

Decide what you want from new contract

Members of Numark plc gathered to hear about some of the opportunities and challenges that community pharmacists face once the new contract is in place. **Olivia Timbs** reports

A different approach to the new community pharmacy contract was presented by Musa Dhalla, director of Webstar Health, when he spoke about the changes it offers and the impact it will have on pharmacists. He said that pharmacists faced a number of options and that they need to ask themselves what they wanted to do — or to be — in the future.

The new contract, with its multi-tiers, will no longer be volume driven but outcome driven. Despite this change in emphasis, dispensing would remain the gateway to the future — it would simply be costed under a different formula, Mr Dhalla explained.

To be able to provide advanced services — incidentally the first clinical service for which pharmacists are to be paid under a national contract — means that the pharmacist must be able to sit down with the patient, not be overheard and remain undisturbed. This middle tier of the new contract — involving face-to-face review of a patient's prescription — will only be possible when these elements have been accredited. Moreover, the premises and pharmacist will have to be further accredited before the pharmacist is in a position to provide the top tier of services in the contract — enhanced services. Mr Dhalla

pointed out that questions remain over who will actually do the accreditation but it seems likely that it will fall to the primary care trust to do the initial accreditation and then monitor it on an ongoing basis.

Pharmacists have to be aware that gross profits will flow in a different way under the new contract and that the income from dispensing will be lower but clinical services will be remunerated. What is important, suggested Mr Dhalla, is to focus on the sort of service you provide: "Is it largely a dispensing service or do you see yourself as a pharmacy with a public health focus or a chronic disease focus?"

Mr Dhalla warned that pharmacists should be aware that the traditional idea — if you double your dispensing activity you will double your income — will not hold. "The effort you put into chasing purchasing margin will be dissipated," he said. Nevertheless, pharmacists who do process a lot of prescriptions should think how to maximise their profits through automation and the use of support staff.

Pharmacists should consider why patients come to their premises. "Is it the location, the service you provide, the relationship with local GPs, your facilities or your particular mix of

prescriptions?" If, for example, the pharmacy is situated in a high street it may process many prescriptions but they take up a small part of the business (say about 50 per cent) and the pharmacy has no particular relationship with GPs it will tend to depend on passing trade. "This would give you the basis for giving your pharmacy a public health focus," Mr Dhalla suggested.

If, on the other hand, prescriptions tend to come from one or two GP practices, and the pharmacy is situated close to a health centre, and there are strong relationships with the GPs the pharmacist could build on those relationships and develop chronic disease management services, he thought.

Mr Dhalla emphasised that these were only examples, and that most pharmacies were a mixture of dispensing, public health and chronic disease management services, but pharmacists should analyse where they are currently. Because of the change in service provision and the fact that profits will flow in different ways pharmacists need to re-evaluate the infrastructure of their business, their skills and those of their staff and their buildings. Pharmacists need to start planning and give some thoughts to the focus they want to have.



David Wood, chief executive of Numark plc, opened the autumn conference by saying that pharmacists have just one opportunity with the new contract to change the way that they provide services: "And if you do not grasp those opportunities, others will step in," he emphasised. This set the tone for the conference that looked in more detail at some of the opportunities ahead, as well as the challenges and difficulties the profession is about to face.

Numark plc's autumn conference took place on 18 and 19 September at Center Parcs, Longleat, Wiltshire

POM to P switches to focus on long-term conditions in future

One of the first major POM to P switches took place about 20 years ago, according to John Blenkinsopp, independent consultant to the pharmaceutical industry, when ibuprofen became available without a prescription.

Since then, there has been a steady trickle of other products, nearly all for specific indications. And since the legal procedure for making switches was made more streamline two years ago many more switches will be in the offing.

Dr Blenkinsopp explained that switches will need to be accompanied by much improved patient information and next year there will be "user testing" to make sure customers understand what the products are and how they are to be used. Britain, he said, is leading Europe in the idea that "health care starts with self-care" and that with the UK taking over the EU presidency next year this is something that is likely to be high on the political agenda.

Dr Blenkinsopp also pointed out that the emphasis on POM to P switches would change from those for acute conditions to

chronic conditions (following the recent lead of simvastatin). Between now and the end of the year the Medicines and Healthcare products Regulatory Agency will start consulting on five new switches. It is expected that 10 per year would follow.

He also expressed the opinion that with these additional medicines more easily available pharmacists could become much more involved in patient care. He cited the example of heartburn, for which GPs gain no points for treating under their new contract. "GPs do not want to see patients with heartburn" so there is an opportunity for pharmacists.

But he emphasised that this would lead to changes in working practices for pharmacists. Among the most important challenges, he suggested, is the provision of consultation areas that are "signposted, seated and secret" and the burden of keeping records. However, by developing relationships with primary care trusts and GPs there is a great opportunity for pharmacists to take over the management of various chronic conditions and share their care with local GPs.

