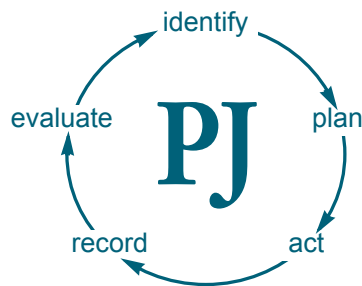


THE NEW NATIONAL HEALTH SERVICE

(2) UNDERSTANDING THE NHS IN SCOTLAND

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This article reviews some of the recent changes to the National Health Service in Scotland that affect pharmacy and gives an overview of future changes



identify gaps in your knowledge

1. Do you understand how the NHS is structured in Scotland?
2. What are the key planning documents that identify local priorities?
3. Do you know the basic principles of the proposed new pharmaceutical contract?

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").

Since July 1999, Scotland's health has been a matter for the Scottish Parliament. Much has changed over the four years since devolution, including the way the National Health Service functions in Scotland. Significant health-related events in the Scottish Parliament during its first term included the introduction of free personal care for the elderly and a new Mental Health Bill.

Pharmacy has benefited from the publication of "The right medicine: a strategy for pharmaceutical care in Scotland"¹ in February 2002 and the rejection of the Office of Fair Trading's recommendations on the control of entry regulations for community pharmacies.

HEALTH STRUCTURES

The duties of the Scottish Executive Health Department (SEHD) include the development of health policy and the administration of NHSScotland. The SEHD is responsible to Scottish health ministers for the performance of the service.

There are 15 NHS boards — 12 mainland and three island boards. The overall purpose of boards is to ensure the efficient, effective and accountable governance of the local NHS system and to provide strategic leadership and direction for the local system. Their functions cover the development and implementation of local health plans (LHPs), the allocation of resources and the performance management of the local NHS system. Currently, under the 15 boards, there are 28 NHS trusts. Acute trusts deliver hospital based services (including tertiary services such as specialist cancer services) and primary care trusts (PCTs) are responsible for the delivery of primary care services (including family, community and mental health services).

PCTs currently incorporate local health care co-operatives (LHCCs). LHCCs were originally set up in 1997 as voluntary groups of general practitioners working to support the delivery of care to their local communities. The key objectives of LHCCs are to provide services to patients within identified resources, to develop clinical priorities for their locality, to support the implementation of LHPs, and to support and develop multi-professional primary care teams based around GP practices so that care can be delivered to patients as close to home as possible.

LHCCs hold budgets for a range of services, including prescribing and cash limited general medical services (GMS). It is worth noting, however, that LHCCs in Scotland are not involved in the commissioning of care. There are currently 79 LHCCs in Scotland. They vary in terms of their level of development and degree of multidisciplinary and multi-agency input. Most have some form of input from pharmacy, be it in terms of prescribing advice or through a pharmacist sitting on the clinical or management board.

However, the existing structure is set to change. The recent White Paper "Partnership for care"² proposes a new management structure for NHSScotland. Acute and primary care trusts are to be abolished and will become operating divisions of NHS unified boards from April 2004. Operating divisions will take on the operational management role for the NHS board, but will have none of the statutory powers trusts currently have — the aim being to devolve much of the decision making to front line staff. Some boards (eg, Borders and Dumfries and Galloway) have already adopted this system and others are testing different organisational structures.

In addition, LHCCs are to evolve into community health partnerships (CHPs), with closer working and planning relationships with local authorities and a direct report to NHS unified boards. CHPs seek to build on the best examples from LHCCs. Their overall focus is on health improvement of local communities, providing services for local people and involving them in the planning and delivery of health care and health services.

The NHS Reform (Scotland) Bill 2003 was introduced to the Scottish Parliament in June 2003 and, if passed, will come into force in April 2004 giving the legislative framework to many of the organisational and management changes proposed in "Partnership for care".

