

# How change will impact on pharmacists

Pharmacy faces many changes in the coming months and these were discussed at the AAH convention this week. **Clare Bellingham** reports

**A**dditional and supplementary enhanced services are the real wins of the new pharmacy contract. Essential services are not because most pharmacists are providing these already, Felicity Cox, chief executive of Watford and Three Rivers Primary Care Trust said. "I would like to see pharmacists moving quickly to [providing] additional and enhanced services. So, between now and October, my PCT will be focusing on how to get our community pharmacists in the best position to be able to do this."

However, two substantial issues need to be addressed before the new pharmacy contract is implemented: clinical governance and premises. "In terms of clinical governance, we want to work with pharmacies to ensure they have good patient safety systems, good risk management systems and standard operating procedures. We need to be sure that pharmacists have access to and are updating their clinical skills." She suggested that some of the training will be funded and that, for this training, the PCT will determine what clinical area the training should be in, according to local need.

There are also issues around confidentiality and Caldicott. "A lot of this is to do with having private areas. But if pharmacists have consulting rooms then they change their accessibility and one of the advantages of community pharmacists is that they are accessible without an appointment," she commented.

Improving premises is an issue that will have to be solved, Ms Cox said. "There is a huge amount of business planning to do. We know that 80 per cent of pharmacists' income comes from the NHS, but where does the profit come from? If shelves of shampoo are pulled out to put a consultation area in, how will this affect profits? We need to do some work on this to help understand how to invest in premises to get to the next level of service delivery."

How the locum workforce fits the new picture will also have to be discussed. "If a pharmacist is going away for two weeks can [the pharmacy] just stop providing a service? I suggest not. Maybe this means there is a new role for locum pharmacists or, perhaps, for the introduction of travelling locums who provide the services in different places."



**Felicity Cox: pharmacists must be proactive**

Community pharmacists need to get engaged with PCTs, Ms Cox stressed. "I would say to pharmacists, between now and October [when it is hoped the new pharmacy contract will start to be implemented], don't wait, arrange to meet your PCT and get engaged." She added that prescribing advisers are not the best point of contact, because their role was not to consider the wider primary care agenda. Instead, tell the primary care development team or the chairman of the professional executive committee about what you can do, she advised.

"As a PCT chief executive, one of the things that makes my heart sink is when somebody says to me 'if you tell me what you want I will do it'. That is not good enough," she said. "I want

community pharmacists to tell me what skills they have and what they are interested in. Pharmacists can become PCT players by being proactive: if you spot a local clinical need, tell the PCT what you can do about it," she advised.

Ms Cox was asked how to approach PCTs that did not appear to be interested in engaging with community pharmacists. "All PCTs are subject to delivering the same standards and targets, if you focus on these and the PCT does not listen then they are foolish."

Another question highlighted the fact that PCTs say that all the prescribing budget has been spent on over-prescribing by GPs so there is no money for pharmacists to undertake special projects. David Colin-Thomé, national clinical director for primary care, Department of Health, said: "There is no such thing as a prescribing budget." PCTs do have an overall budget, but they choose to say that a certain amount is for prescribing, he explained.

Ms Cox also discussed other Department of Health initiatives that are having an impact on pharmacy. "We have recently been running an expert patient programme and the spin-offs from this have been fascinating, such as patients being better able to cope with other illness.

But one of the problems we have is who will run expert patient programmes in the future," she said. "Maybe there is a role for pharmacists.

Patients trust pharmacists and relate to them in ways that they do not relate to their GP. It is a different relationship, and one that is a great strength for pharmacists."

She added: "It is interesting that one of the key things that inspectors from the Commission for Healthcare Audit and Inspection have been looking at recently is how the PCT engages with the new professions it now has a responsibility for and, particularly, how the PCT engages with community pharmacy," she said. "This means that community pharmacy has been noticed, which is, perhaps, half the battle."

## New pharmacy contract must let pharmacists develop over time

The new pharmacy contract should allow pharmacists to develop over time, said Steven Williams, chairman of the Pharmaceutical Services Negotiating Committee's contract planning committee. A Government aim of the new pharmacy contract is to reward quality not volume. "We disagree with this statement. The new contract should reward quality and volume," he said.

"The contract needs to recognise the need for considerable investment in IT. We will not be able to deliver the new contract without significant progress in IT, not just for the electronic transfer of prescriptions but pharmacists also need greater access to the integrated patient record. We need the Government to commit to that and to fund it, not just fund the kit but the ongoing costs around it," he stated.

It will be important to ensure that essential and advanced services provide the funding for community pharmacy, Mr Williams said. "We cannot allow the key funding of pharmacy to be reliant on local services provision. The core, basic funding that provides pharmacists' existence must come from centrally funded services," he explained.

Another principle that the PSNC has adopted in relation to funding is that there should be no cross-subsidy between service levels. In other words, each service should be funded in its own right. Funding must be evidence-based and, to help with this, a joint cost inquiry has been carried out and agreed. "We now have an agreement between us and the Department of Health as to what the costs of running the current service are," he

The AAH Convention took place in Monaco from 17 to 22 April. Clare Bellingham attended the convention courtesy of AAH Pharmaceuticals Ltd

said. "Funding must deliver a fair return for contractors' investment otherwise people won't invest in pharmacy," he added. In order to do this, the PSNC had commissioned a financial institution to develop a fair return model, he explained. "That has now been handed to the DoH and we are negotiating on that basis."

