Mr Paul Thomson  
Primary Care Division  
Scottish Executive Health Department  
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Dear Mr Thomson

Appliance Contractors Consultation Document

The Scottish Pharmaceutical Federation (SPF) is the trade body representing owners of more than 1,000 community pharmacies in Scotland. Although the Scottish Pharmaceutical Federation has not been formally consulted about your proposals, we have a huge interest in this subject as we represent most of the community pharmacies in Scotland.

Having read the consultation document, we feel there are a number of issues which need to be considered which have not been addressed in your paper. The SEHD is right to be concerned about whether the current arrangements represent value for money. However, to us at least, the consultation seems perhaps a little unfocused and uninformed.

The consultation document does not consider how pharmacy contractors are currently reimbursed or remunerated, and yet draws comparisons between the supplies from appliance contractors and community pharmacy contractors. We do not feel that those responsible for what happens next can make informed decisions unless they understand the complete picture.

The SPF would like the SEHD to reconsider the consultation document and summarises our suggestions as follows:

- **Our preference:** a level playing field for appliance and pharmacy contractors to deliver a patient-centred service with a quality-based remuneration system.

- **Stoma Nurses**
  We suggested that the NHS in Scotland should employ stoma nurses directly

- **Supply**
  The supply of appliances should be reasonably remunerated whoever makes the supply.
Service Standards
If patients require "additional services" (such as flange-cutting), the SEHD and others, including patient representatives, should determine what these services might be and introduce a structured framework to provide and pay for these, irrespective of which contractor provides them. Not all appliance contractors, and not all pharmacies may wish to provide these services.

We believe that the pharmacist who dispenses ostomy appliances for a patient should also dispense their medicines, as this allows for more comprehensive pharmaceutical care – a cornerstone of the SEHD’s pharmacy strategy The Right Medicine.

Accessories
Supply of accessories should not be regarded as part of the service standards. Any non-Tariff items (eg disposal bags) considered necessary should be listed in the Drug Tariff

Remuneration
Remuneration based on a patient-centred quality service would make most sense and remove incentives to encourage the prescribing of large quantities of expensive items. If the quality standards are not met then a fee for supply should be paid. Remuneration should relate to the aspect of service (supply, flange-cutting, domiciliary visit) rather than to the nature of the provider. This should be reviewed as part of the SPGC’s negotiations for a new pharmaceutical contract, with an appliance service being seen as a supplementary service.

Sponsored Stoma Nurses
As the consultation document states (paragraph 17), if appliance companies withdraw their contribution to the NHS (ie the provision of nurses) the NHS will have to make up the deficit.

The SEHD is concerned that if it pays appliance contractors less it will lose the “free” nursing posts, and that patients will lose the “additional services”. But no other nurses are sponsored in this way in the NHS. And stoma nurses are not free!

We recognise that the services and support on offer from a specialist stoma nurse must prove invaluable for this patient group, as indeed are services from any Clinical Nurse Specialist.

However, as far as we know, the permanent sponsoring of nurses within the NHS by companies who stand to gain directly from the work that the nurses do, is unique to the appliance sector.

Some charities eg Macmillan Cancer Relief Foundation sponsor specialist nurse (and other) posts during the establishment of the posts, with the NHS then taking over the funding, after a certain amount of time. The Wellcome Foundation and others have sponsored the start-up of specialist epilepsy nursing posts (Epilepsy Action Sapphire Nurses), and again, as NHS Trusts see the benefits they take over the funding. We believe that this is the way to encourage innovation without bias and compromise. Most, if not all, other Clinical Nurse Specialists, are employed directly by the NHS or, in the case of palliative care nurses and some other nurse specialists, through voluntary sector not-for-profit or charitable organisations.

In paragraph 17, the consultation document states "It has been suggested that sponsoring nurses may compromise clinical judgment and lead to patients being recommended to use the sponsor’s dispensing services or products”. Community pharmacists are only too aware of what happens when a stoma nurse in their locality is sponsored – suddenly there are no more new appliance prescriptions presented in pharmacies, and gradually, existing patients also cease to present their appliance prescriptions at the pharmacy.
The consultation document mentions that (paragraph 15) "many of the larger appliance contractors are understood to make significant cash and service contributions to pan UK NHS stoma care, and to a lesser extent incontinence care". But where does the money come from? How do appliance companies make their money, from which they can make this significant contribution to the NHS? We believe they make their money almost entirely by supplying their products to patients via NHS prescription. So, the "free" nurse provided to the NHS is paid for via the income generated from NHS prescriptions.

