Response to "A Vision for Pharmacy in the New NHS"

from

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1 NPA response to 'A Vision for Pharmacy in the New NHS'

Introduction

1.1 The National Pharmaceutical Association (NPA) has a full understanding of the community pharmacy sector and community pharmacists. We have in membership virtually all pharmacy owners throughout the United Kingdom. As a voluntary membership organisation we must respond to members' needs and understand their problems, as well as their aspirations.

1.2 The *Vision* document is written for all sectors of pharmacy within the NHS and the NPA endorses its overall aim – to ensure the pharmacy as a whole becomes an ever more important component of the developing NHS. Our submission concentrates on the sector we know best – community pharmacy. It is intended to be constructive and supportive, and focuses very much on practical issues related to the implementation of the *Vision*.

1.3 The NPA fully supports the Government's plan to extend the range of professional services available from community pharmacies, within the NHS. It is important to acknowledge from the outset that the *Vision* must be based on the premise of improving patient safety and care. For the last two decades, through our "Ask Your Pharmacist" public education campaign and other major initiatives, we have been at the forefront of promoting extended roles for community pharmacists who are at the heart of health care in local neighbourhoods. Independent surveys have repeatedly shown that people place their community pharmacists at the top, or very close to the top of the list of health professionals they trust most. And they greatly value the service currently provided by community pharmacists to whom they have convenient access. Change must be designed to enhance, not adversely affect these considerations.

1.4 In addition the NPA welcomes the Government's acknowledgement that community pharmacy represents a significant untapped resource for improving health and hopes that the *Vision* will be a springboard for many improvements tangible to patients and the wider public.

1.5 The V*ision* also emphasises the development of cognitive skills. However, the NPA considers Government has made a fundamental omission by not recognising the potential to develop further the 10,000 strong community pharmacies in England as a distribution network for health care related items, such as welfare foods, incontinence products and rehabilitation equipment, and as having the potential to be part of the solution to dealing with national medical emergencies.

1.6 We have addressed the questions raised at the end of the *Vision* document, from the perspective of community pharmacy. We also wish to highlight some important issues about which our members are concerned. We are uneasy on several scores.

1.7 First, the Government must consider its *Vision* for the future of community pharmacy in the NHS, alongside the other contemporary issues that will have a significant effect on the sector. These include the Generics Inquiry and the forthcoming changes to Control of Entry Regulations. Pharmacists cannot be expected to embrace with enthusiasm the changes needed to realise the *Vision*, and to make the necessary investment to achieve them, while so much uncertainty about their future exists within their environment.

1.8 Secondly, it is important to recognise that the *Vision* outlines considerable changes, the vast majority of which will occur in the community pharmacy sector. For the implementation of this *Vision* to become a reality and a success, it is important that a large proportion of the community pharmacy sector is in a position to embrace the changes required.

1.9 The change management process must not be underestimated and it is essential that a measured and stepwise approach be adopted so community pharmacists are taken along the change journey. The NPA will have a key role in providing members with the necessary resource and support to take them through this process.

1.10 Thirdly, we have concerns that two of the proposed initiatives in the *Vision* document may be mutually antagonistic. We firmly support the proposal to seek to ensure that community pharmacy is better recognised, both by the public and other health care professionals, as an integral part of the NHS. However, it seems to the NPA Board that the proposal to permit NHS professional services to continue to be provided from community pharmacies in the absence of a pharmacist is bound to be a significant barrier to achieving the recognition intended. People directed by other NHS agencies or health professionals to seek advice from a community pharmacist are bound to be frustrated and dissatisfied if, having followed that recommendation, they find there is no pharmacist to consult. And,

we have serious concerns that insufficient thought will be given to the level of education and competence required for the person who is intended to "manage" the pharmacy in the absence of a pharmacist if public safety is to be maintained at its current very high standard. Pharmacy technicians trained to NVQ/SVQ level 3 will, in our considered view, fall considerably short of the level of education and training required for this function, notwithstanding the intention that they be registered. Considering the Government's intention to establish community pharmacies as an integral and highly accessible part of the NHS, the NPA is far from convinced of the wisdom of pursuing a policy of leaving pharmacies without the effective personal control of a pharmacist, perhaps, even, for long periods.

1.11 Fourthly, we have misgivings about the conclusion drawn in paragraph 3.16 that, if some community pharmacies focus on the provision of highly efficient dispensing services, they will relieve other pharmacies of dispensing workloads. Assuming that pharmacists' remuneration will still be linked to dispensing it is hard to see how this conclusion can be drawn. Moreover, in our experience, dispensing workload is related to one main factor – location. That is unlikely to change under any new arrangements. Pharmacies in locations which provide high dispensing workload – particularly those close to medical group practices – are also likely to be in the forefront of embracing extended roles.

1.12 Fifthly, we wish to emphasise our misgivings about a significant absence of detail or policy statement concerning the need for a robust IT infrastructure to support the implementation of the *Vision*. There is also a lack of detailed information on the access community pharmacists will have, to those parts of patient records that they will have to consider if the best possible quality of service is to be provided. Patients have expressed no misgivings about pharmacists having access to all the information needed to ensure their best interests are served. It is important that no artificial barriers are placed to this flow of necessary information, particularly on any supposed ground of concern about the maintenance of confidentiality. As the consultation paper makes clear, the Code of Ethics and Professional Standards under which all pharmacists practise, wherever they are located, is absolutely firm on the need for patient confidentiality to be maintained.

1.13 We urge that, regarding all proposals in the *Vision*, artificial target deadlines should not stand in the way of mature consideration of all the implications. The public interest should, at all times, be the priority driving factor. In particular, in considering change to the dispensing process arrangements, which have shown to operate well and safely over many years, a stepwise arrangement must be adopted. The first step should be to assess the outcome of the mandatory introduction of standard operating procedures. These are intended to encourage pharmacists to delegate all the technical aspects of the process, while maintaining

patient safety. The next stage should then be to allow dispensing and other selected professional operations to be undertaken by support staff, headed by a technician with enhanced qualifications, who has direct access, when necessary, to a pharmacist who remains at all times on the premises. This would enable the establishment, from practical experience, of the level of education and training that would be needed to ensure the technician had the identified competencies to maintain patient and customer safety in the absence of the pharmacist, while overseeing dispensing and the sale of P medicines, as well as providing advice or treatment of minor ailments. It will then become apparent if the policy is indeed a sensible one, again making patient and customer safety a priority.

1.14 The NPA looks forward to playing its full part in taking forward an ambitious programme of development and hopes that the *Vision* is the starting point for significant investment and patient-focused reform. We will be happy to clarify any points that may arise from consideration of our submission and would welcome a meeting to discuss the major issues that we have identified.

2 To what extent does the statement on 10 key roles for pharmacy reflect your understanding and expectations of pharmacy?

2.1 The NPA considers that the roles as written represent Government's vision for pharmacy – not the profession's. No pharmacy organisations or practising community pharmacists contributed to the development of the *Vision*. Thus, there is little ownership amongst the key stakeholders – pharmacists – of the ideas it contains.

2.2 In thinking about the 10 key roles for pharmacy, it is important to remember that for community pharmacy, professional development must also recognise commercial realities for contractors. Changes to the Control of Entry Regulations threaten to increase the number of pharmacies – and destabilise the local pharmacy network. This could have a disastrous impact on both investors' willingness to lend pharmacy owners money – and on pharmacy owners' willingness to risk further investment in staff, premises and IT. Community pharmacy can deliver the 10 key roles suggested, but only in an environment where contractors feel secure enough to invest to develop services in line with the *Vision*. The key roles need to recognise that a sustainable pharmacy business is a prerequisite of the professional role in community pharmacy.

2.3 In general, the *Vision* paper and specifically this section make no reference to the business contribution of pharmacy to the local health economy and to the local economy in general. This is crucial when one looks at the regeneration agenda as highlighted by the "Ghost Town Britain"[1] report. Within this, maintaining the high street shopping experience is key.

