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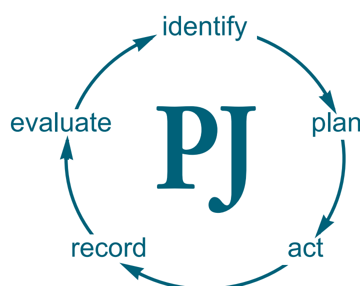
THE NEW NATIONAL HEALTH SERVICE

(1) UNDERSTANDING THE NHS IN ENGLAND

By Georgina Craig, MA

Since the election of the Labour Government, the National Health Service has undergone much remodelling. This article is the first in a series about the new NHS. It reviews the new structures in England and what they mean for pharmacy. Later articles will look at NHS structures in Scotland and Wales



identify gaps in your knowledge

1. Do you understand how the NHS is structured in England?
2. Do you know which planning documents you should familiarise yourself with to identify local priorities?
3. Do you understand the developments in primary care that are likely to impact on pharmacy in the future?

Before reading on, think about how this article may help you to do your job better.

The Royal Pharmaceutical Society's areas of competence for pharmacists are listed in "Plan and record," (available at: www.rpsgb.org.uk/education). This article relates to "political, economic and managerial aspects of the NHS" (see appendix 4 of "Plan and record").

Over the past few years, the National Health Service in England has undergone radical structural changes. These are by no means the first changes, but this time the stakes are higher. The Labour Government has pledged significant increases in NHS funding and the new structures must deliver visible improvements in care before the next election if the Government's gamble is to pay off.

PRIMARY CARE TRUSTS

In England, the pivotal management body affecting community pharmacy is the primary care trust (PCT). There are 301 PCTs across the country and by 2004 they will hold 75 per cent of the total NHS budget. They will manage budgets for local services and commission hospital care. PCTs vary in size and population covered. High Peak and Dales PCT has a chief executive who is a pharmacist.

Each PCT has a board of management, with a majority of lay appointees (non-executive directors). The board is responsible for the governance of the PCT and is accountable for its use of public funds and the quality of care provided. However, on a day-to-day basis, many PCT decisions are made by the PCT executive committee (PEC). This has a maximum of 18 members, the majority of whom are professionals. Most PECs are dominated by general practitioners and nurses, but increasingly pharmacists are winning places on them. Around 47 per cent of all PCTs now have a "PEC pharmacist" and numbers are increasing all the time. This is a challenging role to take on, but it provides huge opportunities for personal and professional development.

A number of PCT committees develop plans and proposals for the PEC to consider. Important ones for pharmacy include the prescribing committee, the service redesign committee, the estate planning committee the clinical governance committee and the finance committee. These are described in Panel 1.

Ms Craig is head of NHS service development at the National Pharmaceutical Association

PANEL 1: PCT COMMITTEES

The prescribing (or medicines management) committee The prescribing committee is responsible for planning and overseeing spending on the drugs budget. This is the committee that PCT prescribing advisers work most closely with.

The service redesign committee (or primary care development) committee The service redesign committee considers different options for service development that will help the PCT to meet its targets. It is a key committee for community pharmacy since, ideally, it should be considering how to develop services in pharmacies.

The estate planning committee The primary care estate is the building stock owned by the PCT (eg, community clinics and hospitals and some GP premises). Not every PCT has an estate planning committee, but every PCT has an estate plan. Close liaison with the lead committee on estate planning is essential so that community pharmacy is aware of planned changes in the primary care estate.

The clinical governance committee The clinical governance committee oversees the implementation of clinical governance within the PCT. Because pharmacy services are subject to clinical governance and community pharmacy can help with risk management in other parts of the systems (eg, reducing prescribing errors), pharmacy involvement with this committee is essential.

The finance committee The finance committee holds the PCT purse strings and has the ultimate say on how PCT budgets are spent.

PCTs hold pharmacy contracts and manage the pharmaceutical list. However, some do this through an agency arrangement where one PCT takes on delegated responsibility for this function on behalf of its neighbours.