Most of the basic structure of the new contract has already been described [see PJ, 19 July 2003, p77]. One of the new ideas being explored in the contract negotiations is for pharmacists to develop their own public health plan, in conjunction with PCTs, so that they can choose and plan which public health services to deliver, Mr Williams explained. Another proposal that seems certain to be introduced is for pharmacists to be re-

quired to report all adverse incidents to the National Patient Safety Agency.

The PSNC still believes that a minor ailment service should be form one of the essential services within the new pharmacy contract. "But the Department of Health is refusing point blank to do this," Mr Williams commented.

He asked the Government to adopt a system of pharmaceutical needs assessment whereby PCTs assessed patients' pharmaceutical needs. "By doing that, existing and new contractors will be able to provide the services that patients want."

Once the details of the new contract have been decided, a ballot of contractors will be held. "We hope this will take place in the early summer," he said.

## How the Department of Health is modernising the health service

The Department of Health is following four principles that the Government has set out to modernise the public sector, David Colin-Thomé, national clinical director for primary care, Department of Health, explained. They are the introduction of a national framework of standards, devolution of power to a local level, improved rewards and conditions of employment, and increased choice.

Increasing patient choice is a concept that the medical world is struggling with, he explained. "One of the concerns is that patients will have unrealistic expectations but the [Building on the best] choice consultation made it clear that they do have a sense of perspective. What they want is more input into their care." So in future everybody will have their own web-based "health space" where they can state how they want to be treated. He explained that the real challenge the health service faces now is moving from a "static model" in which the service is free but patients are told what they need, to a new model in which patients have more choice, more access to medicines and an easier path to services.

Dr Colin-Thomé said that an experiment using digital television to improve access to health information that had been carried out in Birmingham will be expanded this year. "Some patients were able to consult nurses from their own living rooms," he said.

In another development, community pharmacists could become practitioners with special interests. "Once the community pharmacist contract is in place, we are looking at having community pharmacists with specific clinical interests to serve the needs of the community beyond that which their pharmacy serves so that the pharmacist becomes a resource for the PCT," Dr Colin-Thomé said.

"Chronic disease will be the biggest challenge facing the world in the next 10 to 20 years," he said. For instance the number of

people with diabetes is likely to double [see Panel]. "I regard community pharmacists as having a key role in supporting the self-management of chronic disease."

According to the World Health Organization, the health service has been based on responding to acute illness rather than identifying it in advance, he said, so use of American models, such as Kaiser Permanente, is now being investigated. Patients with complex cases who were most likely to be readmitted to hospital had to be identified and helped. A trial of a service doing this had saved one GP practice £1m in hospital costs over a four-year period.

Better chronic disease management also fits into the public health agenda to reduce health inequalities. "Basically the poor get it worst: if you look at incidence of chronic disease it is greater in the poor, but severity and onset of disease is also worse."

Dr Colin-Thomé concluded that the direction that the Government was taking in its approach to the health service meant that there were many opportunities in primary care. "The potential for community pharmacists to have a pivotal role has never been as high as it is now," he said.

### Roles in diabetes

The number of people who develop diabetes in the next 10 years looks likely to double and there are many opportunities for pharmacists to play in diabetes management, Jane Grant, advanced practitioner in diabetes, University Hospitals of Leicester, told the convention. Potential roles included educating patients about diabetes management, offering medicines management services, providing information about blood glucose testing and helping to prevent diabetes by helping patients reduce risk factors.

## Getting the pharmacy strategy to work

"The only way to get the pharmacy strategy to work is to involve all the key players," Margaret Dolan, chief pharmacist of West Lothian Healthcare NHS Trust, said. As chief pharmacist of an integrated trust, Ms Dolan is involved in pharmacy in both primary and secondary care. She pointed out that it was the only integrated trust in the UK, and it had been formed from Lothian Primary Care NHS Trust and Lothian University Hospitals NHS Trust. In the most recent NHS restructuring in Scotland, the trust became Lothian Health, a corporate body, on 1 April.

"People say that Scotland has got it right. The important point is that Scotland is small enough for us to work collaboratively and to communicate with others much more easily than in a larger country," she said.

Over the next few years, pilots will be used to agree the quality standards frameworks for services that pharmacists in Scotland will be providing in the future, she explained. Many of the services are already being piloted, for example the pharmaceutical care model schemes. But Ms Dolan commented: "The key to the success of rolling out these schemes is having a national team of community pharmacists who support other pharmacists in changing their practice: we need this type of support mechanism."

However, there are some issues that need to be addressed. Access is one. "Please do not decide to close on Saturdays," Ms Dolan urged community pharmacists. "It does not give a good impression to the public. Instead, decide to spend Saturdays doing what you want to do, such as taking time to see patients and offer pharmaceutical care." In terms of out-of-hours services, she suggested that people need to look beyond the current boundaries at options such as automation. "Premises are a huge issue: don't underestimate the problems there are with premises. Many community pharmacies have nowhere they can physically expand to, despite wanting to provide a consultation area. This is something we should be making a lot of noise about," she said.

Workforce and IT were other concerns. Scotland faced a pharmacist manpower shortage, she said, commenting that the closure of the Heriot-Watt school of pharmacy in Edinburgh in 1988 had contributed to the problem. "We are facing the problems caused by that decision now." In terms of IT, Ms Dolan said that pharmacy will not survive unless there is a huge investment in IT. She suggested a smart card is needed that identifies the patient, which health professionals they have consulted recently and the outcomes of these consultations.

Ms Dolan concluded: "The future of pharmacy is about looking at the demographics of the local population and identifying what patients require, not what the pharmacist wants."