



*A Vision for Pharmacy
in the New NHS*

Foreword

In 2000, we published our programme for NHS pharmacy services, based on NHS Plan principles. Pharmacists are part of our everyday experience of the NHS in the community and in hospitals. We know that patients and the public value the place that pharmacy has within local communities as a readily accessible source of professional help and advice and, often as a first point of contact with the NHS.

I am pleased to have this early opportunity of thanking all those who have contributed to the significant progress made over the past three years in delivering important changes in the way pharmacy services are provided.



These have been achieved at a time of other changes within the NHS – for example, the new role and responsibilities of PCTs. And we are continuing to work with the Pharmaceutical Services Negotiating Committee and the NHS Confederation on the new contractual framework for pharmacists.

It is now timely to move on to the next stage. A *Vision for Pharmacy* highlights success but also looks forward to how we can build on these achievements.

We are committed to ensuring that pharmacy is an integral part of an NHS that provides high quality services, access and choice for all patients wherever they live and wherever they are treated.

We welcome views from patients, the public, the profession and other health professionals and managers on our proposals for the future.

A handwritten signature in black ink, which reads "Rosie Winterton". The signature is written in a cursive, flowing style.

Rosie Winterton
Minister of State

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1 Introduction

- 1.1 In July 2000, the NHS Plan set out our vision of a service shaped around the needs and aspirations of patients – an NHS that offers patients fast, convenient, access to high quality services, informed choice and a real voice in the design and development of healthcare. In September 2000, we published *Pharmacy in the Future – Implementing the NHS Plan*, our programme for pharmacy services that builds on the principles set out in the NHS Plan.
- 1.2 In 2000, we set pharmacy three challenges

Meeting the changing needs of patients

- Ensuring people can get medicines or pharmaceutical advice easily and conveniently
- More support in using medicine;
- Building on the trust and confidence that people place in pharmacists and pharmacy services

Responding to a changing environment

- A more competitive retail environment for community pharmacy
- Arrangements for securing and paying for generic medicines
- Electronic ordering and home delivery

Maintaining professional standards

- Tackling things that go wrong in a modern, open and transparent process
- Professional education and training that meets the needs of tomorrow's world
- Ensuring pharmacists keep their skills up to date.

- 1.3 Good progress is being made in meeting all three challenges but the pace of our NHS reforms has quickened. We have moved towards greater empowerment of frontline professionals and managers to make the best and most effective use of unprecedented resources for the NHS. And the new GP contract will also make a major contribution to achieving further progress in improving primary care services.
- 1.4 In July 2003, publication of the Government's response to the Office of Fair Trading *The report on the control of entry regulations and retail pharmacy services in the UK* confirmed our commitment to competition and choice as important drivers for improving the range and quality of pharmacy services. And we are in discussions on a new contractual framework for community pharmacy with the Pharmaceutical Services Negotiating Committee (PSNC) and the NHS Confederation. A statement on the new contractual framework was published simultaneously with this paper.

- 1.5 These developments have a significant impact on the future shape of pharmacy services. The time is now right to take stock of our plans so that we can build on the achievements of the last three years.
- 1.6 This paper focuses on community pharmacy. This is where most people have daily access to pharmacy services – and where 73% of active pharmacists work. And it is in community pharmacy where our reforms to improve access and the quality of care will have most impact.
- 1.7 But we want to make the best use of the skills of pharmacists and their staff across all sectors. Considerable progress is being made in modernising hospital pharmacy and we are continuing to support this programme. In primary care, too, there has also been significant progress by pharmacists. Working with GPs, they are making an important contribution to the clinical and cost effective use of medicines.
- 1.8 We want to see further progress made in the range of services that pharmacy offers to patients. And we want to strengthen moves towards integrated approaches to pharmacy and medicines management across local health communities – PCTs are well placed to co-ordinate action to remove continuing barriers to better patient care and to drive forward such integration.
- 1.9 And we will continue to work with the Royal Pharmaceutical Society of Great Britain (RPSGB) in its programme to modernise the regulation and development of the pharmacy profession.
- 1.10 An excellent start has been made in implementing the programme for change in *Pharmacy in the Future*. The new vision sets out ways in which we can consolidate action taken and move on to ensure that pharmacy is – and is seen to be – a strong and integral part of the NHS.