We suggest that the NHS in Scotland should employ stoma nurses directly. Changing the current remuneration arrangements will yield savings to pay for this. It is inappropriate that the NHS makes high payments to these suppliers on the basis that they fund "free" posts!

The SEHD must ensure that patient care is not compromised through loss of nursing posts if sponsorship ends. Ring-fenced monies could be made available for an agreed period to secure these posts, and the change should be carefully managed.

Freedom from sponsorship will enable and encourage stoma nurses to build good working relationships with pharmacists so that both may work together to provide good pharmaceutical care for the patient, even if patients choose to send their prescriptions to mail order suppliers. Appendix I gives an examples of some work done by our sister organisation the National Pharmaceutical Association (NPA) in England to highlight the benefits of stoma nurses and pharmacists working together.

Service Standards

The SPF believes that the service standards described in paragraph 22 can be (and are in some cases) delivered by community pharmacies as detailed below.

Home Delivery within two working days if requested by patient

Home delivery is the only way that a geographically-distant appliance contractor can supply goods to a patient!

It may be appropriate and highly desirable for some patients, particularly immediately after hospital discharge, post-surgery when the patient is feeling vulnerable and weak, or for elderly housebound people living on their own. Many community pharmacists already undertake home deliveries for vulnerable house-bound patients who cannot otherwise get to the pharmacy, whatever their medicine or appliance needs, and do supply appliances to patients at home, even though they are not paid to provide this service.

However, it is difficult to understand why the SEHD wishes to treat this client group differently from any other vulnerable client group, and there are no formal arrangements in place to provide home delivery of medicines and associated goods in general.

Many patients, particularly those who have ileostomies, are no longer debilitated from the illness that triggered their surgery. They are often young and well and very able to visit pharmacies (or anywhere else). It is more difficult for a pharmacist to keep check on pharmaceutical aspects of care if he or she never sees the patient, so good patient contact is essential. And some stoma nurses feel that it is desirable for patients who are well enough to collect their items themselves - this encourages them to take responsibility for their lives.

Some appliance contractors have suggested that home delivery avoids "embarrassment" for patients, and we know that this is used as a "selling point" for the services of appliance contractors. However, we believe that this is not an issue as community pharmacists deal with potentially embarrassing issues every day in their pharmacies - sexual health, piles, and even mental distress are all at least as potentially "embarrassing" as stoma bags.
Most pharmacies keep supplies of appliances for their regular customers and obtain them in almost all cases later on the same day, or on the next day via pharmaceutical wholesalers. The NHS Terms of Service, in any case, require pharmacy contractors to supply such items “with reasonable promptness”.

Ironically, in the very small minority of cases where there is difficulty in obtaining supplies, our members tell us that this almost always involves a product from an appliance manufacturer who also holds an appliance contract.

In Ayrshire and Arran PCT as part of the ECCI project it is proposed that stoma nurses will be able to send discharge details directly to community pharmacies prior to discharge via secure electronic means. This approach will enable pharmacies to prepare for patient discharge in a timely manner and be better prepared to meet the two day service specification. We recommend this model to the SEHD and suggest it be trialled in other areas of Scotland.

Measuring and Fitting at the patient’s home if requested

Stoma appliances are not usually measured for and fitted at the patient’s home, and we think it unlikely that appliance contractors would undertake this activity themselves. When required, it is a role undertaken by a stoma nurse, not an appliance contractor, and we believe that this is part of her job, rather than an additional service supplied by an appliance contractor.

Trained continence advisory nurses may fit some incontinence appliances in this way.

Some pharmacists undertake the measuring and fitting of trusses and elastic hosiery at the patient’s home, either because they have no fitting room on their pharmacy premises or because the patient is housebound.