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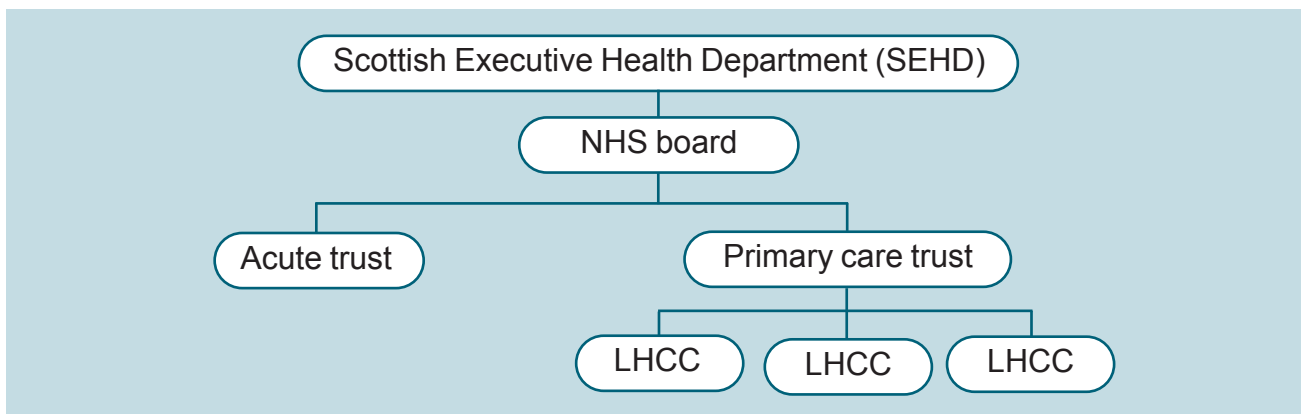


Figure 1: Existing structure of NHSScotland

Figures 1 and 2 show the structure of the existing NHSScotland and the proposed structure of NHSScotland from April 2004, respectively.

PLANNING AND POLICY

In relation to planning, the SEHD publishes national priorities and targets annually (each September), which Scottish health and social care organisations need to meet over the following year. As soon as the national targets are released, acute trusts and LHCCs are asked to put together their proposed input into the LHP. This is then collated into a draft LHP at NHS board level. A final LHP is agreed between NHS boards and the SEHD during January and February each year, ready for the NHS financial year starting that April. The LHP describes how local health and social care organisations will meet the SEHD national targets and is a key planning document.

Community planning is another important level of local planning. It is defined as any process through which a council comes together with other organisations to plan, provide for, or promote the wellbeing of the communities they serve. Such planning leads to the publication of a joint health improvement plan. The joint health improvement plan seeks to tackle health improvement in its broadest sense through partnership working.

Joint health improvement plans must reflect and include LHPs, and certainly should not contradict them. In order to enable integration, the timetable for their development is similar, and in many areas, unified boards and local councils will overlap planning processes through joint planning committees so closely that one meeting may address both plans.

INVOLVING PATIENTS AND THE PUBLIC

Public and patient involvement in NHSScotland is an ongoing theme, reinforced in "Partnership for care". Public involvement is to be sought in discussions around the changing pattern of health care and this means seeking the public's views at an early stage. This agenda will be carried forward through a new Scottish Health Council and through public partnership forums at LHCC (and in

the future CHP) level. Pharmacists have an important contribution to make in this area because they are often the first and last port of call for patients using NHS services.

PHARMACY IN NHSScotLAND

"The right medicine" remains the main planning document for pharmacy specific initiatives. It contains 60 actions in four main areas that will enable pharmacists to provide direct patient care more effectively. The four areas are:

- Redesign of hospital pharmacy services
- Health improvement
- Pharmacist involvement in chronic disease management
- Community pharmacist involvement in the treatment of minor illnesses

Progress during the first year has been steady. Notable successes include the continued investment in community pharmacy premises, the establishment of a Scottish adverse drug reaction reporting centre, the NHSScotland logo displayed in all community pharmacies and the roll out of NHSnet connections for all community pharmacies across Ayrshire and Arran.