2.4 The NPA feels that the 10 key roles as written are not aspirational enough for the profession. It is also not clear whether the 10 key roles are intended to cover all sectors of pharmacy. The NPA believes that all pharmacists make vital, but different, contributions to the NHS. So it is difficult to capture 10 key roles for the whole profession. It is also important to note that the 10 key roles should be understandable and inspirational to other stakeholders including patients, other health professionals and other branches within the Department of Health. In view of this, the NPA has identified its own 10 key roles for community pharmacy.

10 key roles for community pharmacy

To deliver professional pharmacy services to local communities
Delivering services from a network of appropriate premises through a sustainable pharmacy contract based on local needs and integrated planning to enable pharmacy to contribute to the achievement of wider local and national quality targets.

To contribute to the health care agenda as a fully integrated part of the NHS family
Providing services, as part of the NHS primary care team, that fully utilise the skills and competence of all pharmacy staff; within the context of community based premises; and using information management and technology (IM&T) to maximise health gain to patients and the NHS.

To assure patient safety
Using robust clinical governance and quality frameworks, standard operating procedures and proper procedures to store and record Controlled Drugs in order to maximise the safety of prescribing and dispensing practice, and the prevention, detection and reporting of adverse drug reactions and medication errors, thus leading to improved patient safety and confidence.

To provide convenient access for patients
Increasing capacity within the NHS and improving choice for patients by being a first port of contact, located at the heart of neighbourhoods and communities, for advice on self-care, the treatment of minor ailments – both within and outside the NHS – and by signposting to other health care providers.

To manage patients with chronic and enduring medical conditions
Delivering services including repeat dispensing, medicines management, diagnostic testing and therapeutic drug monitoring, and pharmacist prescribing in line with evidence based national service frameworks (NSFs).

To contribute to reducing health inequalities
Contributing, as a business, to the local economy and the development of sustainable communities, and delivering services including public health, health promotion, health improvement and harm reduction initiatives, especially in the most deprived areas.

To be the primary source of advice on medicines
As the expert in the use of medicines, advising patients, and other health professionals and agencies on their safe and effective use.

To contribute to seamless, safe medicines management
Taking responsibility for medicines management services; and working in partnership with patients, their carers and fellow professionals in primary care to ensure safe passage through this key part of the patient journey, thus contributing to the prevention of admissions and delayed discharges. Also, working in partnership with colleagues in primary and secondary care to ensure the patient journey between the two sectors is seamless and safe.

To empower patients
Forming partnerships in medicines taking through the unique and trusted relationship community pharmacists have with their customers to enable patients to make informed choices about their care.

To contribute to the cost-effectiveness of the NHS
Promoting value for money in the use of medicines and reducing wastage through initiatives such as supplementary prescribing and repeat dispensing, and by increasing patient awareness of the real costs of medicines.

3 Are there other factors that need to be considered in setting out new roles for the profession (eg community pharmacists with a special interest) and how might these be developed?

3.1 The NPA Board welcomes the opportunity presented in the document for the development of new roles for the profession. The proposed framework for the new NHS contract provides a structure for the gradual development of these roles. It is important to allow the reclassification of additional services to enhanced services and enhanced to essential, so that new roles are not only identified but nurtured and developed stepwise within the profession.

3.2 The NPA particularly welcomes the principle of developing a scheme to designate "community pharmacists with a special interest". This will provide a means of realising potential very quickly and recognising tangibly the expertise of the profession's leading edge practitioners who have been moving in this direction on their own initiative having identified the need and benefits. In addition, a clear structure will encourage other pharmacists to follow these pioneers and the overall result will be a higher level of services and higher quality services for patients.

- **The development of the pharmacist with special interests within primary care should follow the same process and be given the same support that is being provided to other health care professionals**

3.3 The NPA welcomes the Department of Health's initiative to widen the remit of the national GPs with Special Interest (GPwSI) Reference Group to cover all practitioners with special interests and the Association is taking an active part in that Group. Most progress so far has been made with GPs and nurses.

3.4 The process for developing practitioners with special interest is following a pattern for each group of practitioners: a Department of Health generic guide to implementing the scheme, followed by a very detailed NatPaCT "how-to-do-it" guide for PCTs, plus a series of more detailed Department of Health guidance on specific clinical areas. The NPA considers the same process should be followed for developing the Pharmacists with Special Interest category.

- **The NPA endorses the observations made so far by the Practitioners with Special Interest Reference Group**

3.5 Frameworks should not be too prescriptive but should make recommendations for good practice rather than specifying absolute requirements.

3.6 The role and competencies of practitioners with a special interest would, in each case, need to be matched with the local, clinical needs identified by the PCT.

3.7 When considering new roles specifically for community pharmacy, it is important to bear in mind the huge difference between primary and secondary care practice. This has been a main concern of the NPA when the Royal Pharmaceutical Society and the Department of Health have considered issues such as skill mix and delegation of tasks to technicians. It must not be assumed that hospital models will work in a primary care setting; almost inevitably they will not. Policy makers must recognise that the primary care setting is very complex and there is a need to work with those who understand that sector when designing new roles and the supporting policies to be applied.

3.8 There is also a need for patient involvement when designing new roles, particularly those of community pharmacists with a special interest. Professionals and policy makers should be careful about imposing on patients their views of what constitutes a quality service. For example, currently patients are focused on the speed of dispensing – a standard which is already high within community pharmacy. If other quality standards are set, it needs first to be confirmed that they will be welcomed by patients.

- **All new roles, at whatever service level, should be designed to fit within the context of broader NHS policy and not in a professional void**

3.9 If the profession develops these roles in the context of "what pharmacy would like to do" rather than "how pharmacy can best serve the NHS" they are unlikely to be sustainable. This will lead to a frustrated pharmacy profession, a disappointed NHS and a missed opportunity to enhance patient care.

- **Within a locality, the development of community pharmacists with special interests should be considered alongside the development of GPs, nurses and other health care professionals with special interests**

3.10 Consideration should be given to various possible models of patient care which involve one or more of the health professionals with a special interest. It may not be necessary, for example, for all three health professionals co-operating in providing a specific service to hold special interest status. Indeed, it may be more cost-effective if only one member of the team is required to be designated as having a "special interest" status.

- **It is important to recognise that all new roles – from essential services to "special interest" services must make economic sense**

3.11 This demand is surely what would be expected from GPs, nurses or any other health professional.

- **There is a need to nurture innovation within the community pharmacy sector**

3.12 There will be considerably more leading edge practitioners within the community pharmacy population if pharmacists have "thinking time" or time with colleagues both within and outside the pharmacy profession to encourage innovative thinking and good relationships, and to develop services and special interests. Government should consider helping to resource this dedicated thinking time by making appropriate training accessible, by funding that training and by funding locum cover to free up time.

- **There is a need for clarity on what is considered to be a community pharmacist with a special interest**

3.13 For example, would such a pharmacist be working at a higher competency level than, say, a pharmacist who is accredited for providing an additional service or an essential service as defined in the proposed new contract framework? This issue needs to be discussed further.

What are the most important factors to be considered in taking forward our proposed changes to the skill mix of the pharmacy workforce?

4

4.1 Skill mix has been a major issue for discussion within the profession for a number of years. The NPA has taken an active part in those discussions and has submitted a full response to the Department of Health skill mix document – "Pharmacy workforce in the new NHS"[2] which was issued in 2002.

4.2 The NPA wishes to emphasise that the organisation is totally in favour of the concept of making best use of all staff in the pharmacy, supporting staff development by training and delegating tasks according to an individual's ability and competence. Indeed, unless pharmacists delegate tasks which others in the pharmacy can undertake, it will be difficult, if not impossible, for them to develop and provide the additional services envisaged in the *Vision* document, in particular in the proposed new contract framework. Virtually all new roles, as set out in the *Vision* and in pharmacy documents preceding it, are based in the pharmacy so the main objective should be to encourage pharmacists to delegate routine tasks to support staff so that they can become more involved in the clinical care of patients on the premises.