Flange-Cutting and Customisation on request

Flange-cutting is needed by some stoma patients whose stoma is an irregular shape, or does not conform to one of a range of pre-cut flanges supplied by manufacturers. The procedure, in most cases, involves tracing the shape of the patient’s stoma onto the uncut flange using a template made by the stoma nurse. The flange is then cut to shape and provides a snug fit, ensuring that body fluids do not come into contact with the skin around the stoma where it could cause soreness and sometimes, excoriation. (A flange is the part of the appliance which adheres to the skin and to which the bag is attached or fitted).

Flange-cutting is a procedure which tends to be shrouded in mystery but is, in fact quite straightforward, and most patients are able to do this for themselves. Those who cannot are usually unable to do so because they have poor eyesight, or their dexterity is compromised through arthritis or similar conditions.

Some pharmacists do provide this service and patients do appreciate it, not least because they receive small quantities at a time which means the flanges stay fresh.

There is a tendency for appliance contractors to supply large quantities at a time (maximum on-cost is obtained with low numbers of prescriptions for large quantities). In most cases, the flange must be removed from its original protective packaging before it can be cut. This exposes the materials to the air, and, six months on, the flanges are less adhesive therefore less likely to stay in place.

Pharmacy contractor remuneration does not provide for this service and the time it takes, but some pharmacists do it anyway, and at no cost. However, the main reason why this does not usually happen in pharmacies is because in order to cut a flange, a template of the patient’s stoma is needed. The stoma nurse makes the template, and of course, if sponsored, will probably send it to her employer/sponsors and not to the pharmacy.
The Provision of a Telephone Helpline, staffed by suitably trained or qualified people

This is the only way that mail order appliance contractors can keep in touch with patients. Community pharmacies always have at least one pharmacist on duty, six days a week who can (and does) answer queries in person or by telephone.

Community pharmacies have the additional advantage of knowing what medication a patient is taking which may be affected or may affect the stoma. Locally based stoma nurses are presumably contactable too, especially during the sort of hours when appliance contractor helplines are open. Patients can also access NHS24 at any time with queries about their health.

The Supply of Disposal Bags and Wipes where appropriate

Appliance contractors have supplied these items for some time as an inducement to gain prescription business. Some pharmacies now provide disposal bags in order to ‘compete’, although strictly this could be considered to be in breach of their Terms of Service.

If disposal bags and wipes are considered by the SEHD to be essential items for stoma patients then we believe that they should be added to the Drug Tariff list so that they may be prescribed.

Although disposal bags may prove useful to stoma patients, it is doubtful whether wipes are a cost-effective use of taxpayers’ money in that we believe that they are unnecessary for most patients. Independent stoma nurses tell us that kitchen roll, soft toilet paper, cut-up pieces of “J-cloth”, or even a flannel will do just as good a job for most patients – again there is no particular mystery about cleaning round a stable stoma. Wipes may provide a convenient alternative, particularly for example when travelling, but could be considered a ‘luxury’ item, and we do not believe they are a good use of NHS resources, other than in exceptional circumstances.

Although the SEHD seems to be under the impression that these items are “free”, bags and wipes are, of course, indirectly funded by the NHS. Almost all ostomy supplies are provided for patients by the NHS, either on GP10 prescription or, to a lesser extent through hospitals, and it is therefore from the NHS that appliance contractors get the money with which to provide these items!

Remuneration and a New Pharmaceutical Contract

We believe that some community pharmacists wish to provide a comprehensive service to patients requiring appliances. They have the advantage of being local to patients and can liaise with stoma nurses (and, where appropriate, continence nurses) and GPs to provide the best possible patient care. In addition pharmacists can provide added value – most patients using appliances will also be taking medicines for related and unrelated disorders, which may or may not be affected by the appliance. Community pharmacists are ideally placed to look at the whole picture.

The Scottish Pharmaceutical General Council (SPGC) has recently announced initial details about a new pharmaceutical contract. It proposes core services to be offered by all community pharmacies and supplementary services to be provided by some contractors or perhaps by way of pooled resources within a locality group. The SPF would like to see the supply of appliances included as a supplementary service in the new pharmaceutical contract.

