

How the new tiered contract for community pharmacy is being built

A new tiered contract for community pharmacy has been proposed by the PSNC. Clare Bellingham finds out more about the proposals

IF all goes to plan, pharmacy's new contract is less than a year away. The target implementation date is April 2004. First, however, before the contract is finalised, the Pharmaceutical Services Negotiating Committee has to strike a good deal for pharmacy with the Department of Health and the NHS Confederation (which represents the interests of primary care organisations).

So what has the PSNC come up with? It proposes a tiered structure of essential, enhanced and additional services (see Panel below).

Initially, all contractors will just offer essential services. Enhanced services will be gradually introduced with the eventual aim that all contractors will offer these services and they will become part of the essential package. Additional services fit on top and contractors will be able to negotiate which of these they offer.

The reason for separating enhanced services from the essential services to begin with is that training, accreditation or new facilities might be needed before they can be offered. A gradual introduction of enhanced services means that pharmacists will be able to undertake training and develop their premises over time.

On top of the basic package of essential services, pharmacists will have the option to offer additional services. Such services will be commissioned by primary care organisations, according to local needs. However, the specification for these services, including their prices, will be agreed nationally. This offers pharmacists and PCOs the potential to develop new and innovative services.

The PSNC views the contract as something that will develop over time. Some ser-

vices that currently fall into its enhanced section might, in the future, become essential services. And, as more additional services are developed, national specifications for these could be negotiated. The committee hopes that this will allow the contract to change according to the needs of patients, the National Health Service and the profession.

WHAT FITS WHERE

Perhaps not surprisingly, dispensing is an essential service. The PSNC has stressed that dispensing is central to the new contract. It says that the dispensing service will include giving advice to patients about the medicine dispensed and interactions with other medicines; making a record of the medicine dispensed and, possibly, any advice given; and providing compliance aids needed by disabled patients.

Repeat dispensing is also an essential service, and marks a development from pharmacists' current role. The PSNC defines this role as "the management of the repeat dispensing process in partnership with the patient and prescriber". It is envisaged this will involve ascertaining that the patient needs a repeat supply of medicine. The pharmacist should then be able to alter the quantity of medicines to allow synchronisation and also to make substitutions when the patient is prescribed, eg, two low-dose tablets where one higher-dose tablet provides the same dose. Pharmacists would then be expected to communicate all significant issues to the prescriber, including, if appropriate, any suggestions of changes to medication. Finally, the pharmacist should give advice about when a medication review is due and educate patients about ordering repeat medicines to prevent wastage.

Another essential service is a role in public health. This will involve many aspects of promoting a healthy lifestyle, for example, advice on smoking cessation, appropriate use of antibiotics, promoting influenza vaccination uptake and suggesting patients undertake appropriate disease monitoring.

Waste disposal, of both medicines and sharps, is seen as an

essential service, as is referring patients to other health care professionals, where appropriate. Clinical governance — including using standard operating procedures, undertaking continuing professional development and reporting adverse incidents to the National Patient Safety Agency — is also classed an essential service.

The PSNC suggests one service in the enhanced category. It is "medicines use review". The aim of such a review is to assess any problems patients have with their medicine and to develop patients' knowledge about their regimens. Such reviews will fulfil national targets on reviews such as those in the National Service Framework for Older People.

Where management of minor ailments fits in is unclear. It could be either an essential or an additional service. It would involve some patients being able to get advice and treatment for minor ailments from the pharmacist but paid for by the NHS. This transfer of care would relieve some pressure on general practitioners, something that is specified in the GP contract.

Many examples of additional services exist. They will have to be agreed with PCOs and will be dependent on local need. A substance misuse service might be perfect for one town but unnecessary in another. Likewise, sufficient need might exist for only one pharmacy in a town to offer an anticoagulant service while another could have a role in home care services. This tailoring will be negotiated at a local level allowing scope for pharmacists to develop services in the way they choose. Some PCTs might be more limited in the services they will fund, perhaps dictated by particular local health issues.

WHAT NEXT?

Negotiating the financial side of the contract is further down the line.

What is in the contract needs to be agreed first. This decision will follow a period of consultation, and roadshows are currently taking place. The PSNC has stressed more than once that this is a "genuine consultation" and the contract described above is a proposal. Contractors' voices will be listened to and alterations made as appropriate.

A ballot will be held later this year to determine if the basic structure is right. It is not until this point that talks over the fine details will be reached.

This is where the financial negotiations will start. However, a basic formula for funding has been proposed (see Panel above)

Structure of the new contract

The structure of pharmacy's new contract proposed by the PSNC consists of different levels of services:

- **Essential services** These are dispensing, repeat dispensing, referring patients to other health care professionals, clinical governance, public health roles, medicines waste disposal and sharps disposal.
- **Enhanced services** Review of medicine use fits into this category.
- **Additional services** Examples of these include substance misuse services, anticoagulant services, emergency hormonal contraception service, palliative care services, diabetes screening and full clinical medication review.