4.3 It is important to note that a substantial amount of time can be freed up immediately, without any need for a change in the supervision requirement, either in legislation or the Code of Ethics. Many pharmacists currently spend far too much time attending to the mechanics of dispensing and undertaking final accuracy checks on dispensed medicines when these tasks can already be delegated within the current law and code to suitably qualified and competent technicians and dispensing assistants.

4.4 The *Vision* document proposes redefining supervision so that "a registered and appropriately qualified technician need not be supervised personally by a pharmacist". When considering relaxation of supervision to this extent, there are two main issues. The first concerns the removal of the requirement in the Code of Ethics that a pharmacist undertakes a pharmaceutical or professional assessment of every prescription at some stage during the dispensing process. The second concerns the removal of the requirement within the supervision process for a pharmacist to be on the premises at all times when P medicines are sold or prescriptions are dispensed and handed out. It would seem that the Government's proposal is to remove both of these requirements. If this is the intention, the NPA has identified a number of important factors for consideration:

- **Patient safety is paramount and must be assured before steps are taken to redefine supervision**

4.5 This must be the top priority at all times. Currently, community pharmacists are recognised by patients and customers as providing a first class service. Considering the many millions of prescriptions dispensed every year, the number of serious dispensing errors is very low. There is currently no evidence to support any assumption that a dispensing service, in the primary care sector, which does not involve direct supervision by a pharmacist will be as safe for patients. Before any decision is taken to allow a change in current requirements, it is important that new dispensing models are tested under very tightly controlled conditions so that the public can be as confident in new models of pharmacy practice as it is in the traditional model. It would be against the interests of the Government, the pharmacy profession and, indeed, patients, if safety was demonstrated to be inferior in pharmacies where the pharmacist was not intimately involved in the pharmaceutical assessment of every prescription or where advice was given and/or treatment recommended to a customer when the pharmacist was not on the premises and so available for consultation.

- **Any new model of medicines supply must be rigorously tested under tightly controlled conditions before a decision is taken to redefine supervision**

4.6 In its consultation "Pharmacy workforce in the new NHS"[2], the Government proposes discussing the development of a protocol medicines supply scheme within which medicines are sold or supplied to patients and customers without supervision by a pharmacist. It is imperative that such a model is tested under the tightly controlled conditions outlined above. Furthermore, in developing such a model the following issues need to be considered:

- The SOPs and protocols that need to be in place to ensure safe supply.
- Robust criteria for referral to the pharmacist.
- Identification of the required level of competence of staff to operate within this model.
- The ability of the model to operate safely, in the public interest, when responsibility is transferred from one pharmacist to another (eg locum and part-time pharmacists).
- Quality assurance.

- Regulation and registration of support staff who would be responsible for dispensing and supply in the absence of the pharmacist (as opposed to regulation and registration of technicians who would not necessarily undertake this new responsibility).

- Assessing the competence of pharmacists and support staff.

- Accountability.

4.7 The NPA is interested in the concept of developing a medicines supply protocol which is centred around the assessment of risk. In other words, at the beginning and throughout the dispensing process, the technician who is responsible for implementing the model and other support staff involved in the dispensing and supply process must assess the possible risk to the patient if the prescription was dispensed incorrectly. The higher the risk the more input would be needed from the pharmacist. The Government has announced, in the *Vision* document, its intention to consult formally on its skill mix proposals by early 2004.

The NPA wishes to be fully involved in that consultation and seeks confirmation that this will be the case.

- **Any change in the interpretation of supervision will require careful scrutiny of training requirements of all pharmacy staff**

4.8 Much progress has already been made within the profession to ensure that staff are properly trained for the tasks delegated to them. Indeed, the NPA has a particular interest here in providing a range of training and education courses and materials for pharmacy support staff. Notable developments are the requirement for a minimum standard of training for all staff involved in the assembly of a prescription and the move towards registration of pharmacy technicians. The requirement for medicines counter assistants to be trained to an accredited standard has been in place for some time. However, the NPA believes that if new models of supply and dispensing are introduced, training requirements for all staff will need to be re-assessed. This will be necessary because current training requirements are based on support staff operating under the direct supervision of a pharmacist, as currently interpreted. Specific issues which need attention include:

- skills analysis
- training needs analysis
- specific job roles and responsibilities
- defining competencies
- time and resources needed
- lag time before suitable staff are competent to work within the new models
- access to and availability of training courses
- defining new levels of staff with enhanced skills
  (For example, if pharmacists are less available to help with advice on the treatment of minor ailments, would a higher level of medicines counter assistant be needed, or, indeed, would pharmacy technicians need to be trained in this area to support medicines counter assistants?)
- CPD support for staff

4.9 Consideration must also be given to the additional qualifications over and above registration with the Royal Pharmaceutical Society of Great Britain, which will be required for technicians who are responsible for dispensing within any protocol medicines supply scheme which does not include direct supervision by a pharmacist. The NPA believes that a significantly higher level of qualification than is currently the case will be needed for this new role. Before deciding what this qualification should be, the exact responsibility of the technician must be established. For example, if the technician is working in the pharmacy when the pharmacist is not on the premises, the responsibilities, skills and competencies required will be different from those needed by a technician who is dispensing medicines without the direct supervision of a pharmacist but while the pharmacist is on the premises.

4.10 The NPA believes that the "foundation" degree, providing it is undertaken as a part-time course while working in a pharmacy, should be explored as a possible, acceptable level of qualification. It is likely that this would be appropriate for an enhanced technician qualification. It would require a higher level of learning but, at the same time, it is an employment related higher education qualification involving much work based and work related learning. It is also a flexible course allowing part time study over a three year period or full time over two years. This would reflect the patterns in some other EU countries, such as Sweden.

Any new skill mix model must be acceptable to all stakeholders

4.11 To maintain confidence in the community pharmacy service, it is essential that models of practice which exclude direct involvement by the pharmacist are acceptable to the public (including patient support groups), other health care professionals, commissioners of health care, pharmacy employers, pharmacist employees, locums and support staff. It is likely that the Government will receive the views of many of these stakeholders as part of the consultation. However, there is concern that perhaps not all stakeholders will have effectively signalled their views. For example, little is known about the views of support staff working within the community pharmacy sector. It is dangerous to assume that the majority will be eager or ready to take on new roles and responsibilities. In addition, if little response has been made to the skill mix debate by individual pharmacists, this should not be taken as a tacit acceptance of the Government's proposals for change. If supervision requirements are relaxed, it is likely that a large majority of pharmacists will find the change management process very difficult and consideration will need to be given to supporting this process. It is possible that allowing pharmacists to leave the pharmacy will be a step too far for pharmacists who currently cannot remove themselves even from the mechanical dispensing process, let alone the pharmaceutical assessment.

4.12 A particular concern is how the public will respond to a new skill mix model which would allow pharmacists to leave the premises and play no part in the dispensing process or be available for advice on the treatment of minor ailments. It is in patients' interest that a pharmacist is present at all times in the pharmacy for the following reasons:

- Community pharmacy is now used routinely as a fourth disposition for NHS Direct. Patients will be frustrated if, when referred by an NHS Direct nurse to a pharmacy, there is no pharmacist available for consultation.

- One of the key strengths of pharmacy is that the pharmacist is freely available without an appointment. This benefit will be lost if the pharmacist is away from the pharmacy and, again, it will frustrate patients who have come to the pharmacy seeking the pharmacist's advice. This is particularly important for PCTs who commission services from community pharmacy to improve access and choice for patients in primary care.

- The absence of a pharmacist would decrease patient accessibility to medicines through reduced possibility of utilising patient group directions. Again, this is important for PCTs who commission services from community pharmacy to improve access and choice for patients.