Key documents The key planning document within the PCT is the local development plan (LDP). This is a three-year plan, currently covering 2003 to 2006. It outlines how the PCT will meet the targets set in the NHS planning and priorities framework.[1] The LDP will, in time, supersede health improvement and modernisation plans.

Another important document is the strategic service development plan (SSDP). Every PCT should have had one since December 2002. The SSDP outlines a vision for service delivery within the PCT over the next five to 10 years and includes planned developments in primary care premises, which will impact significantly on the pharmacy network. For example, the relocation of lots of small neighbourhood GP practices into a large, one-stop primary care centre would undoubtedly affect community pharmacy.

In fact, primary care estate development is a key agenda for pharmacy to influence, especially given the proposed changes to control of entry regulations in England (see p105 and pp113–4 of this issue). Estate planning starts with robust service planning. There are a number of planned pharmacy service developments that will impact significantly on GP services, most notably repeat dispensing and the emergence of pharmacy-based minor ailments schemes. Both will result in a shift in care towards pharmacy. Because of this, entering discussions with the service lead within the PCT (usually the primary care development manager or director of primary care) about service planning related to the primary care estate is a good way of illustrating to PCTs the need for a strategic approach to service development within pharmacy. This is a good first step on the road to sustained funding for additional pharmacy services. The National Pharmaceutical Association has produced resources, explaining the primary care estate agenda in more depth for both PCTs and community pharmacists.[2,3] These are available on request.

STRATEGIC HEALTH AUTHORITIES

Strategic health authorities (StHAs) are responsible for monitoring whether or not PCTs are meeting their targets (ie, performance management). StHAs have been finding their feet over the past year or so. In time, these bodies are likely to take on a supporter-facilitator role, working with PCTs to help them meet their targets, since the balance of power is tilted in favour of PCTs within this relationship. StHAs are also likely to play a role in spreading best practice by networking PCTs that are working on similar initiatives and sharing good ideas across the patch.

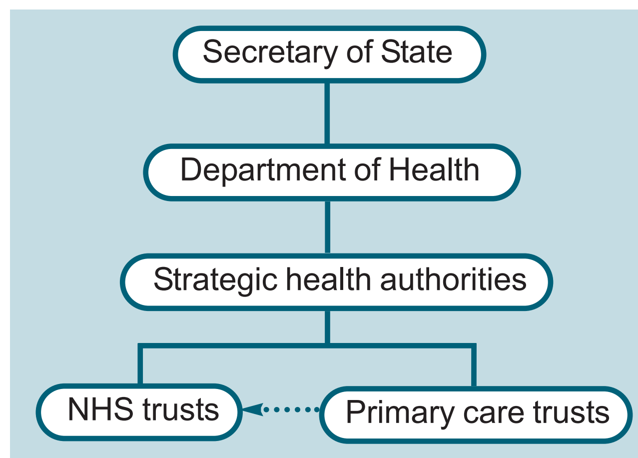
NHS TRUSTS

There are about 275 NHS trusts in England. These are made up of acute hospital trusts, community trusts, mental health trusts and ambulance service trusts. Like PCTs, NHS trusts must meet national targets. Income mainly comes from service agreements with PCTs.

KEY NATIONAL INFLUENCERS

Another important change in the NHS is the decentralisation of decision making. This reflects an emerging political bent towards "localism" within Government. The result is fewer targets being set by the Department of Health (DoH) — PCTs having much greater freedom to set their own agenda — and further downsizing of central administration. The recent National Service Framework (NSF) for Diabetes is a case in point. The DoH has left it to PCTs to develop their own frameworks and targets within a set of national standards. This is in stark contrast to the NSF for Coronary Heart Disease launched in March 2000, which was far more prescriptive. That said, there are other ways in which the central administration of the NHS will continue to exert influence on PCTs. The NHS Modernisation Agency is a notable example. The agency employs over 700 people and is tasked with helping the NHS to roll out the modernisation agenda. In some ways, it acts like an internal consultancy service for the NHS, providing PCTs with know-how, help and support to try new ways of working and to develop their management competencies. The plan is to devolve much of its work to StHAs over time, thus reinforcing their role in facilitating PCT development.

