

# Yes! Minister — the story continues

By **Graham Phillips**, a community pharmacist from Hertfordshire

**B**y way of counterpoint to my letter entitled "No! Minister" last week (*PJ*, 8 December p655), let me take up the challenge of surmounting "the perceived barriers to pharmacists' greater clinical involvement, delivery and health involvement" and propose solutions so "pharmacists can plan, develop and invest with confidence" as reported in the *PJ* (1 December, p611).

## First challenge

How can we ensure that the provision of advanced services can better be linked into primary care trusts' assessment of local pharmaceutical needs?

This is straightforward. A national template for pharmaceutical care needs assessments that fully integrate community pharmacists with PCT "must-dos" around medicines management, near-patient testing and public health should be developed. All are critical areas for the NHS, where pharmacy can play a crucial role. The assessment must also evaluate the potential for primary to secondary care shift, which is the big prize (more of this later).

PCTs must be required to conduct assessments meaningfully in contrast to the current situation where they often do not happen at all or, the results are ignored. There should be a nationally agreed, properly costed menu of enhanced pharmaceutical care services, complete with service level agreements, training where required and audit tools. There has to be ring-fenced money to commission these services and each PCT will use its share of the ring-fenced money to purchase those services identified by the local needs assessment.

Despite this national approach, local flexibility can still be retained: PCTs will have the option to develop any of the nationally agreed enhanced services further if they only partially meet local needs. For example, if the area has an unusual ethnic mix, exceptionally high levels of health inequality or if there are other specific environmental factors, local services should be developed to cater for these needs.

These higher level services ("enhanced plus" for the purposes of this article) will be commissioned based on need and the required top-up funding will be paid for from the PCT's own pot. Such service development must be shared nationally creating a database of enhanced plus services. Such a database would be an invaluable tool to inform future service development, the longer-term evolution of the national pharmacy contract, and as a basis for future training requirements. It is easy to see how pharmacists with a special interest and consultant pharmacists will fit into such scenarios. They will be the local leaders whose commitment, special-



ist knowledge and vision will drive the profession forward.

## Second challenge

How can we make sure that the quality of services continually improves, eg, by harmonising accreditation requirements?

Delivery on this ambitious agenda will require training, accreditation and, ultimately, both specialisation and revalidation. Practice research will also be an essential tool to provide an evidence base to present to commissioners.

These are exactly the services our new professional body should be providing, leading and stimulating. This would work in conjunction with "something akin to a medical deanery" (to paraphrase government thinking). This will require collaboration on the ground between the current Royal Pharmaceutical Society branches that are working with contractors via local pharmaceutical committees, the schools of pharmacy that will have a huge role to play, and the Centre for Postgraduate Pharmacy Education.

Suddenly our local networks will be working in synergy and this nebulous professional body "akin to a royal college" will be providing something of tangible benefit that pharmacists can understand, value and want to join: a professional body that can directly influence and support individual pharmacists' practice, one that can provide for our professional aspirations, support continuing professional development and embrace revalidation.

It will also bring an end to the absurdity of post-code accreditation. I speak from experience here; a few years ago I was the smoking cessation lead for the local primary care group. I set up level 2 smoking cessation training for all the local health professionals including GPs. The neighbouring PCT refused to accept my accreditation because I had not done "their" course. Madness.

So, is all of this a pipe dream? Wishful thinking? Pie in the sky? No. Much of it is already happening in various places in a piecemeal, haphazard and unco-ordinated way. There is some fantastic work going on, but it is restricted by post-code and driven by enthusiasts often in their own time and often at their own cost. It is almost always under-resourced and rarely shared. The new professional body must draw all the threads together thereby providing the crucial leadership the profession so patently lacks.

What of the new regulator? The General Pharmaceutical Council? It will be for this body to quality assure that everything is working in the interests of patients and the NHS.

## Third challenge

Could a "funding floor" be developed and, if so, how would it work?

Funding floor? In a word? Yes. We already have the global sum but it is far too heavily based on prescription volume and the vagaries of buying power — it remunerates outputs not outcomes and, in some ways, opposes the agreed direction of travel. The en-

tire contract must evolve to a much more clinical, outcomes-based model: a community pharmacy quality and outcomes framework. This together with the new global sum for enhanced service funding described above will provide the funding floor.

#### Fourth challenge

Are the tiers of the contract the right ones for the future?

The current tiers are a perfectly good start. We need to make them work properly before abandoning them. There has been far too much deck chair rearranging in the NHS. We need stability, predictability and a period of bedding-in before we make yet more changes.

So, I believe the profession has already come up with most of the answers. But it is for politicians to create the right environment, seed the opportunities and support the solutions. Having addressed the minister's challenges, I have some challenges of my own for Government to address:

- Practice-based commissioning must evolve from its current dysfunctional role (practice-“biased” commissioning) to be genuinely patient-centred, patient-based commissioning. The Government must ensure that it is patients and the public, not the vested interests of any particular professional group, that are central.

- PCTs must be obliged, empowered and supported to involve all the primary care team when commissioning — no more closed shop for GPs and no more externalisation of pharmacy. Pharmacy must have a meaningful seat at the table and commissioning processes must involve all the stakeholders. PCT performance management must change to ensure this happens.
- Many strategic health authorities currently have wholly inadequate pharmacy input. This must change. SHAs must be required to performance-manage PCTs and ensure that commissioning is patient-centred, unbiased and transparent.
- Primary care contracts, especially those of GPs and community pharmacists, must work in synergy. Currently they do not. If there has to be competition it must benefit patients and not any one professional group. SHAs and PCTs must play their role.
- The Darzi review must, as a principle, not as an entreaty, foster stability for community pharmacy. Perhaps a hub-and-spoke pharmacy model is the solution.
- The 100-hour exemption is a disastrous political fudge. It must go and go at once before incalculable damage is done.
- Government must pledge to reinvest the £400m clawed back from community pharmacy to fund the opportunities out-

lined. The attrition must end now. There must be a period of stability while the details of the White Paper are worked up.

- There should be an end to the expectation that community pharmacists behave as professionals while being treated like market-traders.
- There should be an end to 10 years of one pharmacy review leading to another. The White Paper must provide permanent, sustainable solutions that the profession can sign up to. Politicians must take responsibility and make decisions instead of abdicating everything to yet another review.

Despite record investment, the NHS has had some tough years. There remains a huge financial and political prize, which is making the secondary to primary care shift a reality. Crucial here is the opportunity for service redesign. Put the patient at the centre and use the entire primary care team (pharmacy included) to deliver. The cost saving will more than pay for the necessary investments in pharmacy and more widely in primary care. It is said that “politics is the art of the possible.” Not only is all of this possible but patients and the public will love it.

*Although Graham Phillips is a member of the Royal Pharmaceutical Society's Council, this article and his recent letter “No! Minister” (8 December, p655) were written in a personal capacity.*

Advertisement