– The absence of a pharmacist from the pharmacy would significantly reduce the number of opportunistic interventions. This could potentially undermine the *Vision's* emphasis on the key role that community pharmacy has to play in public health. In a typical day, the community pharmacist intervenes many times, in the patient's interest, during the dispensing process or when a medicine is supplied. Unfortunately, these pharmacy based interventions have not, in the past, been recorded. They should not, however, be ignored in the policy decision process on a proposed new model.

● Government should not underestimate the costs of moving to new skill mix models

4.13 Staff who are more highly trained and with more responsibility will, naturally, seek higher salaries. In addition, the cost of training will be very significant. These costs must be taken into account when negotiating funding for the new pharmacy contract.

In what ways can we ensure that community pharmacy is better recognised as an integral part of the NHS?

5

5.1 This is an important question because the NPA has already identified that recognition as an integral part of the NHS is a key element in ensuring effective introduction of a wider range of community pharmacy services. It is clear that, while community pharmacists already play a vital role in providing NHS services, the perception is that community pharmacy businesses are not part of the "NHS family".

5.2 It will take time before community pharmacy is fully recognised as an integral part of the NHS. This will involve cultural shifts within the pharmacy profession and among other health professionals and commissioners. It is, therefore, important to start working towards this goal as soon as possible whilst recognising that it will take several years to achieve.

5.3 The following issues are key to ensuring better recognition of community pharmacy as an integral part of the NHS:

- **Community pharmacy must be in a position to, and be seen to, respond to local needs and to deliver on NHS priorities**

5.4 For this to be achieved, it is vital that all Primary Care Trusts (PCTs) have an active PEC pharmacist and that they all develop management capacity and expertise in strategic planning of community pharmacy service development and the pharmacy network.

5.5 PCTs also need to consider carefully who should lead the strategic planning process in relation to community pharmacy. In many PCTs, this work has traditionally been allocated to the domain of the prescribing team – and their professional input into the process is crucial. However, pharmaceutical advisers already have a significant workload – and in many areas are likely to be closely involved in implementing the new GMS contract – especially the quality framework. PCTs need to consider whether its existing pharmacy team will be able to handle the workload resulting from these new policy developments. Experience to date across England suggests that a winning combination for the integration and development of community pharmacy services at PCT level is a pharmaceutical adviser, a pharmacist PEC member and a community pharmacy facilitator, working closely together with the Local Pharmaceutical Committee to drive the process forward. The community pharmacy facilitator role should focus solely on

community pharmacy issues and facilitate the development of a strategic vision of how community pharmacy fits within wider PCT policy such as the Strategic Service Development Plans (SSDPs) and community pharmacy's contribution to supporting the targets in the Local Development Plan (LDP). The facilitator need not necessarily be a pharmacist.

5.6 In addition, there is an increasing need for a "whole systems" approach to PCT planning, and it may make sense, from a management perspective, for the appropriate PCT director or contract service manager to lead the pharmacy service planning processes, supported by the community pharmacy facilitator and others. In this way, PCTs can ensure that planning and thinking about community pharmacy development is integrated from the start.

5.7 It is also important that PCTs involve community pharmacy owners in planning. The most appropriate place to go for this input is the Local Pharmaceutical Committee.

5.8 Another possible way of helping with integrated planning would be for the Modernisation Agency to produce a "template" for LPCs/PCTs for the joint identification of local needs that are already being met by community pharmacy, as a benchmark tool to establish future community pharmacy services within the NHS.

5.9 A particularly important Government priority is that of reducing health inequalities. Greater recognition and support should be given to pharmacists' role in helping to tackle this issue. Pharmacies that are located in deprived neighbourhoods must also be supported so that they do not become non-viable with the development of One Stop Centres and the proposed change in the Control of Entry Regulations. A requirement for PCTs to include a long term strategy for community pharmacy premises within SSDPs would facilitate this. Successful work in this area would increase the visibility of the role of community pharmacists within the NHS and thus result in better recognition of community pharmacy as an integral part of the NHS.

● Community pharmacy must have the ability to match patient data with other parts of the service

5.10 Data connectivity is fundamental to delivering patient-centred support and integration with other centres of care within the NHS. Reference has been made in the *Vision* document to pharmacists gaining access to "elements of patient information" that they "may need to deliver appropriate health care services". Reference has also been made to intended discussions about community pharmacists accessing required information from the common health record (integrated care record service – ICRS). Unfortunately, however, both the required details and commitment are absent from the *Vision* document. Access to at least part of the patient's care record will be an essential prerequisite not only to ensuring community pharmacy is recognised by patients and other health professionals as part of the NHS but also to ensure effective introduction of a wider range of services. Indeed, the quality of one of the services listed as an essential service – repeat dispensing – would be very much below optimum without the pharmacists involved having proper access to patient records.

5.11 In addition to the political issues regarding IT, Government needs to recognise that it must make available additional financial resources to support IT – for both software and hardware.

It is covered in more detail in chapter 11.

● There must be genuine co-operation between community pharmacists and other health care professionals

5.12 Community pharmacists will always be seen as the "NHS outsiders" if they are not given the opportunity to work closely with other members of the NHS team. New services, such as supply of medicines by PGDs, repeat dispensing and, in particular, supplementary prescribing, will help to facilitate this.

5.13 Moreover, community pharmacies and pharmacists are, and will be, an increasingly significant part of the patient journey in the primary care setting. Therefore, they must be fully involved with other health professionals in such work as developing primary care pathways. PCTs have a role to play in fostering closer working relationships.

5.14 Co-operation is also facilitated by helping GPs to regard community pharmacists as "solutions to their problems", ie NHS professionals who can help them to deliver their contract quality framework. This is discussed further in paragraph 6.4.

- **There must be an interface between community pharmacy and other community stakeholders – such as local authorities and social services**

5.15 Involvement in local health care planning is wider than the NHS. Therefore, community pharmacy must not only be more visible within PCTs and amongst other NHS professionals, it must also have the opportunity to interact with other local stakeholders. To facilitate this, there must be a requirement on local authorities to engage community pharmacy in local estates planning and in developing public health related strategies. In the past, the community pharmacy sector has been regarded mostly as a private partner, or provider of finance. This is simply not acceptable. Community pharmacists, like colleagues within PCTs and other health care professionals, are important service providers and, as such, they should be entitled to a place at the planning table. This is particularly important in relation to public health, in view of Government's decision to increase the role of the pharmacist in this field – as is evident from the Chief Pharmaceutical Officer's 10 key roles for pharmacy and the Government's decision to develop a framework for a pharmacy public health strategy by 2005.

- **Patients, commissioners of services and Government must perceive community pharmacy as a member of the NHS family**

5.16 The Government's proposal to establish a clear NHS identity for community pharmacies, particularly by enabling use of the NHS logo, will help to achieve this, as will continued Government investment in public education initiatives, such as the winter planning campaign to encourage more use of community pharmacies, where appropriate.

5.17 Direction of appropriate NHS Direct cases to community pharmacies will also strengthen the message that community pharmacy is part of the NHS. And as the first port of call for many NHS users, community pharmacy should also be engaged and fully utilised in the First Contact programme.

5.18 Regarding PCTs, more reference to community pharmacies from NatPaCT would place our members amongst the other NHS professionals. The NPA would welcome the opportunity to work with NatPaCT to develop PCTs' competencies which will ensure PCTs are including community pharmacies in their thinking and investment.

- **Community pharmacy must be seen as a partner in delivering patient-centred care**

5.19 This goal will be achieved only if all the previous bullet points are addressed and the services outlined in the new contract framework are widely provided.

6 How can closer working partnerships be fostered between community pharmacy and hospital pharmacy with other health professionals and with those commissioning and managing NHS services?