Key priorities for "The right medicine" implementation team for the current year include:

- Supplementary prescribing (40 pharmacists are enrolled on the first supplementary prescribing course due to start at Robert Gordon University, in Aberdeen, in September 2003 and many of these are practising community pharmacists)
- The ongoing delivery and development of the pharmaceutical care model schemes (a stepped framework is being implemented and further work is under way to develop schemes for specific chronic conditions such as epilepsy and asthma)
- The further roll out of the direct supply of medicines initiative. This is an initiative started in Tayside and Ayrshire and Arran where community pharmacists are providing NHS treatments

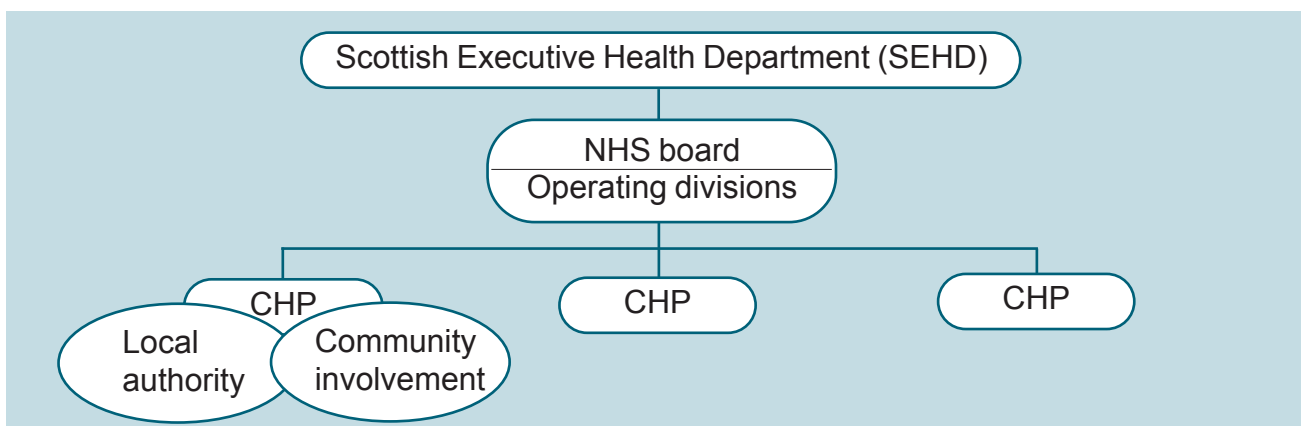


Figure 2: Proposed new structure for NHSScotland from April 2004

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. Contact your local primary care trust to find out how to get involved in the pharmaceutical care model schemes or get involved with your pharmacy locality group
2. Engage with the SPGC when the draft contract for pharmaceutical services is published to ensure that you have your say.
3. Get a copy of your NHS health board's LHP and identify areas where community pharmacy could have a role to play.

evaluate

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

for patients with minor illnesses. Work to develop a framework for extending this service across Scotland is in progress

- Continued work on the e-pharmacy programme, including e-prescribing and the use of robotics in hospital. One development is the electronic transmission of prescriptions, which is being rolled out across Irvine, Kilwinning and Dundonald LHCC
- The establishment and progression of pharmacy locality groups to provide a forum where pharmacy practitioners from all settings can work together to identify local priorities for service development and fully integrate into local health and community planning processes at LHCC (and CHP) level. Interim guidance on pharmacy locality groups is expected over the coming months

ENSURING PROGRESS

The performance assessment framework allows the SEHD to manage the performance of NHS boards through an annual accountability review. It is a self-assessment tool that gives an aggregate picture of an NHS board's performance. Progress on implementing "The right medicine" is one of the criteria in the performance assessment framework, which means that boards will be motivated to implement local action plans.