One sticking point is management of minor ailments, which could be either an essential or an additional service.

right).

In addition, an inquiry into the cost of service is currently under way. A survey of 470 contractors was carried out at the end of June to determine costs of staff, property and other overheads. The PSNC will use this information in negotiations over funding the new contract.

Proposing this new contract is not the end of the battle: the PSNC still faces months of hard work. There are negotiations with the Department of Health and NHS Confederation, and a fair number of dilemmas to solve (see below). But let us hope that this new tiered contract is a step towards recognising the professional roles that pharmacists can offer.

● *The Journal* is planning a news feature about pharmacists' views on the new pharmacy contract. Pharmacists with comments should contact Clare Bellingham by e-mail at clare.bellingham@pharmj.org.uk by 8 August, giving their views and, if possible, a daytime contact telephone number.

Funding the new contract

The basic formula proposed for funding the new contract is:

<div style="background-color: #4a69bd; color: white; padding: 5px; margin-bottom: 5px;">Cost of service</div> <div style="text-align: center;">+</div> <div style="background-color: #4a69bd; color: white; padding: 5px; margin-bottom: 5px;">Fair return</div>	=	<div style="background-color: #4a69bd; color: white; padding: 5px; margin-bottom: 5px;">Remuneration</div> <div style="text-align: center;">+</div> <div style="background-color: #4a69bd; color: white; padding: 5px; margin-bottom: 5px;">Profit on purchasing</div>
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Implementing the new contract: dilemmas facing the PSNC

A number of sticking points face the PSNC before the new contract can be implemented. Jonathan Buisson asked Sue Sharpe, chief executive of the PSNC, to explain how the committee hopes to overcome these obstacles

THE two biggest sticking points for the new pharmacy contract will be agreeing a framework of new services and then agreeing the funding for it. The framework of services will have to be supported by the community pharmacists who will provide them, the primary care organisations (PCOs) that will commission them and the Department of Health, which will ultimately pay.

The biggest disagreements are likely to revolve around the issue of which services should be deemed essential, and provided by all contractors, and which enhanced or additional, provided by a chosen few.

The most obvious example of this is the provision of treatments for minor ailments on the National Health Service to people exempt from prescription charges. Citing successful pilots in England and Scotland, the PSNC wants this to be "essential". The Department of Health is understood to have concerns about the costs and would prefer it to be "enhanced or additional". However, the role of pharmacists in reducing the workload of general practitioners through treating minor ailments was highlighted in the new GP contract. Sue Sharpe sees an opportunity through the pharmacy contract for PCOs to meet some of their targets for access to health care professionals and reducing GP workload.



Sue Sharpe: We need to protect those providing quality services

Once the framework is agreed, the question arises whether all pharmacies will provide more than just essential services. This may involve accreditation of staff and premises, refurbishment or fitting of consultation areas and improved communication links with GP surgeries. All of this will cost money and the issue of who will pay for it will be a thorny one. In the new GP contract, PCOs are expected to pick up many of these costs.

In terms of funding, discussions are still at an early stage and the PSNC is at pains to say that no costs or funds have yet been agreed. Some general principles have been agreed. "We are concerned to avoid 'funding at average'," Sue Sharpe says. "The small but efficient independent community pharmacy is our benchmark. The new contract will have to support services at this level." The aim of a fair return for pharmacists' work is also crucial. "Once we have worked out the costs of existing services and added new services, there has to be an element of 'money required to keep pharmacy healthy'" Mrs Sharpe notes. Bluntly, this is the profit made by pharmacies which allows them to borrow money from banks and for the businesses to be sold as going concerns. "If there is no profit, then there is no incentive for any pharmacist to go into business. We need to protect those phar-

macies that are providing good quality services." The PSNC has engaged its own experts to look into what might be considered "a fair reward" in other businesses and, thus, in pharmacy.

On the other side of the remuneration equation is the issue of the profits made by pharmacists when purchasing drugs for dispensing on the NHS. In the past, this was an area both sides were reluctant to talk about. The issue is also closely linked to reimbursement for generic medicines, something the Government has been looking at for the past two years. The cost-of-service and income inquiries currently under way are aimed at giving the Department of Health a better understanding of this area. The PSNC wants to keep the two issues linked. It has proposed a profit-sharing model which would give pharmacies a separate income stream while encouraging competitive pricing and thus producing savings for the NHS.

Hanging over all of this is the Government's response to the Office of Fair Trading report on control of entry. Sue Sharpe says that if there was total deregulation and a flurry of new supermarket pharmacy openings, the PSNC might come under pressure from some contractors to negotiate a simpler, supply-based contract, similar to the current one. "This would be a contract for those who are not going to be providing services to a loyal customer base. It would be quite a change and we would have to go back to the drawing board."

The Government's response, due this week, had not been published at the time *The Journal* spoke to Mrs Sharpe.