Fostering closer working partnerships between community pharmacy and hospital pharmacy

6.1 It is vital that community pharmacists and hospital pharmacists work closely together to ensure the best possible outcome of the patient's journey. This becomes increasingly important as Government implements its policy to move services from secondary care into the community. Community pharmacists can learn from their hospital colleagues.

6.2 The NPA suggests the following:

- The establishment of routine meetings between the NHS Chief Pharmacist; PEC pharmacists and pharmacy staff within PCTs and LPCs.

- It should be made clear to hospital boards that there is a responsibility at point of discharge for hospital pharmacy to communicate with community pharmacy.

- Pharmacists within community and hospital practice should establish procedures for smooth transition of a patient from primary to secondary care – both in emergency and in routine situations. This is increasingly important as hospitals implement policies involving patients taking their medication into hospital with them. Joint hospital and community pharmacy research should be encouraged and funded. Currently, the NPA and the Guild of Healthcare Pharmacists, with the financial support of Merck, Sharp and Dohme, offer an annual educational grant for pharmacy practice research involving both community and hospital pharmacists. Additional funding from the Government would help to increase pharmacy practice research in this area. This is discussed further in paragraph 7.8.

- Consideration should be given to community pharmacists working sessions within hospitals – as is currently the case with GPs. This may become particularly beneficial as community pharmacists with special interests emerge.

6.3 In order to take these ideas forward, the NPA suggests that the Department of Health considers creating a joint community pharmacy/hospital pharmacy forum.

● Fostering closer working partnerships between community pharmacy and other health professionals

6.4 In answering this question, the NPA is restricting its remit to primary care and makes the following suggestions:

- Community pharmacists need the opportunity to interact more with other health care professionals. Meetings often take place during the day making it difficult for pharmacists to attend because of their supervision obligations and their workload. Locum cover should be funded to allow pharmacists to attend such meetings.

- Health care professionals need to be incentivised to work together. For example, to encourage GPs to talk to community pharmacists, there should be a target to this effect in the quality indicators within the new GMS contract – as indeed, there is for GPs to communicate with PCT pharmaceutical advisers.

● Fostering closer working partnerships between community pharmacy and PCTs

6.5 The key issue is that all PCTs must have an active PEC pharmacist and a community pharmacy facilitator on the staff as well as a pharmaceutical adviser. Full consideration of this issue has been given in paragraphs 5.4 and 5.5. In addition, the NPA suggests the following:

- As is the case for developing relationships with other health professionals, pharmacists need dedicated time to be able to attend meetings within PCTs.

- Within the NatPaCT competency framework, via league tables, primary care pharmacists should be targeted to work with community pharmacy to identify needs and services.

- To facilitate the presence of a PEC pharmacist on every PCT, the Commission for Health Improvement (CHI) should make the appointment of a PEC pharmacist one of its performance indicators for PCTs' engagement with community pharmacy.

- Another of CHI's performance indicators for PCTs' engagement with community pharmacy should be one for regular meetings with LPCs.

What are the key elements needed for the effective introduction of a wider range of community pharmacy services?

7

7.1 It is important to note that the vast majority of services outlined in the *Vision* document are already provided by many pharmacists. However, these are often inadequately funded and dependent on a fragile, cross-subsidised system. It is frustrating for both pharmacists and PCTs when services provided prove to be of great value but have to be stopped when a funding source runs out. It is vital, therefore, to ensure existing services are underpinned before consideration is given to wider provision. Appropriate delegation of tasks to competent staff is a key element. This has been addressed in chapter 4.

7.2 The proposed new contractual framework will provide a good basis for wider implementation of extended role services. We would envisage that once community pharmacists get to grips with establishing the essential services envisaged in the framework, many will seek to provide both enhanced and additional services. As these services become more widespread, we would expect some of them to move into the essential services category. This stepwise approach is the best way to ensure more widespread delivery of a greater range of community pharmacy services.

7.3 However, the following key elements are needed for effective implementation of these services through community pharmacy:

- **Adequate support for and within PCTs to encourage them to implement new services**

7.4 Mention has already been made in paragraphs 5.4 and 5.5 of the need for dedicated staff in PCTs responsible for community pharmacy developments, of the need for every PCT to have a PEC pharmacist and of the need for PCTs to have regular dialogue with LPCs.

7.5 However, PCTs need to be supported in other ways. A Prescription Pricing Authority (PPA) payment mechanism is needed for paying pharmacists for additional services. Currently, the need to allocate PCT staff time to administer payments to community pharmacists is a major barrier. Also, to stop PCTs wasting valuable time reinventing the wheel by duplicating work on developing local services, there is a need for the development of robust, practical tool kits for additional services. The NPA is already working on one for minor ailments but these tool kits need Department of Health support, for example, by NatPaCT endorsement and promotion via the NatPaCT website.

A robust business case for pharmacy and the NHS (win/win solutions)

7.6 Pharmacy owners must be able to make returns on their investment in new services to ensure sustainability. They must also retain acceptable returns on their business as a whole – new services must bring investment that is synergistic to the overall business. The higher the risk of business failure, the higher the return on investment must be. Equally, new services must be cost-effective for the NHS. If this equation balances, new services will be successful, sustainable and thus be adopted widely.

7.7 Good current examples of win/win solutions are minor ailment schemes and the provision of EHC via PGD. Implementation of these services has been successful for the NHS because they provide solutions to specific problems (ie the need to reduce pressure on GPs' time and the need to reduce teenage pregnancies). The implementation of these services has been successful because they build on pharmacists' existing expertise, contribute to the long term viability of the business, provide synergy with existing work, benefit the patient and take advantage of the ease of access to services that the community pharmacy network provides. By examining the implementation of these services we can learn lessons about the key issues associated with the introduction of sustainable models into community pharmacy practice. Other services that meet these criteria will also succeed.

7.8 Win/win solutions can also be found within the GMS contract. There are many opportunities for community pharmacy to contribute to the achievement of the GMS quality framework. Repeat dispensing, for example, will ensure that standards related to the request for repeat prescriptions (numbered Med 4 and Med 8 in the framework) are much easier to achieve. Medication review will help contribute to the GMS quality framework standards on medication review (numbered Med 5 and Med 9).

A stable business environment

7.9 Currently, there are a number of factors that are destabilising the pharmacy business environment and their full impact remains uncertain. Until these are addressed, it is unlikely that pharmacy owners will invest in the introduction of new services. Changes to the Control of Entry Regulations threaten to increase the number of contract pharmacies – and destabilise the local pharmacy network. This could have a disastrous impact on both the willingness of financial institutions to lend to pharmacy owners – and on the willingness of pharmacy owners to risk investment in staff, premises, etc. If the Government is truly committed to making

this *Vision* a reality, it should recognise this – and ensure that the promised "balanced package of measures" is as tightly defined as possible to create as great a degree of certainty in the market as possible. As previously mentioned, in paragraph 5.5, PCTs should be required to include a long term strategy for community pharmacy within SSDPs.

7.10 For additional services commissioned by PCTs, the introduction of long term contracts would help to increase business certainty. The requirement for PCTs to have three year local development plans should facilitate this. Currently, community pharmacies are often contracted to provide additional services on a yearly basis. Pharmacists never know whether the service will be continued from one year to the next. As previously mentioned, even if they are providing a service of superb quality which is truly beneficial in meeting local needs, there is still a possibility that money will run out and the service will be cut. Three year contracts would enable pharmacy owners to plan better and invest the necessary resources to provide those services, with greater certainty of a reasonable return on investment.

7.11 The current Generic Medicines Inquiry is also contributing to instability and uncertainty within the sector. The re-calibration of prices and then the implementation of the new prices will impact significantly upon community pharmacy income. The new contract will be based upon a cost of service model and then a fair return. Funding the new contract is currently under discussion. It is now understood and accepted by all parties to the negotiations that reimbursement – particularly the retained profits associated with the purchase of generic products – provides a significant contribution to the overall funding of a pharmacy business. It is also clear that the current levels of remuneration do not provide sufficient resource to ensure the viability of the typical community pharmacy. If Government wishes pharmacists to make less money out of purchasing medicines, it must recognise that, to remain viable, these pharmacy businesses will need to generate income from other sources.

