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Rising to the challenges of the future

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What do patients want from pharmacy now? Do they just want an efficient medicines supply service or do they also want accessible clinical advice about their medicines and their treatment. The answer must be both.

The NHS is in the middle of developing a complex range of financial, technical and professional changes to health care systems that will alter — beyond recognition — the manner in which the pharmacy profession practises. These drivers for change appear to be refocusing the key elements of our profession and moving them slowly from a traditional "medicines/product" base to a newer "service/medicines management"-based role. The change from a focus on product to one that focuses on service has critical implications for all those involved.

This fundamental repositioning of our role cannot be ignored, especially if we are to manage the process effectively. Important strategic and operational processes such as performance management and standards, education and training, pharmacy practice and reimbursement need to be carefully considered in the context of this evolutionary transformation.

Pharmacists are experts in the manufacturing and supply of medicines. We have spent many years being trained to formulate and dispense medicines. Extemporaneous dispensing of a wide range of formulations has, until a few years ago, been a significant part of the pharmacist's role. The continued development of convenient and ready-made medicines provided in patient packs by the industry appears to be reducing the need for some of our existing range of skills. Also, the impending introduction of automated dispensing technology will most probably reduce the need for pharmacists to provide significant input to handling the product and supply in the future. This increase in efficiency in the provision of a medicine supply will potentially release the pharmacist to look at expanding their skills into other critical roles. These roles may not be traditional product-oriented ones, but rather service-focused ones.

There is significant awareness now that patients continue to have problems with taking their medicines despite our existing attempts to improve their pharmaceutical care. For example, the wastage found from ad hoc medicines "dump" campaigns and the high incidence of hospital admissions due to iatrogenic disease are worrying features of this problem.

Many patients may not be receiving the optimum preventive health care support that they require from a modern health care service. The significant resources now invested must deliver tangible improvements in this direction.

Patients clearly desire and need more information about their diseases and the medicines that they take. The information they require is more than what is available from a patient information leaflet. Patients would prefer easily accessible clinical advice about the medicines they have been asked to take. Pharmacists, because of their expertise, now have an opportunity to provide a medicines management service to patients.

The medicines management service-based role will inevitably expand. The role may, however, require a slightly different set of skills from that of managing the traditional product/medicine-based dispensing or extemporaneous preparation service

The management of services is different from that management of products. Although many may regard the differences as small, the variations could have a major impact on the way we do things. Pharmacy services, as for other services, are intangible. So unlike medicinal products, they cannot be made on a production line nor can they be seen or touched before they are used. The pharmacy service will be consumed at the time that it is given and so cannot be put on a shelf like medicinal products. Services will inevitably be variable and will be dependent upon the skills and expertise of the individual pharmacist involved. The effectiveness of the pharmacy service provided will also be dependent upon the person receiving the service.

Services are therefore characteristically more difficult to manage than products and will present pharmacists and their managers with a new set of challenges.

Evolution or revolution?

Evolutionary changes from a medicine/product focus to a service/medicines management focus has already become well established in the hospital pharmacy sector. The growing demand for a wide range of pharmaceutical services which are not just supply oriented has changed hospital pharmacy from a dispensary-based service to a more clinical service, eg, patient counselling, anticoagulant clinics, formulary management, product evaluation, clinical audits and protocol development.

This service transition has taken approximately three decades. Understanding the evolutionary process may be helpful in formulating practices to manage today's changing world.

Hospital ward pharmacy services started in the 1970s. Before then, prescriptions were routinely brought from wards to pharmacy departments by nurses. It was recognised that there was a more efficient way to monitor ward prescriptions than wasting nurses' time by frequently visiting hospital dispensaries.

At that time hospital pharmacists generally did not review patients' notes. In the 1980s, following the expansion of ward pharmacy, the development of clinical pharmacy occurred. Here, pharmacists took a greater interest in the clinical needs of individual patients. There was insufficient clinical information on the prescription chart alone to enable safe dispensing to occur. Ward pharmacists were ideally positioned to review patients' notes, including laboratory results. Complex clinical interventions were made possible which improved patients' clinical outcomes. Extensive clinical pharmacy training courses were introduced to assist in supporting this new role and these are still widespread.

The clinical role was expanded further as directorate structures developed within trusts. Each directorate was given its own drug budget to manage. The role of clinical pharmacist now required additional services in order to support the financial needs of the directorates. The new clinical directorate pharmacists were asked to assist the health care team in controlling their ever-increasing expenditure on medicines.

A few trusts have now introduced consultant pharmacists. Much of this latest role will resemble that of an independent practitioner and so will include prescribing, research and clinical governance issues. Pharmacists in these roles will tend not to be involved in supply functions, such as dispensing or extemporaneous manufacturing. They will, perhaps, not even see these particular pharmacy services as their responsibility. These pharmacists have moved on: they have evolved into becoming experts and providers of pure services.

The primary care sector is now beginning to show similar patterns of change owing to the demands of patients and budget holders. The introduction of primary care trust advisers, medicines management projects and clinical governance initiatives is perhaps the beginning of this evolutionary process. The new pharmacy contract will look at reimbursement for a wider range of services than ever before, eg, cholesterol management and anticoagulant services. I suspect that soon there will be little difference in the level of service provision between these health care sectors.

The only difference between the sectors will be that the hospital sector has had three decades to evolve while the primary care sector has considerably less time to adjust to the new service demands. Despite the short time scales, there are positive signs that the revolution is occurring.