Opportunities for pharmacists in the provision of chronic disease management in primary care

As yet there are few examples of community pharmacists providing chronic disease management services in a community setting — they mainly take place in GP settings, said Alison Blenkinsopp, from the department of medicines management, Keele University. However, she suggested in her talk, that the Government has plans that would change that and give pharmacists more opportunities to become integrated members of the primary care team.

Professor Blenkinsopp started by defining what is a good way of describing chronic disease management (CDM) and she said that in the US the phrase “anticipatory care” is often used. “In other words, minimising and preventing future problems,” she explained.

At its best CDM improves patient outcomes, reduces health inequalities and lessens hospital use.

Professor Blenkinsopp described the pyramid of care that has been developed to illustrate the needs of people who are chronically ill and require health care. Most patients are at the base of the pyramid. They are able to function with basic care or “usual care with support”. Patients in the middle tier require “assisted care”. These are patients at high risk of developing problems if they are not treated properly, explained Professor Blenkinsopp. At

the top of the pyramid is the group who need “intensive case management”. In other words, these are the complex cases (such as patients with chronic obstructive pulmonary disease and heart failure) that require a great deal of medical input and absorb most resources.

Furthermore, research indicates, she said, that between 25 and 30 per cent of patients with chronic illnesses want to be more involved in their care and can be taught how to change their dosages and how to respond to different clinical signs (the expert patient).

Health resources, therefore, can be better targeted to slow down the progression of disease and provide most support for the really ill.

Professor Blenkinsopp spoke about the two pilots schemes that are running in the UK based on US managed care models: Kaiser Permanente and Evercare (*PJ*, 15 May, p601). Currently 2 per cent of high risk patients drive 30 per cent of hospital admissions. The concept of Evercare is that by the employment of case managers, patients can be kept out of hospital, their use of medicines is reduced and there is greater satisfaction for families.

She also described the scheme for strategic health authorities to ensure that “community matrons” are employed all across England by April 2005 and the further Government plan for 3,000 advanced primary care nurses (30

per primary care trust area) be in post by 2008 caring for 250,000 patients.

Professor Blenkinsopp spoke about the focus of the new general medical services contract on chronic conditions and how much of the Government thinking is along the lines of self-care of longer-term conditions. Illness needs to be caught early and prevented from deteriorating. The move to increase the number of POM to P switches is all part of this Government strategy.

Within this thinking there should be many opportunities for pharmacists. They could provide practice-based clinics with or without supplementary prescribing skills, they can provide medication review on a simple monitoring and support basis (the base of the chronic disease pyramid) or provide surveillance and risk reduction for the use of high-risk medicines. They can also offer support for self-management.

Professor Blenkinsopp recognised there are barriers to overcome to achieve this. Pharmacists need access to patient records and providing CDM demands a high standard of record-keeping. Ultimately, across the whole primary care team, the question will need to be asked, who provides what care and where? And whoever provides care should give patients the same message.

Make sure that local GPs are on side

Richard King, director of Pharmacy Consulting Ltd, gave his experiences of implementing medicines management projects. He spoke in general about how medicines management schemes could fit in with the new contract. He also described the benefits of involving the pharmaceutical industry in establishing medicines management programmes in providing training, for example, and other resources.

It is important when offering a service to make sure local GPs are on side, so that when pharmacists make recommendations for product or dosage changes, for example, they accept the benefits. It is also important to ensure that patients are not alarmed by the process, that they accept that the exchanges with the pharmacist will be confidential.

One of the unintended consequences of medicines management is that once patients have gained trust in the system, pharmacists often find they want to stay chatting for a long time. It will be a challenge for pharmacists to learn how to end consultations firmly but politely and make sure patients leave.

Who will accredit pharmacists and their premises for providing advanced services?

Will it be possible for a pharmacist to continue a service that would be classified as enhanced before they are even accredited for providing advanced services, and who will be doing the accrediting of the pharmacist and his or her premises for providing advanced services? These were some of the challenging questions asked at the conference. Some of these questions remain to be resolved, but Musa Dhalla believed that the accrediting will be undertaken by primary care trusts — whether they want to or not. This is despite the fact that advanced services are to be funded nationally through the global sum and PCTs would not benefit from the provision of advanced services per se, he said. The speakers were in agreement that PCTs would have to do the initial accreditation and then monitor the situation annually. However, when it comes to enhanced services, the PCT would have to be more involved. If a PCT wants a particular service and commissions it from a pharmacist, the PCTs will have the responsibility to provide training if any were necessary.

Garry Myers, a Numark member and a member of the Pharmaceutical Services



Musa Dhalla: accreditation likely to be undertaken by primary care trusts

Negotiating Committee, advised delegates to become involved with their local pharmaceutical committee. “LPCs should be in dialogue with the PCT on implementation of the contract. Moreover, LPCs, as statutory bodies, represent all pharmacists, not just the multiples, and this is the way for the individual pharmacist to become involved.”