HOW FUNDS ARE ALLOCATED

Funding for Scotland is allocated in the Chancellor's budget. The allotment of funds to NHSScotland is then decided by the Scottish Parliament. The proportion of funds granted to health services is usually calculated on a historical basis plus a percentage growth. Once health funding is decided, it is up to the Scottish Finance Minister, with the approval of the Scottish Parliament, to "cut the cake" as he or she sees fit. First of all, funding is top-sliced for central services such as the SEHD, national projects, special NHS boards and other bodies such as the Common Services Agency (the body responsible for supporting front-line patient care by providing and co-ordinating essential national and regional services including the Scottish National Blood Transfusion Service and the practitioner services division, which co-ordinate the payment of prescriptions to community pharmacists on behalf of PCTs). The remaining money is then shared among the NHS boards, using the "Fair shares for all"³ formula, which takes into account variables like deprivation and rurality. Other funding streams flow into the NHS at local level, including funding for the local implementation of "The right medicine" or from projects where the NHS is not in the lead, but has an important part to play. Such initiatives might be led by local authorities, social inclusion partnerships (multi-agency partnership bodies

tasked with the co-ordination of activities to promote social inclusion, prevent social exclusion and develop innovative models of working), voluntary bodies and even private business.

The Scottish Executive's budget for pharmaceutical services covers the fees for community pharmacy contractors and appliance suppliers. The majority of the budget covers remuneration through a system of fees and allowances and is subject to a global sum negotiated with the Scottish Pharmaceutical General Council (SPGC), community pharmacy contractors' representative body. The global sum for 2003 to 2004 is £93.2m.

THE NEW PHARMACY CONTRACT

The SPGC is in the early stages of negotiating a new contract for pharmaceutical services. This will introduce a new system of remuneration for pharmacy contractors, which will encourage pharmacists to make better use of their wide range of professional skills in improving patient care. The new contract will help pharmacy contractors deliver "The right medicine" and will focus on the nature and quality of professional services (pharmaceutical care).

It is expected that the new contract will consist of two elements:

- Core services provided by all community pharmacy contractors, covering three main areas of chronic disease management (repeat dispensing, pharmaceutical care model schemes and medication review), health improvement and acute care (including pharmacist prescribing for minor ailments through the direct supply of medicines initiative)
- Supplementary services, which should be available to patients but not necessarily from every contractor (for instance, services to residential and nursing homes, domiciliary oxygen, drug misuse services and out-of-hours provision)

The SPGC plans to consult pharmacy contractors fully on the principles and implementation of the new contract.

COMMENTS ON THE FUTURE

In Scotland, there has never been a better time for pharmacists to engage with LHCCs as they evolve into CHPs. Although the principles of CHPs have been laid out in the "Partnership for care" document, the details are still subject to discussion, so pharmacy has the opportunity to contribute to the debate. The development of pharmacy locality groups provides the opportunity for all sectors of pharmacy to engage with CHPs.

As in England and Wales, one of the important influences on pharmacy practice in the coming year will be the new general medical services (GMS) contract. GPs voted to accept the contract and the expected changes will have knock on effects on the whole of primary care service delivery, including pharmacy (see *P7*, 26 July, p123).

Pharmacy in Scotland is changing rapidly. "The right medicine" sets out a shared vision for a modernised pharmacy service and much has been achieved to date. However, delivering this vision will depend on all pharmacists in Scotland understanding the agendas and working co-operatively among themselves, with other health and social care professionals and, most importantly, with patients and the public.

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1. The right medicine: a strategy for pharmaceutical care in Scotland. Scottish Executive 2002 Available at: www.scotland.gov.uk/publications (accessed 9 July 2003).
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FURTHER READING

1. The pocket guide to NHSScotland. The Scottish NHS Confederation. 2001 Available at: www.nhsconfed.webhoster.co.uk (accessed 9 July 2003).