In addition, the NHS Confederation is also emerging as a key influencer. The confederation is the representative body for NHS



The NHS in England

managers and, like the national pharmacy bodies, it lobbies government and the NHS. Its focus is on ensuring that the NHS can be effectively managed and makes the best use of its management resource. However, its role in negotiating both the new general medical services (GMS) contract across the United Kingdom and the pharmacy contract in England indicates that it is starting to take on a subtly different role at national level and that its influence on the NHS in the void created by removal of central direction will increase over time.

KEY LOCAL INFLUENCERS

In the new NHS local people have a bigger say in PCT planning processes. The Government has recently introduced a new system to make this happen. The key local patient representative body is the patients' forum. This is an independent statutory body, which nominates a non-executive director to the PCT board. It is tasked with monitoring and reviewing services and influencing PCT decision making and planning processes.

Local authorities also have a bigger say in NHS planning through overview and scrutiny committees. These committees have existed within local authorities for some time but, since April 2003, all NHS trusts and PCTs are obligated to consult them on significant variations and reconfigurations in service provision. This includes PCT proposals around the development of both local pharmaceutical services and other pharmaceutical services. Although overview and scrutiny committees cannot overturn a PCT decision, their job is to look at the broader social, economic and environmental impact of PCT decisions on the local community and specifically on health inequalities. They also raise issues that the NHS may have overlooked through its primary focus on health services (eg, the impact on the local shopping access of relocating GPs to a new health centre). Populated by local politicians, these committees are likely to be vocal and require PCTs to answer some awkward questions, particularly about the impact of their decisions on issues like regeneration and shopping access. They are potentially an ally for community pharmacy.

An increasingly important planning forum, especially in deprived areas, is the local strategic partnership. This forum includes representation from PCTs, local authorities, the voluntary sector and other statutory bodies and considers issues like the integration of health and social care services. It is a particularly good place for community pharmacy to get its voice heard since pharmacy contributes to both the health and community development agenda by providing access to health services and helping to keep the local economy vibrant.

The local pharmaceutical committee (LPC) is the statutory representative body for community pharmacy owners at local level. Following the abolishment of health authorities, LPCs have restructured, where appropriate, to mirror StHAs or close geographical groupings of PCTs. The LPC is the body that PCTs must consult on key issues like proposals for local pharmaceutical services and contract applications for pharmacies. LPCs also lobby PCTs at local level and many have been successful in making the

case for funding of additional pharmaceutical services such as minor ailments schemes, medication review and supervised methadone consumption.

IMPACT OF THE NEW GENERAL MEDICAL SERVICES CONTRACT ON PHARMACY

The most significant change in primary care since the mid 1990s is likely to be the introduction of the new GMS contract, which GPs have recently voted to accept.[4] The new contract will cover all four countries within the UK as the current GP contract does. However, attached to the proposed new contract is a significant uplift in funding. In fact, much of the increased NHS funding for primary care over the next few years will be channelled through GMS.

The new contract will enable GPs to opt out of 24-hour care for the first time. PCTs will assume responsibility for out-of-hours medical care and this is likely to lead to radical changes in the organisation of out-of-hours services, with GPs becoming less important and other health professionals, notably nurses and pharmacists, assuming a greater role. There are also links between out-of-hours care and the reform in emergency care agenda[5] since many patients who use accident and emergency services could be dealt with safely in primary care.

