

ALL CHANGE FOR COMMUNITY PHARMACY — WHAT THE NHS REFORM AND HEALTH PROFESSION BILL WILL MEAN

The NHS Reform and Health Professions Bill was published recently. What effect will it have on community pharmacy? Dr Hopkin Maddock, FRPharmS, explains

The “NHS plan: a plan for investment, a plan for reform”, published in July 2000, set out the Government’s plan for the modernisation of the National Health Service over the next 10 years. The organisational changes proposed to support this included:

- 1 Developing primary care trusts (PCTs) to fulfil their potential and take on increased responsibilities
- 1 Creating strategic health authorities
- 1 Refocusing the Department of Health to achieve these aims

Full implementation of the proposals requires primary legislation, and this has been introduced through the NHS Reform and Health Professions Bill, which is now going through Parliament.

THE STRATEGIC HEALTH AUTHORITY

Part 1 section 3 of the Bill describes a strategic health authority (StHA) as a new organisation that will lead the strategic development of the local health service and manage the performance of PCTs and NHS Trusts. The StHA “will be charged with creating a coherent strategic framework for the development of services across the full range of local NHS organisations”.

The StHA will support the improvement of the NHS by working with local PCTs to enhance the involvement of patients, the public and health and social care professions in developing services as well as the implementation of clinical governance programmes to improve the quality and consistency of care.

“Pharmacy in the future — implementing the NHS plan”, published in September 2000, outlined in detail how pharmacy fits into the NHS plan. The implementation of Pharmacy in the Future will require the re-engineering of pharmacy practice. The terms of reference of the StHA as set out above clearly cover the wide span necessary to oversee the cultural and structural changes that are inherent in Pharmacy in the Future.

The community pharmacy service is provided in England by 10,270 pharmacies dispensing 551.8 million prescriptions with a net ingredient cost (NIC) of £5,584.6m, ie, 11 prescriptions per head of the population with an NIC of £10.12. An StHA leading the strategic development of local health services, monitoring the performance management of PCTs and NHS trusts and implementing the pharmacy plan should

ideally have pharmaceutical representation to aid its deliberations. It should also have clearly set out direct links with local pharmaceutical committees.

PRIMARY CARE TRUSTS

A fundamental change in the Bill that will affect community pharmacy is the change of responsibilities from health authorities to primary care trusts (NHS Act 1977, section 17A, as amended by the Bill). PCTs will become the lead NHS organisations in assessing need, planning and securing all health services and improving health. They will lead on the development of all primary care services.

In future PCTs will be responsible for:

- 1 Maintaining the list of pharmacy contractors
- 1 Applications to provide NHS pharmaceutical services by pharmacies
- 1 Applications to provide NHS pharmaceutical services by GPs
- 1 Determination of rurality
- 1 Relocation of premises
- 1 Remuneration and payment systems
- 1 Access to medicines out of hours
- 1 Services to care homes
- 1 Domiciliary oxygen services
- 1 Disciplinary procedures
- 1 Complaints procedures
- 1 Local pharmacy initiatives

To fulfil these requirements PCTs will need to develop “pharmacy needs assessment plans”. In addition to the requirements set out above, PCTs will be involved in the implementation of “Pharmacy in the Future”, including:

- 1 Repeat dispensing arrangements
- 1 Pharmacist prescribing arrangements
- 1 Electronic prescribing implementation
- 1 One stop primary care centres
- 1 Medicines management and concordance
- 1 Provision of emergency contraception
- 1 Continuing professional development
- 1 Clinical governance
- 1 Local pharmacy services
- 1 Smoking cessation
- 1 Services for drug misusers

The existing controls over entry to a PCT pharmaceutical list will not change. The application for entry into the list will only be granted if a PCT is satisfied that the service is necessary or desirable to provide adequate pharmaceutical services in its locality. There are, however, concerns with regard to the potential for abuse of the new responsibilities.

