive of the policy, two did not explicitly express an opinion either way, and one was opposed to the policy. Of those that were generally supportive, some expressed caution about avoiding unintended consequences.

The table below contains a summary of the key ideas and comments that came through in the feedback, grouped by the key theme. A number of submissions touched on similar issues. All submissions have been reviewed and will be considered in developing a final draft to be submitted to the Board of Hutt Valley DHB for approval, regardless of whether or not the feedback provided appears in the document below.

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| **Theme** | **Feedback** |
| Technical Issues | The policy should be renamed Contracting Policy for Pharmacy Services.  The variation to the ICPSA in 2019 amended the relocation provisions and renders the relocation aspect of the policy redundant.  There should be transparency of the process, including weightings attributed to decision-making criteria, detailed feedback being provided to applicants for contracts, panel composition (consumer representative?), and right of appeal.  Is primary care just GPs or does it also include dentists, physiotherapists, other pharmacies?  How will a pharmacy answer Q9 & 10 re staff employed when it hasn’t opened yet?  Will the DHB monitor application information? What if the applicant makes promises that it doesn’t deliver on?  HVDHB could consider seeking reasonable proof of financial viability to mitigate the risk of patient disruption through a business failing.  Will there be a right of appeal to decisions or submissions invited from other providers or general practice? |
| Co-location vs integration | Co-location doesn’t guarantee integration and pharmacies shouldn’t have to be co-located with medical centres. Access to integrated records and the sharing of information and using shared plans of care is likely to be more important than co-location. Co-located pharmacies and medical centres aren’t necessarily working in an integrated way at present. Having a greater number of pharmacies doesn’t need to compromise integration with general practice. |
| Freeing up time for cognitive services – Hub and Spoke | Larger pharmacies have better capacity to redeploy staff and accommodate variations in activity but freeing up pharmacists time for cognitive services can be achieved in several ways – technicians, robots and visiting pharmacists are options. A small pharmacy doesn’t preclude being able to deliver cognitive services although it will likely require operating as part of a hub and spoke arrangement with a larger pharmacy hub. Most pharmacies operate on a reactive basis so smaller spoke pharmacies may need to be better organised and book people in ahead of time. |
| Co-location with products and activities that are harmful to health | What is the DHB’s stance on pharmacies being co-located with activities or products that may result in adverse health outcomes and will the DHB’s position will apply retrospectively? |
| Market Factors | There were mixed views on market structure, innovation and quality.  One view is that a growing number of small pharmacies threatens clinical viability, service quality and service availability, and there is no need for new pharmacies in areas already well served. Two small pharmacies consolidating into one larger pharmacy, can provide a better range and quality of service.  Another view is that all pharmacies start small and there needs to be a pathway for innovative enthusiastic young pharmacists to enter the market and provide competition, and that multiple small pharmacies are preferable to monopolies with large powerful providers and their negative consequences.  One submission noted that the proposed Contracting Policy doesn’t shut the door on new applications, but it does make sure they are aligned with DHB goals.  Contracting policy alone will not be enough to promote the innovation needed to transform relationships and take on new services.  Restricting pharmacy numbers might increase the value of existing pharmacies.  The service provided by supermarket pharmacies are of a lower quality (*no examples given*) as a consequence of the full discounting of the co-payment, which also amounts to predatory pricing.  Fewer pharmacies are located in more deprived or geographically isolated areas as they are less viable under the current funding model. |
| Quality Development | There is greater flexibility to enable quality improvement when staff numbers are greater but a critical factor is having a culture of continuous quality improvement and focusing on patient health outcomes.  Interaction and integration with general practice depends on establishing trust, rapport and a professional relationship, so is independent of size, staff or co-location. Engagement with general practice has been made easier through having clinical pharmacists in practices.  For community pharmacies to provide a reasonable level of clinical services, a greater level of postgraduate qualifications are required than currently exist among community pharmacists. |

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| **Optimum Configuration of Pharmacies** |
| Freeing up pharmacist time may be possible by using technicians in conjunction with pharmacists, especially checking technicians. Pharmacies with 2 or more pharmacists have more flexibility to provide a wider range of services.  Robotic technology can free pharmacists for patient contact and a wider range of services including monitoring and prevention activity.  Not having appointments can make workflow unpredictable, which is compounded by seasonal requirements (such as influenza vaccination). |
| **Additional Quality Requirements That Should Apply To Pharmacist Services** |
| Improve preventative care and focus on wellness, and improving patient health literacy and self-management skills.  Engage more with Maori iwi to understand how to better deliver and monitor care and wellbeing for Maori.  Align community pharmacist services with pharmacist services in general practice/PHOs.  Auditory and visual privacy (away from dispensing/waiting space).  Quality plan in place, including annual patient surveys with actions to respond to feedback.  Use limited funding with pharmacies that can provide the outcomes required. Consider providing contracts for a limited period of time and then review performance.  Quality management should have four points of focus:   * CQI * Meeting or exceeding tangible aspects of service provision * Patient experience, including cultural aspects and equity orientation * Patient outcomes. |
| **Additional Comments Outside the Scope of the Consultation** |
| Consider allocating more resources to higher need populations. In particular, the following should be funded:   * no co-payments for mental health patients * fund full-time pharmacist in medical centres * medicine reviews in community pharmacy * fund minor ailment and wound care in community pharmacy.   Additional funding is required to enable lengthier consultations with patients. |