The second important feature of the new GMS contract is the focus on quality outcomes. A significant proportion of GPs' potential income will come from the achievement of targets set out in the proposed GMS quality and outcomes framework. Many of the targets in the framework relate to improved medicines management (eg, ensuring regular medication review and prescribing in line with NSF standards for optimal treatment). This creates a subtle shift in accountability and responsibility away from the PCT and back to general practice — something some sectors of general practice have been lobbying for since fundholding was abolished. For pharmacy in all four countries, this shift in accountability and resources is of fundamental importance. If GPs are rewarded for achieving quality targets that pharmacist interventions can help to meet, who should pay pharmacists for their intervention? Clearly the NHS will not want to pay twice. This begs the question, who will be the commissioner of pharmacy services in the future? Currently the negotiating bodies in all four countries are embarking on discussions around new pharmacy contracts, which focus on improving quality of care. Ensuring that there is synergy between the GMS quality framework and these new pharmacy contracts will be essential if both are to be sustainable.

Mirroring developments in primary care, secondary care is also undergoing change. It is recognised that in the future, more care will be provided in the community and hospitals are looking at how they can work more effectively with PCTs and social care to prevent bed blocking and to provide specialist, community-based services — especially for those with chronic conditions. This is leading to the development of a variety of "intermediate care" solutions, including dedicated beds in nursing homes. The fact that local authorities will now be penalised if they cannot provide support resources for people to be discharged from hospital is adding impetus to such developments. It is also likely to lead to consultants and other s econdary care specialists providing more community-based services through outreach arrangements or supporting GPs with special interests to do the same.

COMMENTS ON THE FUTURE

The direction of travel in the NHS is for power and responsibility to devolve to local people. Patients will increasingly participate actively in the management of the NHS through new structures like patients' forums. This reaches its ultimate expression in the concept of foundation hospital trusts, which will, in effect, see hospitals owned by the local community. These foundation hospitals will not be under the direction of the Secretary of State, but will have external accountability arrangements with an independant regulator. In time, PCTs may well follow this same organisational model.

The NHS and local authorities will work even more closely together in the future. The first area where more joined up working is being seen is in primary care estate development. In some areas local improvement finance trusts (LIFTs) — an NHS-led public private partnership approach to the financing of new primary care premises — accelerate joint working through the use of standardised planning processes that demand a partnership approach. Local authorities are often key stakeholders in LIFT projects. Furthermore, many non-LIFT areas are recognising the benefits of joint working and are starting to follow a similar model. Under LIFTs, local authorities and PCTs are working together to develop shared premises and service integration is bound to follow. The first "care trusts" — PCTs that are fully integrated and take on the work of social care within a locality (for a list visit www.doh.gov.uk/localservices) — are pointing the way forward for integration of health and social care, and the development of childrens' trusts suggests that the integrated trust model will be applied to a range of client groups who would benefit from a vehicle that can deliver integrated services.

Increasingly there will be divergence in both health and pharmacy policy in the four home countries, with the possibility of different pharmacy contracts and regulations governing entry to pharmacy ownership in each one. Pharmacists will need to seek information to keep up to date with professional practice matters and NHS policy developments of relevance in their country specifically. This will be challenging. Owners with pharmacies close to the borders of two of the home countries or pharmacists who work across two countries will find it particularly so.

action: practice points

Reading is only one way to do CPD and the Society will expect to see various approaches to CPD in a pharmacist's portfolio.

1. Visit the Department of Health (www.doh.gov.uk), and NatPACT (www.natpact.nhs.uk) websites and familiarise yourself with their contents. Add them to your "favourites" and visit them regularly to see what is new (note: you can subscribe to new@natpact, an alert service at the website).
2. Ask for a copy of your PCT's local development plan and use it to identify areas where you can contribute.
3. When the new GMS contract is approved, get a copy of it and study the quality and outcomes framework. Contact your local GPs to discuss how you can work together to improve quality of care for patients.

evaluate

For your work to be presented as CPD, you need to evaluate your reading and any other activities. Answer the following questions:

What have you learnt?
How has it added value to your practice? (eg, have you applied this learning or had any feedback?)
What will you do now and how will this be achieved?

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