The programme 3 Years on: Improving Patient Access

- **Improving patient choice** by making it easier for prescription only medicines to become available over the counter, with greater support for people choosing to care for themselves and their families.
- **NHS Direct referring people to their local pharmacists** where this is the best way of getting the help they need. About 5% of callers are referred to community pharmacies and we expect this to increase. Evaluation shows high customer satisfaction.
- **NHS walk-in centres** also make referrals to community pharmacists where appropriate.
- **Health Promotion and Public Health.** Increasingly, people are looking to their local pharmacist for advice and help on, for example, smoking cessation, emergency hormonal contraception and substance misuse.
- **One stop centres** are likely to include pharmacies. Many modern primary care centres have a pharmacy on site or nearby.
- **Improving out of hours access to medicines.** Further guidance will be published later in 2003. By 2004, most patients will be able to receive their medicines at the time and place of their consultation.
- **Repeat dispensing,** making it possible for patients to get their repeat medication for up to a year without having to contact their GP surgery. Pathfinder sites have been set up in 32 PCTs with more PCTs to implement the scheme in 2004.
- **Electronic Transfer of Prescriptions:** 3 pilot schemes have been completed demonstrating that prescriptions can be transmitted electronically both accurately and securely.

The programme 3 Years On: Helping people get the best from their medicines

- **The medicines management collaborative** already involves **106 PCTs, 10,000 GPs and 480 pharmacies** in schemes that demonstrate innovation and good practice in medicines management. Their roll out across these PCTs will help a potential **20 million people make better use of their medicines**.
- **The community pharmacy medicines management** project is testing a structured intervention programme for people with coronary heart disease, including the review of medicines, discussion of problems with patients and, where appropriate, referral to the GP. Results are expected in 2004.
- **The hospital pharmacy medicines management framework** is helping to ensure that NHS hospitals use medicines effectively in meeting the needs of individual patients.
- **The Medicines Partnership**, based at the Royal Pharmaceutical Society of Great Britain, leads the development of partnerships between patients and health professionals, to achieve better patient understanding of their medicines and more active management of their own care. In October 2003, the Medicines Partnership, together with stakeholders in industry, patient and NHS organisations and the professions, will raise awareness through *Ask About Medicines Week*.
- **Regular medication reviews** are a key principle in the NSF for Older People. Pharmacists are already making a major contribution in improving the care of older people.
- **Other NSFs** (such as diabetes, children's services, renal, and long term conditions) will include guidance on effective medicines management and making the best use of health professionals, including pharmacists, to improve the quality of services and tackle health inequalities.

The programme 3 Years On: Redesigning services around patients

- **Local Pharmaceutical Services schemes** are in place in 10 PCTs with a further 8 PCTs expected to start later in 2003. The next wave of applications is due in September 2003. To date, pilot schemes include:
 - Provision of pharmaceutical services in deprived areas where there is no other healthcare service
 - Improved access to medicines and advice out of hours through integration of pharmaceutical services with other out of hours services
 - Support for patients in taking medicines – for example, older people, patients taking a number of medicines, and those with minor ailments
 - Services for substance misusers
- **Supplementary prescribing**. The legal framework is in place and the first pharmacists will be prescribing by the end of 2003. This is an important step in improving patient care, improving access to medicines and making better use of pharmacists' skills. And an important step towards more flexible team working between health professionals across the NHS.
- **Improving hospital pharmacy services**. Patients can now continue to use their medicines when admitted to hospital. This, together with dispensing for discharge, ensures their medicines are ready on the ward when they go home – reducing delays and reducing waste.
- **Progress towards a new contractual framework** for community pharmacy services
- **The control of entry regulations** reformed and modernised.

The Programme 3 Years on: Ensuring high quality services and getting the most from staff

- **Clinical governance for community pharmacy services**, supported by resources and guidance. We have commissioned the Centre for Pharmacy Postgraduate Education (CPPE) to provide training for pharmacists and clinical governance facilitators.
- **Enhancing the safety of medicines**. Increased pharmacists' reporting of adverse drug reactions, including non-prescription medicines – via the Yellow Card Scheme.
- **The National Patient Safety Agency (NPSA) programme to reduce the level of risk to patients**. Many pharmacists are already contributing to the reporting of errors and lessons learned.
- **Modernising professional regulation** through a major RPSGB programme, including the introduction of mandatory continuing professional development.
- ***Improving Working Lives for the Pharmacy Team*** (2001) – a good practice toolkit to enhance the working lives of pharmacists, pharmacy technicians and other pharmacy support staff.
- **A third more pharmacy students** than ten years ago. Since 1997 with the move to a 4-year degree, a 15% increase in new students – instead of the expected fall. New schools of pharmacy are expected to provide additional graduates from 2007 onwards.
- **Continuing rise in pre-registration places**. Around 50 extra places expected to be commissioned in NHS hospitals for 2003/04 compared to 2002/03. And a planned 25% increase in training places for pharmacy technicians over the same period.
- **The Pharmacy Workforce Planning and Policy Advisory Group**, led by the RPSGB, is scoping future pharmacy needs and advising on the management of supply and demand.
- ***Pharmacy Workforce in the New NHS*** (2002) – proposals for making better use of the pharmacy workforce.