The successful outcome of negotiations between PSNC and the Department of Health on the payment structure for the new contract is a vital component in the creation of a stable business environment.

Increased resources

7.12 It is impossible for community pharmacies to provide a wider range of services without increased resources being made available, some of which should be ring-fenced for community pharmacy. No other health care professional, or indeed any other professional, would be expected to provide more services for the same – or even less – money. The outcome of negotiations between the Department of Health and GPs on their new contract illustrates this point well.

7.13 Increased resources can also come from ring-fenced Government funding, for example, for improving access to NHS services and sexual health. However, it must be made clear to PCTs that when commissioning services with ring-fenced money, they should consider other providers, such as community pharmacies. This rarely happens at present.

7.14 However, in addition to investment in new services, resources may also take other forms – for example, help with development of premises and IT, and funding of dedicated time for involvement in planning and the development of relationships with the primary care team. Resource is also needed for training for new roles and for training in change management, as well as for CPD for pharmacists and support staff. At the British Pharmaceutical Conference in September 2003, the Health Minister announced that an additional contribution of £1 million would be made available to help support training of technicians and assistants. While this is welcomed £100 per pharmacy is not sufficient to train all support staff to the level required to take on tasks envisaged in the *Vision*. Also, presently, Government funding for the training of support staff in the form of Modern Apprenticeships and National Vocational qualifications comes with many restrictions, such as age limits (only available to the under 19s), entry criteria and completion deadlines. The process of drawing down this funding is extremely complex and bureaucratic for members.

7.15 ***The provision of substantial, additional resources would demonstrate the Government's commitment to the future of community pharmacy. This would give community pharmacy owners the confidence to make significant new investments in their NHS businesses. In short, if the Department of Health is serious about harnessing community pharmacists' skills, enhancing community pharmacists' contribution to health care and fully integrating community pharmacists into the NHS it must be prepared to match these words with the necessary investment to secure the implementation of the process.***

Proper integration within the NHS

7.16 Proper integration within the NHS will play an important role in ensuring effective introduction of a wider range of community pharmacy services. The NPA welcomes the Government's intention to introduce the NHS identity to pharmacies providing NHS services. As previously mentioned, this will help not only the public but other members of the primary care team to identify community pharmacies as an integral part of the NHS and an access point for a range of NHS services.

7.17 However, community pharmacy needs, in addition, to be much more visible and better understood within PCTs. Reference has already been made to the need for CHI to be encouraged to include, as an appropriate performance indicator for engagement with community pharmacy, the appointment of a PEC pharmacist.

7.18 We have also already stated that PCTs should be encouraged to facilitate the development of closer working relationships between medical practices and community pharmacies, and that a possible way of achieving this would be to introduce into the GMS contract quality framework, an indicator on working with local pharmacists. In addition, to ensure proper integration within the NHS, community pharmacists must be fully integrated into NHS IT systems. In particular, pharmacists need access to the NHSnet and patient records. IT is considered in more detail in chapter 11.

7.19 Integration of community pharmacy within the NHS should cover both planning processes and local practitioner teams. It is important that pharmacy policy is integrated within both national and local NHS policy development processes and planning frameworks. This can only be achieved if national and local policy makers understand the patient's journey and care pathway – and recognise the community pharmacist's important role within this pathway. This will ensure services fit existing and developing models of care within the NHS as a whole.

A realistic timetable for implementation

7.20 As previously mentioned, the NPA supports the proposed new pharmacy contract framework, especially its stepwise approach to introducing new ways of working and new service provision. However, it must be recognised that pharmacy owners need time to plan. Implementation of the new pharmacy contract will be one of the greatest upheavals for community pharmacy since the introduction of the NHS.

7.21 The Government has indicated that it would like to start implementing the new contract by April 2004 – and that implementation will be gradual. It is important to focus on some "early wins" to help pharmacists gain in confidence. The more predictable the future is, the more effectively pharmacy owners will plan and invest, and the more comfortable they will feel about change.

How might we effectively develop and make best use of consultant pharmacist posts?

8

8.1 The document mentions development of the role of consultant pharmacist and implies that these posts will be developed in the secondary care sector. It is important that these positions are also developed in the community pharmacy sector as patients need access to clinical excellence, regardless of setting. The term 'consultant' has traditionally been applied to those with expertise in a specialist area or those with a higher level of skills and knowledge. This could link with the initiative to designate 'community pharmacists with a special interest' which is discussed in chapter 3. But, in our view, there is also a role for more highly qualified generalists who could take a more holistic view of a patient's medicines. The model for community pharmacy would have to develop alongside that for hospital pharmacy but we envisage the two roles being very different – hospital models do not necessarily work in primary care settings.

Prescribing

8.2 We would expect that the first wave of community consultant pharmacists would be supplementary and/or independent prescribers to improve patient access to NHS services.

Retention and motivation of pharmacists

8.3 A new career structure could help with the retention and motivation of pharmacist staff within the community pharmacy sector. The post of consultant could be something for younger, less experienced pharmacists to work towards.

Funding for community consultant posts

8.4 Specialist or generalist community pharmacist consultant posts could be funded by PCTs. Such pharmacists could practise from a number of community pharmacy premises within the PCT, holding clinics on various days to improve patient access to specialist advice. They could also support medicines management in community pharmacies.

9 What do you consider to be the main barriers to be overcome in decision making on the clinical and cost-effective use of medicines across local health communities?

9.1 The NPA recognises that this is a very broad question with far reaching implications around, for example, the management of NICE guidance, the current influence of the pharmaceutical industry, and the various influences that impact on a GP's decision to prescribe. On a general point, the NPA believes that there needs to be a wider view taken by the Department of Health of community pharmacists' ability to improve patients' health and wellbeing. At present, pharmacy responsibility rests within the Department's Pharmacy and Prescribing Branch. As such, pharmacy seems to be viewed alongside "prescribing" as a cost centre and therefore part of a problem rather than a solution.

9.2 The rest of the NPA's response to this question will focus on the role that community pharmacy has to play to overcome key barriers in decision making of patients, GPs and PCTs on the clinical and cost-effective use of medicines.

9.3 The key role that community pharmacy has to play in helping patients, GPs and PCTs remove barriers to improving the clinical and cost-effective use of medicines, is in increasing its role in medicines management.

9.4 The evidence base shows that pharmacists' involvement in medicines management both improves patient care and saves NHS money. Therefore, a key issue is to ensure that every PCT implements pharmacist-led medicines management programmes. Excellent work is already being undertaken through the medicines management service collaborative and through the community pharmacy medicines management project. Further development of medicines management schemes in community pharmacy could be supported in the following ways:

- **Focus PCTs' attention on community pharmacy medicines management**

9.5 This could be done in a number of ways, for example by making community pharmacy's contribution to improved medicines management part of the NatPaCT competencies, or an indicator in a CHI review, or ensuring the role of community pharmacy is discussed in practical implementation tools for PCTs such as those produced to support the implementation of the NSF for older people.

9.6 As previously mentioned in paragraph 5.5, it is also important that PCTs have the infrastructure to support community pharmacy service developments.

- **Ensure that GP practices and community pharmacies communicate on a regular basis**

9.7 As previously mentioned, a possible way of achieving this would be to introduce into the GMS contract quality framework an indicator on working with local pharmacists.

- **Allow community pharmacists access to patient records**

9.8 Access to patient records is essential to enable the pharmacist to have a complete picture of the patient during medication review, and to be in a position to record interventions made in the required informative manner.