According to its paragraph 29, the consultation document is “based on the assumption that it is justifiable to pay higher rates of remuneration to appliance contractors than to pharmacies when they provide additional services”.

We agree that it is, in principle, justifiable to pay higher rates of remuneration to providers of additional services whatever these may be, and in whatever area of care, provided these services improve patient care.
In answer to the specific questions raised by the consultation document, the SPF makes the following comments:

**Are the objectives which SEHD is attempting to achieve the right ones?**

**Objective 1**

Although we agree, of course, that any improvements in quality of service provision to meet patient needs are to be welcomed, these services do not currently form part of any terms of service for NHS contractors. We do not want to dismiss these services – and we acknowledge that many patients have benefited from them. However, they have mostly been provided over the years as inducements to secure highly-paid prescription business. These have been twofold:

- to the patients themselves, in the form of free accessory items and home delivery etc
- to the SEHD, through NHS Trusts, in the form of “free” nursing posts

**Objective 3**

We agree that contractors, whoever they are, should be allowed a reasonable return, and that this needs to support any additional services that are deemed necessary and desirable, but we do not agree that this should include the sponsorship of nurses.

**Objective 5**

The SEHD is right to be concerned about disruption to patient care if the current system is changed.

We believe that the two main issues that merit consideration if ostomy appliance companies withdraw their contribution to the NHS are access to nurses and flange-cutting. Provision of any other "additional services" can be arranged through other routes, and we do not believe that patient care will suffer unduly if they are denied the other inducements.

The provision of flange-cutting services should be reimbursed as an identified service and could continue to be supplied by appliance contractors or could be supplied by community pharmacies. (We acknowledge that the latter, because they have mostly been denied access to patients' templates hitherto, may need some extra training before this option can be fully implemented).

NHS-employed nurses would be free to work closely with other local healthcare practitioners, including PCT prescribing advisers and GPs to introduce appropriate prescribing protocols for the supply of appliances to ensure that prescribing is cost-effective and that patients have the supplies they need.

**Is the SEHD right to consider that a revision of the arrangements for paying appliance contractors best meets the objectives of the review, or is one of the other options outlined in Annex B to be preferred?**

We think that a revision of the arrangements is essential. However, we do not support any arrangements which allow for the sponsorship of nurses through the "backdoor" of NHS prescription payments.

Apart from the sponsorship of nurses, which we think should be abolished, we do not believe that the provision of "additional services" is (or should be) within the exclusive domain of appliance contractors, apart from perhaps the (exceptional) measuring and fitting of complex incontinence devices.

With the removal of sponsorship, there should then be a level playing field for appliance and pharmacy contractors, with a remuneration framework based quality-based service standards. Payments for an item of service should be the same whoever provides the service if the standards are not met.

Our preferred option is thus a modified Option E. Any remuneration package must be negotiated with SPGC as a supplementary service in the new pharmaceutical contract.
Are the service standards and the types of appliance to which those standards should apply, proposed by SEHD appropriate?

Setting service standards is a step in the right direction to a patient-centred quality driven service, but more work is needed around what the standards should be to give the most benefit to patients.

We are unconvinced about the need for service standards to include telephone advisory services – after all community pharmacists answer queries by phone (and in person) every working day, and presumably so do stoma nurses.

We do not think that the supply of disposal bags and wipes should be included in the proposed standards, as we think they should be available on prescription if considered necessary.

Where the standards are met, should the payment continue to be a flat rate of on-cost or would a tendering option deliver a more cost-effective service.

We do not agree with paragraph 23, which suggests that where the proposed standards are met, remuneration for appliance contractors should remain at a level approximating the current level. Since the current remuneration allows for huge profits which provide for nurse sponsorship, it seems inappropriate to relate current levels of pay to these service standards which, in most cases can be provided by pharmacies.

To suggest, as the SEHD does in paragraph 24, that where the proposed standards are not met, that appliance contractors should be paid the same as pharmacies implies that pharmacies currently meet none of the standards! Some pharmacists measure and fit trusses, all supply prescribed ostomy and other appliances within two working days (and many will deliver where necessary), many would cut flanges if they only had access to patients’ templates, and all answer queries daily by phone and in person.

