Community Pharmacy Contracting Policy:

What you told us

We appreciate the time people took to consider this consultation 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, 7 were generally supportive of the policy, 2 did not explicitly express an opinion either way, and 1 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.

Theme	Feedback	Outcome / DHB Response
Technical Issues	The policy should be renamed Contracting Policy for Pharmacy Services.	Agreed – The funding of pharmacist services outside of the ICPSA will be covered by Hutt Valley DHB's existing policy for service procurement.
	The variation to the ICPSA in 2019 amended the relocation provisions and renders the relocation aspect of the policy redundant.	Agreed – Relocation provisions should reflect the ICPSA
	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.	Agreed – The process should be transparent and the DHB undertakes to ensure that the process will result in it providing full feedback in response to an application so an applicant can understand how a decision has been reached. Weightings of decision making criteria have been added to the policy, as has panel membership. We don't believe a consumer panel member is appropriate in considering a contracting policy matter, but we do believe consumer input is appropriate for service quality and design matters.
	Is primary care just GPs or does it also include dentists, physiotherapists, other pharmacies?	Primary care in this context is principally GPs. Terminology in the policy has been clarified.
	How will a pharmacy answer Q9 & 10 re staff employed when it hasn't opened yet?	HVDHB expects a proposed new pharmacy to have developed a business case that will include assumptions

	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?	about staff numbers and other matters, and will request this as part of the application (as other DHBs do). HVDHB will monitor the new pharmacy service delivery as part of its overall monitoring of pharmacies. DHBs do not consider appeals in relation to service commissioning decisions or contestable processes. The DHB encourages applicants to ensure that all relevant information is included in the application. The success of an application will rely on the merits of the application and applicants ensuring cognisance of the decision-making criteria. The DHB won't seek input from other (pharmacy) providers as there will be conflicts of interest, but is open to considering support provided by 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.	Agreed – integration is more important (co-location may provide an opportunity for integration but will not guarantee it). The relationship between pharmacies and general practice is more complex with a larger number of smaller pharmacies/practices.
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.	Agreed – These are all valid ways that will enable cognitive services to be provided and HVDHB welcome initiatives such as hub and spoke that enable better use of technology and visiting pharmacists while maintaining good access for service users.
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?	Applicants will be asked how they will manage or mitigate the negative health effects of pharmacies being co-located with such services and activities.

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. 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.	The DHB's primary responsibility is to seek the optimum arrangement for the most effective and efficient delivery of health services in order to meet local and disability needs for its population. A contracting policy doesn't close the door on enthusiastic and innovative young pharmacists setting up a new pharmacy and there are several ways of becoming a pharmacy owner. New pharmacies are not required for innovation to occur and that there is clearly competition between existing pharmacies with people from the same suburbs choosing to use different pharmacies, not necessarily the local ones. With a slowly growing Hutt Valley population, more pharmacies will hinder achievement of the strategic direction. Across DHBs there is significant variability in the size of pharmacies (by average population served). Hutt ranks 13th of 20 DHBs with 4668 people per pharmacy (5 DHBs have averages above 5300 and 2 below 4000). We agree that aside from Contracting Policy, collaborative work between pharmacies general practice, consumers and the DHB will be necessary to improve integration. A contracting policy for the Hutt Valley with its 30 pharmacies is expected to have little or no effect on the greater Wellington market of 96 pharmacies and no effect on the NZ market of over 1000 pharmacies. Investigation of predatory pricing is outside the remit of DHBs and submitters are encouraged to raise those concerns with the Commerce Commission as the appropriate agency to investigate those concerns.

	Fewer pharmacies are located in more deprived or geographically isolated areas as they are less viable under the current funding model.	Hutt Valley DHB encourages people to provide it, and other appropriate agencies, with specific feedback about service quality concerns. DHBs agree that the current funding mechanism for pharmacy does not adequately recognise equity factors and will continue to strive to address this at a local and national level.
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.	Noted – DHBs have signalled a greater emphasis on the quality provisions of the pharmacy contract (ICPSA). Quality improvement is an ongoing process and is difficult to assess at a point in time. Agree – Both integration and clinical pharmacists in primary care features as part of Hutt Valley DHBs strategy, *Future Pharmacist Services*. Noted

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).	Agreed – This is consistent with the strategy for Hutt Valley pharmacist services. Agreed – There seems considerable potential to use robotic technology. Agreed – More proactive management of patient contact may enable pharmacies to smooth out workflow patterns.

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.	Thank you for these suggestions. We will strive to incorporate these into commissioning for pharmacist services. We note in particular that pharmacies in general have some way to go to ensure they are adequately managing auditory and visual privacy for patients. We welcome improved arrangements that ensure better privacy while also maintaining good workflow arrangements for pharmacy staff.
Other Comments - **Funding**	Consider allocating more resources to higher need populations. Fund: • 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.	Noted – This is outside the scope of this consultation. HVDHB notes that a range of funding sources could be employed to address these needs. The *"more funding"* view is inconsistent with both local and national strategies, and the current funding environment. It assumes an unchanging pharmacy operational environment. The preferred strategy is to free up time for pharmacists to enable lengthier patient consultations, partly through working with pharmacies on projects to achieve that and partly by placing less funding emphasis on medication supply.