9.9 The need for community pharmacy to be fully embraced within the IT agenda is discussed in chapter 11.

- **Community pharmacy should be given every opportunity to develop its role in helping patients and the NHS with better use of medicines**

9.10 Opportunities for community pharmacy could be further developed if:

- There was more education of PCTs, GPs, and pharmacists working within primary care of what community pharmacy does and what it has to offer in terms of improving medicines use.
- All PCTs had ring-fenced budgets to support community pharmacy development.
- Workforce Development Confederations (WDCs) considered the training needs of community pharmacy on an equal footing with those of other health care professionals.
- PCTs were supported to develop additional services as part of the new pharmacy contract.
- There was a better use of skill mix within pharmacy. This has been discussed in chapter 4.

- **Consideration should be given to a community pharmacy specialist role in medicines management**

9.11 There are various levels of intervention that community pharmacists can, and do, make to improve medicines management. The more involved level (or Tier 3) involves pharmacists conducting face-to-face medication reviews with patients either in the pharmacy, GP practice or a patient's own home. The *Vision* document makes reference to the development of a scheme to designate "pharmacists with a special interest". See chapter 3. Tier 3 medicines management would be an ideal specialist role.

- **Improve communication at the primary/secondary care interface**

9.12 Currently there is a lack of communication with community pharmacy about discharge medication. Possible mechanisms to encourage greater communication between hospital and community pharmacy have been discussed in chapter 6. In addition the NPA considers there is a need for the development of a standardised form to be used when transferring patients from hospital to the community and, where appropriate, from the community to hospital.

- **POM to P switches**

9.13 The NPA fully supports the Government's intentions to increase the range of medicines which pharmacists can supply without prescription. This will not only increase access to these medicines and increase patient choice, but it will also encourage those people who can afford it to purchase medicines rather than draw on NHS prescribing budgets. Restricting these medicines to pharmacies will ensure patients' choice to self-medicate is appropriate and safe.

9.14 In 2002, legislation was changed to facilitate the POM to P reclassification procedure. One element of this new procedure which concerns the NPA is that of controlling the quality of training material which forms part of the reclassification process. There are no written guidelines within the reclassification process which ensure training material is of an acceptable standard. Applicants are only required to "make clear what provision has been made for appropriate education and training". The MHRA has made it clear that it scrutinises all training material but there are no criteria against which to judge it – and no opportunity for outside bodies to scrutinise it as part of the reclassification consultation.

The NPA considers that, when pharmacists recommend a non-prescription medicine they should base that recommendation on recognised evidence based clinical guidelines – just as would be expected of any health professional working within the NHS. Patients should also expect the same standards of service if they choose to seek advice outside the NHS. The only factor which does not need to be considered in this case is cost. The NPA believes, therefore, that standards should be set for training material to support POM to P switches. Two important elements should be that the training material covers the therapeutic group in which the product sits and that treatment should follow the same clinical guidelines as would be used within the NHS, with the exception of cost consideration. If patients receive the same high standard of service outside the NHS, more will be encouraged to choose this option.

● Ensure the benefits of repeat dispensing are maximised

9.15 Repeat dispensing by community pharmacists has been shown to decrease waste and improve patient compliance. Therefore efforts should be made to maximise repeat dispensing. This will require community pharmacists to:

- be able to make dispensing discretions (eg changing quantity or optimising doses)
- have access to an electronic patient record.

● Support community pharmacists to provide prescribing advice to GPs

9.16 The pharmaceutical industry has a potent influence on GP prescribing practices. The role of the community pharmacist in providing prescribing advice to GP practices, alongside the PCT prescribing team, should be enhanced. This could be done by ensuring that community pharmacists have the same training and development opportunities as PCT pharmacists, for example, easy access to National Prescribing Centre resources and training events.

Involve community pharmacy more in the implementation of NICE guidance

9.17 Generally, PCTs receive no additional funding or resources to support the implementation of NICE guidance. This is, therefore, a major task for PCTs. Community pharmacy could be utilised to support PCTs with implementation, for example by helping patients to understand NICE guidance, or by supporting GP practices with the practical aspects of implementation.

How can we make best use of supplementary prescribing by pharmacists to improve patient care?

10

10.1 The NPA is confident that the first wave of pharmacist supplementary prescribers will demonstrate that giving pharmacists a greater involvement in, and responsibility for, the treatment of patients with long term illnesses, will result in better patient care. It will also be seen to enable GPs to devote more time to other primary care services which only they are qualified to provide. If, as expected, pharmacist supplementary prescribing demonstrates these benefits then the objective must be to move as many patients as possible to this type of care. If this decision is taken, PCTs must be able to make the best use of pharmacists in the community as practice based pharmacists alone will not be able to cope with the large lists of patients on long term therapy, within their GP practice. Encouraging community pharmacy based supplementary prescribing will have the most impact on increasing patient access and on the *Choice*[3] agenda. The NPA is also encouraged by the Government's intention to develop a framework for independent prescribing by pharmacists. This will greatly contribute to increasing access to NHS services, particularly as independent prescribing becomes the norm within community pharmacy.

10.2 In order to develop community pharmacy based supplementary prescribing, there are a number of issues which must be addressed.

● Community pharmacists must have access to patient records

10.3 This is more of a problem for community pharmacists than for their pharmacist colleagues in primary care settings. The current Department of Health guidance states that both the independent and supplementary prescriber must share access to, consult, and use, the same patient record, and that the supplementary prescriber should not have a separate system of records. The NPA recognises that at the outset, community pharmacists will have to work with patient held records but this must be a temporary measure. As previously stated, community pharmacy must be fully incorporated within the IT agenda.

- **Pharmacist supplementary prescribing must be a generalist rather than a specialist role**

10.4 While the NPA recognises that the training course for supplementary prescribing requires the pharmacist to concentrate on specific conditions, once qualified as a supplementary prescriber, a pharmacist must be regarded, like a GP, as a generalist prescriber. It should, of course, be a professional standards requirement that any pharmacist supplementary prescriber recognises his or her limitations and does not undertake a prescribing function outside his or her competence. If this generalist approach is not maintained, neither the NHS nor patients will receive maximum benefit from this service. Many patients cared for in community pharmacies have multiple conditions and could, arguably, gain the greatest benefit if supplementary prescribing for them is community pharmacy based.

- **Consideration must be given to the support required by community pharmacists to ensure their full potential in this role is realised**

10.5 The NPA is an organisation which is very much focused on the needs of its members at a very practical level. Its focus is on helping to turn Government policy into reality by identifying and, in many cases, providing the support needed by individual pharmacists, to undertake new roles. Training for the supplementary prescribing role is but a small part of turning this part of the *Vision* into reality. Government needs to give consideration to other ways of supporting the development of this role. For example, community pharmacists need to understand clearly where supplementary prescribing fits into the overall medicines supply picture – for example, how does it relate to supply via patient group directions, medicines management services or repeat dispensing services? They also need to understand how PCTs' health care targets are set to enable them to engage with the planning process and identify where supplementary prescribing will help to meet those targets.

- **PCTs should be encouraged and incentivised to train community pharmacy supplementary prescribers**

10.6 The NPA recognises that PCTs cannot be directed from the "centre". However, ways should be sought to introduce specific targets for PCTs to train community pharmacy supplementary prescribers. For example, PCTs should be required to state their position on supplementary prescribing, as they currently have to for LPS.

GPs should be made aware of the benefits of supplementary prescribing

10.7 The full benefits of supplementary prescribing by pharmacists will not be realised unless the concept is fully supported by GPs – not only because GPs are required as mentors during training but also because they will be the initiators of supplementary prescribing care programmes for their patients.

10.8 Consideration must be given to how national awareness can be achieved, either by the Department of Health or through PCTs, or a combination of both.