If sponsored nursing posts cease, and with it the main source of influence over prescribing, there may some merit in a small on-cost for expensive items similar to that allowed for pharmacies. However, this should be linked to rational prescribing – patients and their GPs should be discouraged from ordering large quantities at a time, particularly for older patients and those with recent stomas.

We would not be in favour of the tendering option proposed as Option B. We are unaware of how cost effective the Lothian incontinence agency scheme is in reality. Community pharmacists are paid cost price for supplying the incontinence products but often asked to deliver to patients at no extra charge. The additional costs of administrating agency schemes does not meet SEHD's fifth objective. Finally we believe that agency schemes tend to be unresponsive to patient’s needs and a community pharmacist has reported incontinence products being supplied to a patient for a number of months after the patient died.

Should there be a global sum for appliance contractors?

A global sum for appliance contractors would help to reduce the current open-ended expenditure and reduce the perverse incentives arising from the current system.

NHS employed stoma nurses would be able to work with LHCC based pharmacists and GP practices to introduce appropriate prescribing protocols for the supply of appliances. This will ensure cost-effective prescribing and that patients have the supplies they need.

Is the SEHD right to consider that there is no justification for paying more for an appliance when it is dispensed by an appliance contractor rather than community pharmacy and that, therefore, reimbursement of appliance contractors should be subject to the same discount deduction as for community pharmacies?
Of course! The discount deduction for pharmacies reflects discounts obtained from pharmaceutical wholesalers. Appliance contractors will obtain their supplies in different ways from each other and from community pharmacies. The SEHD should determine what discounts are available to appliance contractors, as well as the cost implications of the vertical integration of some companies, and those contractors who are also appliance manufacturers, and apply an appropriate discount scale, which may the same or different to that applied to community pharmacies.

Is the SEHD right to consider that agency arrangements should be banned? Are the proposed changes to terms of service sensible?

While we are not happy about the existence of agency arrangements, we have no strong views on this, as we believe that with a level playing field they will disappear. They have only arisen as a consequence of the irrational current remuneration.

While the SEHD might feel that agency arrangements are not good use of NHS money, the arrangements have, in fact, been cost-neutral to the NHS under the current system, and patient care has not been compromised.

We hope that you find our comments useful and constructive. We will supply any clarification you may require.

Yours sincerely

Ian Johnstone
Chairman
PHARMACIST AND STOMA NURSES WORKING TOGETHER: 
WHAT CAN BE ACHIEVED

In 1994, together with an independent stoma nurse, the National Pharmaceutical Association set up a small project within the geographical area of an NHS Hospital Trust, to explore the benefits of working together for patients discharged from hospital.

For the purposes of the project, pharmacies were selected to provide a good geographical spread across the NHS Hospital Trust catchment area so that patients had easy access to a participating pharmacy if they so wished.

The stoma nurse trained participating pharmacists in flange-cutting and other issues. Patients could choose where their prescriptions were dispensed: at a participating pharmacy, a non-participating pharmacy or an appliance contractor. Together, we devised a hospital discharge form, with copies sent to participating pharmacies ahead of patient discharge.

Those who chose a participating pharmacy had a smooth transfer to home life, and pharmacists and the stoma nurse were able to deal with any problems or refer to each other. As well as ensuring that appliance needs were met and problems sorted the pharmacists identified several significant drug-related problems including:

- the continued prescribing of medicines to treat pre-surgery problems
- prescribing of inappropriate drugs eg diuretics in an already-dehydrated ileostomy patient with high fluid output
- prescribing of enteric-coated medicines and gelatin capsules which, for some patients, passed out of the stoma unabsorbed
- prescribing of constipating drugs in colostomy patients

The pharmacists were also able to identify existing patients who had never seen a specialist nurse which resulted in some long-standing stoma-related problems being sorted out. Everyone benefited.

Unfortunately, the nurse was coming up to retirement and her replacement was sponsored, so the arrangements broke down. The pharmacists in the geographical area concerned now have no easy access to the stoma nurse without fearing loss of prescriptions, so there is no incentive for team-working. New patients automatically have their prescriptions sent away for mail-order dispensing.