

# Why the skill mix document presents a pharmaceutical paradox

By Stephen Axon

**A**nalysis of the responses to "Pharmacy workforce in the new NHS" reveals an interesting paradox. The Royal Pharmaceutical Society, representing public interest and the professional aspirations of all pharmacists, is content that patients' interests can be served by reducing pharmaceutical supervision of dispensing whereas the contractor bodies, so often accused of being over-focused on financial issues, advocate maintaining higher professional input into routine medicine supply. It was the *Pf* (5 October, p468) that raised the financial aspect, so absent from the paper itself: "The Government must finance the change in practice properly. It would be unacceptable for it to top-slice the global sum . . . and hand over the balance to primary care trusts for them to hand out to those pharmacists who wish to offer different pharmaceutical services."

If less skilled staff supervise dispensing it is difficult to argue for payment at pharmacists' rates and it makes good sense to deploy the higher-level skills elsewhere.

Few would question that changes in pharmacy practice should be properly financed but the temptation to tinker with the current remuneration system must be avoided. However, without financial modelling involving those currently providing the service the document asks community pharmacy to accept an open-ended commitment to an unpriced service opened up to greater inter- and intra-professional competition. With the Government's track record on remuneration, is this going too far? It is certainly in stark contrast to the way the GPs are approaching their new contract, where the responsibility for negotiating both the service and the payment system lies with the General Practitioners Committee.

If, as suggested, new services are to be commissioned by PCTs rather than as part of the national contract, top-slicing the global sum to redistribute to other pharmacists will not be the issue. Pharmacy will face external competition to finance the services from medicine and nursing while PCTs will decide internally whether to use community pharmacists or to employ staff who may be, but need not necessarily be, pharmacists to provide them.

Furthermore, the Department of Health has yet to give an indication that it places real financial value on the new services. We see small local payments for public health involvement usually linked to accreditation. We see a small sum per patient offered for repeat dispensing. We see what were promising local initiatives not progressing beyond pilot stage for lack of money. And we see no suggestion of the level of reward for highly skilled services or of medicine management skills as core services. We may draw our own conclusions from the Pharmaceutical Services Negotiating Committee's database

([www.psnco.org.uk](http://www.psnco.org.uk)) as to the DoH's general commitment to extending the community pharmacy role.

There is also recent evidence of considerable overlap in the new roles:

- Doubt has recently been expressed about the pharmaceutical care approach to asthma unless the role is increased to embrace initial prescribing
- At this year's British Pharmaceutical Conference, Dr Jim Smith suggested that pharmacist prescribing is not a new role but simply a formalisation of an existing service in diabetes and hypertension clinics. He then went on to say that pharmacist prescribing would only take place where there is local need when it would depend upon the initiation by the independent prescriber
- Dr June Crown, although more positive in her approach to independent prescribing, likened it to current OTC sales and recommendations, which is certainly not a new role

It seems that increased technician responsibility so clearly spelt out in the document is not applied further up the primary care chain by allowing pharmacists to put their knowledge of medicines to best use as independent prescribers. Have we already forgotten the meetings in the late 1990s between the leaders of the profession and the previous Secretary of State and the list of medicines and conditions drawn up by Society as a result of those meetings?

**E**ven before the Nuffield report recommendations, pharmacists argued about the competence of technicians to dispense without supervision. More recently we have been asking whether, or for how long, and under what circumstances, a pharmacist might be permitted to be absent from the pharmacy to carry out other professional work. In the light of the paper perhaps we should rather be looking at whether increased central control by the Society by registration of technicians and other support staff will reduce the "serious medication errors" referred to in the paper or whether the reliance currently upon the professional competence of a supervising pharmacist is still more conducive to patient safety.

The important issue from the patient safety standpoint is the confidence the public has in the service, best illustrated by six million visits to pharmacies each day. Highlighting the patient's entitlement to know that

support staff in pharmacies are well trained and competent seems to undermine this. Indeed, the lack of public interest in qualifications stretches to the pharmacist as illustrated by the need felt so often to refer to "the graduate in the high street". In the final analysis patient confidence and safety comes back to a single point of reference — the ready availability of advice from the pharmacist wherever pharmaceutical activity is taking place.

Will the slogan "Ask your pharmacist, you'll be taking good advice" soon become obsolete?

As the Society links registration with competence, the assertion that "the modern pharmacist's professional role is not to undertake detailed supervision of the dispensing and sale of medicines" followed closely by confirmation that pharmacists remain professionally and legally accountable for the performance of their staff appears inconsistent. Vicarious liability notwithstanding, whether it is a case of pharmacists extending their role into independent prescribing or technician dispensing without supervision, the empowerment to carry out professional duties should carry with it professional responsibility.

The statement in the report that the model where pharmacy technicians provide medicines without supervision "should not necessarily be the norm" is an interesting one. If unqualified support staff may no longer be employed in dispensing it must follow that if no formally qualified member of support staff is employed in the pharmacy the dispensing must be carried out in its totality by the pharmacist. The corollary of this is that, in practice, wherever "checking" technicians are employed, pharmacist involvement in dispensing will be minimal.

The DoH and the Society have looked at delivery of the professional service without taking sufficient account of the fact that the current service is provided by independent contractors who invest in employment of staff (however mixed) and in the purchase of medicines. It is, therefore, comforting to read in paragraph 62 that the paper is not settled Government policy and to have Dr Jim Smith's assurance that a formal consultation paper will follow once the views of the pharmacy organisations have been considered.

The "new contract" for pharmacy contractors is not due before 2004 but, with the Society's implementation date of January 2005 for all dispensing staff to be appropriately trained, time is getting short. The danger, therefore, remains that the Society, eager to expand its regulatory empire and central control of dispensing may agree to a professional model as a "done deal" leaving the other pharmacy organisations without any bargaining counters with which to negotiate a fair reward for contractors and, ultimately, pharmacists and their support staff.

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