Consideration should be given to time management issues related to the provision of a community pharmacy-led supplementary prescribing service

10.9 There are many issues relating to time management. Flexibility is needed on the structure and methods of training for supplementary prescribers. Programmes involving a considerable number of face-to-face contact hours are great obstacles for community pharmacists. It is important to analyse carefully the outcomes of the current training programmes and establish whether the amount of face-to-face contact hours currently required is justifiable in relation to the resulting competence of the qualified supplementary prescriber.

10.10 In addition, the actual service or process must be carefully analysed so that pharmacists can better envisage how the service will be provided. For example, consideration has to be given to issues such as forward planning, the establishment of appointment systems, patient expectations, time taken providing the service (preparation for appointments, contact time with the patient, record keeping, etc.). A full understanding of the actual service is needed before pharmacists can consider other issues such as skill mix (whether or not a second pharmacist will be needed in a pharmacy providing this service) and to enable the service to be properly costed so that a realistic payment can be negotiated by PSNC.

11 Is our approach to information management and IT in community pharmacy the right one?

11.1 The approach to Information Technology in the *Vision* needs to be totally consistent with the National Programme for IT in the NHS. Pharmacy systems are expected to provide data in a standard format to populate ICRS for every prescription item dispensed and possibly also for other health care services. Consideration for medicines supplied without prescription to be included is also under discussion. Pharmacy systems also need to be able to receive and transmit electronic prescription messages for ETP, as yet unspecified for a national prescriptions service.

11.2 For pharmacists to prescribe either as independent or supplementary prescribers in a safe and effective way they will need access to information about the patient. The type of information required will probably differ, not just by disease but also in relation to the patients themselves just as it does for the GP. ICRS is planned to be in place around 2010. In the meantime other mechanisms for information flow need to be identified.

11.3 The *Vision* appears to assume that all community pharmacy systems work in the same way and to the same level of functionality. In practice this is not true. The development of the new functionality that will be required should be appropriate for the whole of community pharmacy, to ensure uniformity. Historically, allowing the private sector to fund and develop these types of systems has created such diversity both in pharmacy and in the NHS. The NPA welcomes the fact that this is something that the National Programme for IT is now addressing. The issue of who pays for the development of the new systems and infrastructure necessary for pharmacy is fundamental in the negotiation of a new contract and is likely to affect the availability and suitability of IT to enable pharmacists to deliver the *Vision*.

How can community pharmacists help to improve the health of the population and reduce health inequalities particularly for hard to reach communities?

12

12.1 The evidence base for community pharmacy input generally into public health is strong, as shown by the recent reviews on "The contribution of community pharmacy to improving the public's health", commissioned by the RPSGB and PharmacyHealthLink[4]. However, in order to make the most of community pharmacy's contribution to public health, it is essential that economically viable pharmacies are located at the heart of the community in deprived neighbourhoods.

12.2 The NPA welcomes the Government's decision to develop a framework for a pharmacy public health strategy by 2005. This will build on the current role. The NPA also welcomes the opportunity for input to the Chief Pharmaceutical Officer's Steering Committee which has been established to work on the framework.

12.3 However, as part of its response to this consultation, the NPA wishes to make the following points:

- **Community pharmacy must be given the opportunity to engage particularly in the regeneration agenda**

12.4 Community pharmacy services must be considered as an integral part of NHS services when strategic service development plans are developed at local level. Often community pharmacy is thought of as just a funding stream for new premises (particularly within LIFT projects) rather than a provider of NHS services. When considering regeneration, community pharmacy must be kept at the heart of the community for it is in that position it can make the greatest contribution to improving health and reducing health inequalities.

12.5 The Department of Health's own research shows the importance of a pharmacy situated within communities when it cites a pharmacy as one of the three core businesses which make a difference between a viable business community and one that fails. The other two businesses are a health centre and a source of cash – usually provided by a post office. Without these three businesses, the business community declines, reducing access to local services and fresh foods – with an associated reduction in health and wellbeing for local people. Thus, the actual presence of a pharmacy in a community is, in itself, a contributor to the health and wellbeing of the population. The wide range of services provided from that pharmacy is an additional bonus for the community.

12.6 Deprived areas are particularly vulnerable to decline when communities are unsustainable. People from low income households make twice the number of visits to the GP as a high income professional. It is, therefore, likely that the former will also visit the pharmacy at least twice as often. Thus, for both health access and economic reasons, having health services close to home is particularly important in deprived neighbourhoods. All these issues need careful consideration if the full benefit of community pharmacy's contribution to public health and to reducing health inequalities is to be achieved. Consideration must be given to encouraging pharmacists to open community pharmacies in deprived neighbourhoods – by offering a stable and sustainable business proposition, including, for example, deprivation payments for pharmacies, long term contracts, easy access to other sources of funding (such as Sure Start[5] and Neighbourhood Renewal[6]).

12.7 All these issues will best be tackled if community pharmacy is considered and fully consulted when PCTs draw up strategic service development plans.

- **Community pharmacy must be integrated into local authority and PCT planning mechanisms**

12.8 It is important that community pharmacy is consulted and considered on all planning issues at local level. Action has to be taken to ensure this happens because in the past, as previously mentioned, community pharmacy was not regarded as part of main line primary health care. Ways of achieving this include making it a requirement for Overview and Scrutiny Committees to consult or work with LPCs when considering local health issues; or making community pharmacy's contribution to public health part of the NatPaCT competencies, or an indicator in a CHI review; or by ensuring the role of community pharmacy is discussed in practical implementation tools for PCTs such as those currently produced by the Health Development Agency and the National Treatment Agency. In addition, community pharmacy should be involved in local strategic partnerships and public health networks.

The public's expectations of community pharmacy must be enhanced

12.9 Currently, the public mistakenly does not regard community pharmacy as a contributor to improving public health and reducing health inequalities. Pharmacies are often judged by the speed of dispensing rather than any quality measure or wider health service. There is a need for more Government support to promote the community pharmacy as the first port of call for advice on health matters and to inform the public of the contribution community pharmacy can make to the public health agenda.

Consideration should be given to a community pharmacy specialist role in public health

12.10 The *Vision* document makes reference to the development of a scheme to designate "pharmacists with a special interest". Public health would be an ideal specialist role, particularly for those pharmacists situated in pharmacies in deprived areas.

Community pharmacy's role in signposting should be maximised

12.11 One of the essential services envisaged in the new pharmacy contract is that of directing patients to the appropriate other health care providers. Pharmacists will be most effective in this role if they are able to refer people directly to other health care professionals and agencies rather than, as is generally the situation now, through the GP.

References

1 New Economics Foundation. (2003) *Ghost Town Britain: a lethal prescription. The impact of deregulation on community pharmacies.* New Economics Foundation, London. Available at: www.neweconomics.org

2 Department of Health. (2002) *Pharmacy Workforce in the New NHS – Making the best use of staff to deliver the NHS Pharmacy Programme*. A discussion paper. Department of Health Publications, London. Available at: www.doh.gov.uk/pharmacy/workforcediscussion

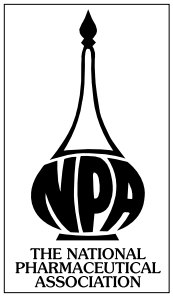
3 Department of Health. (2003) *Choice, responsiveness and equity in the NHS and social care*. A national consultation. Department of Health Publications, London. Available at: www.doh.gov.uk/choiceconsultation

4 C Anderson, A Blenkinsopp, M Armstrong. *The contribution of community pharmacy to improving the public's health: Evidence from the peer-reviewed literature 1990-2001* (Report 1, 2001) PharmacyHealthLink and the Royal Pharmaceutical Society of Great Britain, London.

A Blenkinsopp, C Anderson, M Armstrong. *The contribution of community pharmacy to improving the public's health: Evidence from the UK non peer-reviewed literature 1990-2002* (Report 2, 2003) PharmacyHealthLink and the Royal Pharmaceutical Society of Great Britain, London.

5 Details available at: www.surestart.gov.uk

6 Details available at: www.neighbourhood.gov.uk/nrfund.asp



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