

"Shifting the balance of power" - how will it impact on pharmacy in England?

The implementation of 'Shifting the balance of power' has major implications for pharmacy in England.

Dr Robert Calvert, FRPharmS, consultant in medicines management at North and East Yorkshire and Northern Lincolnshire Health Authority, explains

In July 2001, the Government published 'Shifting the balance of power within the NHS - securing delivery', its blueprint for organisational change in the National Health Service. This was followed in December 2001 by 'Shifting the balance of power - the next steps' (see www.doh.gov.uk/shiftingthebalance). The implications for primary care of the changes set out in the first paper have been reviewed by Dr Hopkin Maddock.¹

The changes set out were implemented in April 2002. The new organisation has and will continue to affect pharmacy and its development in both primary and secondary care. This article will show that pharmacists need to consider the implications of the revised structure and reporting arrangements when planning future developments of the pharmacy service.

The organisational boundaries of the new strategic health authorities have now been brought into line with the nine government offices set up in 1994. These are:

- North East
- North West
- Yorkshire and the Humber
- East Midlands
- West Midlands
- East of England
- London
- South East
- South West

These offices bring together several Government departments, including the Department of Health, for the provision of regional services. Within the NHS, adjacent GOs have been combined to give four regional offices. These are:

- London
- South (includes South West and South East GOs)
- Midlands (includes East of England, West Midlands and East Midlands GOs)
- North (includes North West, North East and Yorkshire and the Humber GOs)

A director of health and social care is based in each regional office. The director works directly with the NHS and is responsible for performance management of health authorities. In addition, the government offices of the Department of Health

all linked to the regional office of the NHS through the appointment of regional directors of public health, who are accountable to the director of health and social care and also to the chief medical officer at the DoH. The use of the term 'regional' for both the new regional departments of health and the government office of the regions has caused confusion.

The role of the four directors of health and social care includes:

- Supervision and development of social care
- Supporting the chief executive of the NHS in assessing performance of the whole system
- Public health

These are key responsibilities that impact on many aspects of pharmaceutical services.

As has been found in the past, a lack of the presence of pharmacy in decision-making circles can result in oversight of the contribution the profession can make in many areas of health care.

The old style regions did have access to pharmaceutical and prescribing advice from their regional pharmaceutical advisers. These posts provided a link between the Department of Health, the office of the chief pharmacist, the regional office and the old health authorities.

This link has not been retained in the new DoH regional offices. However, the directors of public health in the government offices forming DoH North region have appointed a pharmaceutical public health adviser working part time to each government office. A similar appointment has been made in DoH Midlands region.

There has, therefore, been a reduction in availability of professional pharmacy advice at the DoH regional offices. This might diminish the input of pharmacy into policy development in the long term.

STRATEGIC HEALTH AUTHORITIES

The health community within each regional office has been grouped into a number strategic health authorities, soon to be called health authorities.

Groups of the new health authorities (Figure 1) are coterminous with the DoH regions and replaced the 95 former health authorities from 1 April 2002.

The new HAs have three key functions:

- Creating a coherent strategic framework
- Agreeing annual performance agreements and performance management
- Building capacity and supporting performance improvement

All NHS organisations within a health authority, ie, primary care trusts and NHS trusts, are held to account through the new health authority.

The new health authorities have chief executives appointed on the basis of a franchise plan presented by chief executives during the appointment process. The franchise document sets out the delivery plans for the local health community.

Each plan describes the organisation and ways of working for the new health authority. Hence, there are several different models for running the new health authorities, however, they all have common functions of:

- Developing a strategic framework for delivery of services across all local organisations
- Supporting patient and public involvement
- Brokering solutions between PCTs when conflict develops
- Fostering partnerships with universities and further education
- Performance managing PCTs and trusts and workforce development confederations
- Ensuring delivery of safe, quality services through effective clinical governance arrangements in PCTs and trusts

These are key strategic and developmental responsibilities.

Few of the new health authorities have appointed professional staff with specific roles in relation to pharmacy practice and prescribing practice. Many new health authorities have at present chosen to seek such advice as required from primary care trust pharmaceutical advisers within the new health authority. Most are still feeling their way as to how they will function in the new NHS.

They may include pharmaceutical advice within the health authority once clear about strategic development and implementation.

PRIMARY CARE TRUSTS

Each of the new health authorities comprises a number of PCTs. PCTs are the cornerstone of the new structure. Strengthening and development of PCTs is central to shifting the balance of power. The main roles of the PCTs will be:

- Improving the health of the community
- Securing the provision of high quality services
- Integrating health and social care locally

From this month, PCTs have become responsible for the delivery of the majority of old health authority functions. This will include responsibility for contractor professions including pharmacy. Most PCTs have at least one pharmaceutical/prescribing adviser on their staff. Pharmaceutical advisers now have the opportunity to lead the development of pharmacy in their locality through the PCT, in addition to their responsibilities for managing the prescribing agenda. Many PCTs have established new posts to support the professional practice issues within the PCT. There are now over 600 pharmacists working in primary care, either for PCTs or for GP practices.

This development has raised the profile of pharmacy practice in primary care and has led to the development and funding of additional services from community pharmacies in several PCTs. There are now pharmacists on the boards of many PCTs. This involvement in the strategic planning and development of local health care means that pharmacy is now included as a full member of the primary care team.