The NHS modernisation plan announced the development of 500 large, one-stop primary care centres or “super-centres” by 2004 and envisages pharmacies within them. It is known that a PCT in the South West is proposing to set up such a centre, including a pharmacy. No formal application has been made, so that the test of “necessary or desirable” has yet to be decided. It would appear that the PCT would at a future date be both the applicant and the awarding authority, regarding the application.

In addition, health care professionals are to be attracted to practise from the centre by offering competitive rents based on the district valuer’s assessment. Pharmacy contractors, however, are required to tender for the premises; it is known that a seven-figure sum has been included in the centre’s financial projections to ensure viability. The potential for the abuse of the new powers of a PCT is self-evident.

Part 1, section 12, of the Bill extends the functions of the Commission for Health Improvement. These include powers of inspection and investigation of NHS bodies and service providers. The commission must make a report of its views to the Secretary of State.

The view may be either (i) the health care for which the body or service provider is of unacceptably poor quality, or (ii) there are significant failings in the way the body or service provider is being run (including, where the service provider is an individual, the way his practice is being run). The commission’s report may recommend to the Secretary of State that he take special measures in relation to the body or service provider with a view to improving the health care provided.

Part 1, Section 15, of the Bill announces the establishment of patients’ forums, one for each PCT and NHS trust. Under Section 16 — “Entry and inspection of premises” — it states that the Secretary of State may also make regulations requiring any StHA, PCT, or persons providing services under Part 2 of the 1977 Act or piloted services under pilot schemes, to allow members of a patients’ forum to enter or inspect

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premises for the purposes of the forum's functions. This new requirement of inspection is surely going to make the duties of a pharmacy contractor more onerous and needs to be modified at national level.

The Secretary of State needs to be reminded that the Royal Pharmaceutical Society's Professional Standards Directorate, through its inspectorate, is responsible for enforcing the law and codes of professional practice on the supply and retail sale of medicines. He also needs to be reminded that community pharmacy is subject to national and local standards from a variety of sources. To reduce the burden, the Society should negotiate with the Department of Health for the delegation of inspection procedures to the Society's inspectorate. Precedents for such delegation exist and could contribute to the Society's income.

It must also be noted that the Health and Social Care Act 2001 abolished the NHS Tribunal. Since there was an underlying patient safety requirement to bring forward the changes as quickly as practicable, it came into operation on 1 December 2001. PCTs have new powers to:

- 1 Remove people from their pharmaceutical lists or make their continued inclusion subject to conditions
- 1 Refuse applications to join the pharmaceutical list or to make inclusions subject to conditions
- 1 Suspend people temporarily from lists where that is in the public interest
- 1 Act if someone's inclusion (or continued inclusion) in the list would be prejudicial to the efficiency of the service (currently the duty of the NHS Tribunal)
- 1 Act against people who are unsuitable to provide NHS services (for example, because of criminal convictions or sanctions imposed by their regulatory body) or who have committed fraud against or involving the NHS

As now, all persons who wish to provide NHS pharmaceutical services must be included in the relevant PCT's pharmaceutical list. There will be a right of appeal to the Family Health Services Appeal Authority, which is being reconstituted.

Pharmacy contractors have a different status compared with other NHS service providers. Pharmacy services are mainly provided by pharmacy contractors which may be an individual pharmacist, a partnership or a limited company. Limited companies will need special attention in that the "superintendent pharmacist" is legally responsible for the management of the business insofar as it concerns the observance of all legal and professional requirements in relation to pharmaceutical aspects of the business, in all the pharmacies owned by the company.

There is a need to clarify a number of matters with regard to the above, including the distinction between the superintendent and pharmacists employed by the company with regard to disciplinary matters. In addition, the PCTs' powers concerning the

removal of contractors from pharmaceutical lists need to be clarified — will they be able to remove a branch of a company from the pharmaceutical list as opposed to the company? The complexity of these matters may be the reason that Statutory Instruments have been published with regard to all the health care professions other than pharmacy.

The profession must express its concerns regarding the probity and transparency applicable to the judgement of the competence and effectiveness of health care professionals. It is surely inappropriate for peers working in the same health care locality to deal with such matters. For example, the constitution of PCT boards and their executive committees could well include representatives of up to 50 per cent of the medical practices in a PCT area. In pharmacy, there is a well known antipathy on the part of some individual contractors to company chemists. This could lead to vested interests and personality clashes, making the disciplinary process difficult to resolve at the local level.

During 2002, it is likely that PCTs will also be required to set up new "supplementary lists" of pharmacists who work for pharmacy contractors. Pharmacy contractors will not be allowed to engage people to provide NHS services on their behalf unless they are on such a list. This will apply to locums as well as permanent staff. As with the main pharmaceutical lists, PCTs will have powers to deal with pharmacists whose fitness to provide NHS services is in question.

The decisions on all the administrative functions and future innovation regarding community pharmacy, set out above, will present major conflicting dilemmas with regard to probity, when decisions have to be made regarding commissioning and, separately, surveillance of professional services and resources. All of these functions will be the responsibility of the PCT executive committee, which has been set up by direction of the Secretary of State under sections 17 and 126(4) of the NHS Act 1977 and Regulation 9(1) to (3) of the Primary Care Trusts Regulations 2000. The Regulations state: "The PCT executive committee shall have no more than 15 members." There is no statutory provision for a pharmacist on the executive committee. But the participation of a pharmacist is essential in debates concerning wide-ranging pharmaceutical services. The Regulations require appropriate amendment.

It must be noted that this committee structure was promulgated before the projected extended role of PCTs was published. The statutory provision for a pharmacist will be crucial in areas where dispensing doctors play a major role in the provision of health care. Amended regulations should be binding not only on PCTs yet to be commissioned, but also on those already in existence.

The financial implications of the changes in the new NHS are that PCTs will be allocated 75 per cent of NHS funds worth in total about £45bn for 2000/01.

Pharmaceutical care in the NHS in England and Wales, including the costs of medicines, is valued at around £6.25bn, equivalent to 14.3 per cent of total NHS funds, thus its administration will account for nearly 19 per cent of PCT expenditure.

Of this expenditure nearly £6bn is funded by pharmacy contractors to cover the costs of NHS medicines. In addition pharmacies sell over-the-counter medicines, which contribute to the community's well being, worth some £1.65bn in England in 2000 an increase of 2.5 per cent over the previous year. PCT executive committees, as presently constituted, will have powers to make decisions, which will have a major impact upon pharmacy contractor's financial arrangements and budgetary projections, without any community pharmacy representative being present.

THE FUTURE OF LOCAL PHARMACEUTICAL COMMITTEES

Pharmacy must be most pleased that the Secretary of State has accepted the argument presented in *The Pharmaceutical Journal* (18 August 2001, pp233-4) in response to the consultation document with regard to local representative committees. He has recognised that in future it is logical for LPCs to be aligned with the new PCTs.

Since the new PCTs will evolve from existing groups of PCGs, which are contemporaneous with HAs, it would be logical to retain the LPCs with their present boundaries. This would aid the Government's intention to ensure there is no fragmentation of services and that there is consistency of service provision. LPCs are independent of any other organisation; they are autonomous and are recognised in, and bound by, the provisions of the NHS Act and the Regulations. The constitution of an LPC specifically reserves places for independent contractors and company contractors. It provides for employee membership in order that the views of employees are available to the LPC. The employee members are expected to voice the views of employees working within the locality, regardless of their employer.

The present LPCs with their diverse representation of different sectors of community pharmacy have shown themselves able to represent the interests of all contractors in England. LPCs constitutions may however, need to be remodelled. Attendance of PCT executive committee nominees as observers should be introduced, because collaboration between LPCs and PCTs will be paramount. In addition task groups could be appointed by the LPC to cover each PCT in its area.

Legislation will not be in place for PCTs to assume their new roles until October 2002. StHAs, however, are expecting to delegate the new roles to PCTs from 1 April 2002. At this late date, LPCs have yet to receive guidance from the Pharmaceutical Services Negotiating Committee as to the strategy they should pursue. However, LPCs must be prepared to take local action immediately.