There are many opportunities for engagement of pharmacy within the developing role of PCTs. However, there may be a tension in some PCTs where there is a preference for using PCT-based pharmacists as opposed to local contractors. This has happened with the provision of prescribing advice to GP practices and, in some areas, advice to care homes.

As with every new development we need to consider the potential impact on pharmacy and develop our strategic approach as to how we can best contribute to patient care in the new system.

NHS TRUSTS

The functions of NHS trusts (acute hospitals and community trusts) do not change following shifting the balance of power. However, they will be affected by the changes. In future NHS trusts will be per-

formance managed by the new health authorities. They will need to work closely in partnership with PCTs and other local partners. We are already seeing the fruits of such collaboration with the implementation of medicines management using patients' own medicines and extended supplies on discharge. Close working relationships between hospitals and primary care will be one of the key factors for the new NHS.

The implementation of shifting the balance of power has major implications for pharmacy. One area of concern within the new structure is the loss of the pharmacy network previously provided by the regional pharmaceutical advisers meeting is advising the chief pharmacist. Alternative ways of ensuring feedback on proposals information on grassroots activities and downward briefing/cascade of information may have to be developed.

Loss of posts in the regional and health authority structures is counter-balanced by a dramatic increase in posts and influence in PCTs. The former regional and old health authority advisers were much involved in strategic planning and development. This role has to a large extent been spelt out for pharmacy at a national level with the adoption of the NHS plan, pharmacy in the future and clinical governance in community pharmacy as the key strategic docu-

ments relating to the development of pharmacy in the NHS.

These have been underpinned by the Audit Commission reports 'A spoonful of sugar' and 'Medicines management framework' and the creation of the National Patient Safety Agency. The role of the new health authorities is to monitor PCTs, which are responsible for attaining the objectives for pharmacy services in the NHS set out in the documents.

Pharmacy itself is in the process of reorganising its professional organisation to meet Government requirements in relation to professional self-regulation. The interaction of the Royal Pharmaceutical Society with the new NHS structures is a key issue for the long-term development of pharmacy practice. Much of the debate about the Society's modernisation programme has focused on internal issues. Perhaps pharmacy should also look to its relationships with external bodies when considering its strategic approach to future developments.

REFERENCE

1. Maddock DH. Pharmacy must be represented when the balance of power is shifted. *Pharm J* 2001;267:233-4.

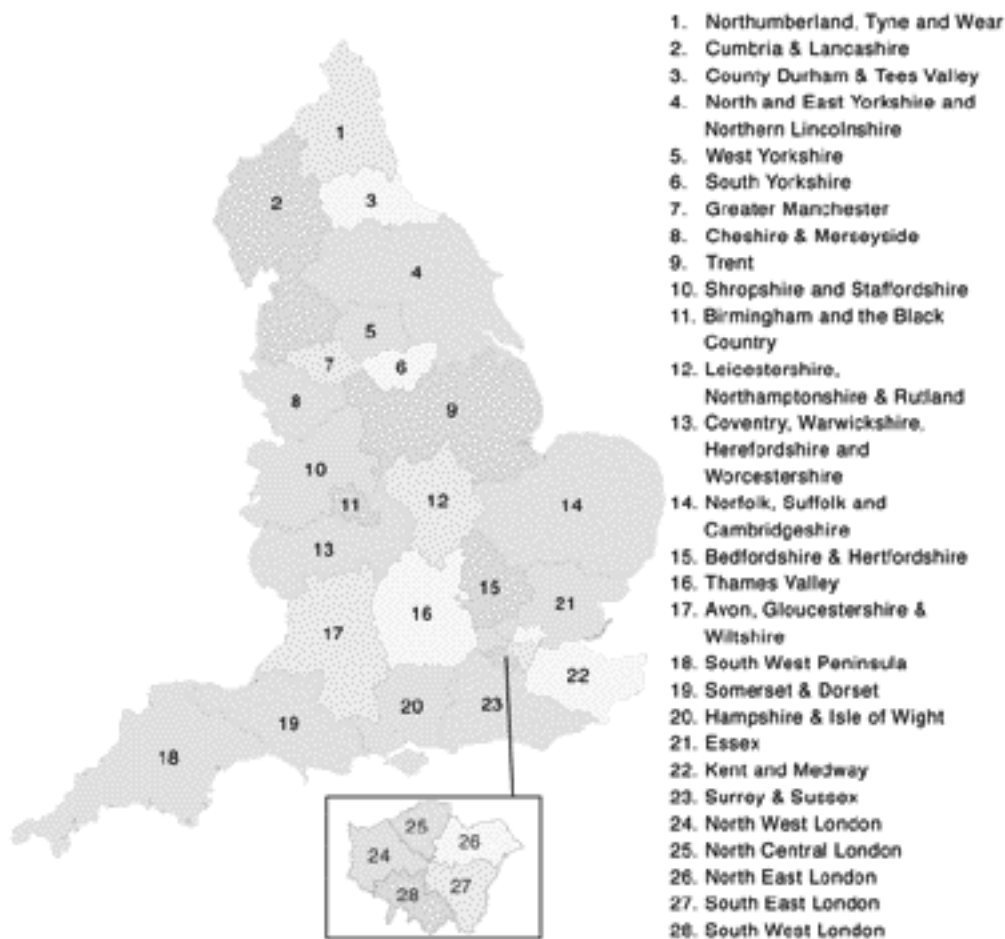


Figure 1: The new health authority boundaries, to be called 'strategic health authorities' as from October 2002, subject to legislation