3 Years On: Other developments

- **RSPGB programmes** on registration of pharmacy technicians and the regulation of other pharmacy support staff.
- **Hospital manufacturing**. Initial £4 million capital investment in 2002/03 to start the modernisation process.
- ***A Pharmacy Service for Prisoners*** (June 2003) set out ways of developing more patient focussed, primary care based, pharmacy services for prisoners that meet identified need. With the transfer of funds for prison healthcare to the Department of Health and responsibility for commissioning healthcare for prisoners devolved to PCTs, pharmacy services for prisoners can be expected to reflect NHS pharmacy services and develop in tandem with these in the future.

2 A Vision for Pharmacy

- 2.1 In the community or in hospital, a prescribed medicine is the most frequent clinical service provided for patients. In England, GPs write more than 600 million prescriptions each year and in a typical hospital 7000 doses are given to patients each day. We are investing unprecedented levels of resource to make sure patients get the medicines they need – more than £8 billion in 2001/02. If they choose, people can also buy a range of effective, over the counter medicines to care for themselves and their families, supporting self-care with advice from their pharmacist.
- 2.2 Ensuring that medicines are used safely, that patients get the maximum benefit, and avoiding the wastage of medicines and losses caused by fraud are more important than ever. We are committed to working with pharmacists and other health professionals to achieve these objectives.
- 2.3 We want to see pharmacists and their staff continuing to play a valued – and valuable role – in meeting the everyday healthcare needs of patients. Delivering a service that offers better access and better choice for patients.
- 2.4 Pharmacy is an integral part of the NHS family. We want to see pharmacists strengthening their contribution to the provision of high quality, patient centred NHS services – in community pharmacies, in other primary care settings and in hospitals.

Chief Pharmaceutical Officer's Ten Key Roles for Pharmacy

- 2.5 The traditional pharmacy role continues to be important but changes in meeting patient needs and technological and scientific advances mean that pharmacists will need to broaden their contribution. The following statement supports that wider role for pharmacy services.
- 2.6 We want to ensure that the best use is made of the skills and knowledge of pharmacists and their staff in a broader range of activities. The following are examples of areas where scientific and technological advances and modern pharmacy practice are helping to meet the future needs of patients. The Chief Pharmaceutical Officer has identified ten key roles that underpin the future direction of pharmacy services and its wider role. These should also form the basis of plans for local pharmacy provision.

Pharmacists and Public Health

- 2.7 The public has ready access to pharmacist in the heart of the community. This means that pharmacists are well placed to make an important contribution to improving public health and the wider promotion of health – such as smoking cessation, sexual health, reducing obesity and minimising health inequalities. *Tackling Health Inequalities: A programme for action* highlights the importance of community settings and services in addressing these inequalities, including community pharmacies: www.doh.gov.uk/healthinequalities/programmeforaction
- 2.8 There is considerable scope to build on these achievements. Pharmacists are probably the biggest untapped resource for health improvement. We will explore opportunities to develop and enhance the contribution that pharmacists can make to reducing health inequalities by providing advice on health promotion, health improvement and harm reduction. The new pharmacy contract will reflect the public health contribution of community pharmacists.

- 2.9 And we will work with the professions to develop the important part played by pharmacists as public health specialists, taking a strategic approach to the health needs of their local community and ways of addressing these through the services that pharmacy can offer.
- 2.10 **We will develop a coherent framework for a pharmacy public health strategy that is fully integrated with our overall approach to improving public health by 2005.**

Supplementary and Independent Prescribing

- 2.11 In *Pharmacy in the Future* we said, subject to the development of supplementary prescribing, we would move towards full independent prescribing. The first pharmacists will begin supplementary prescribing later this year. **Informed by emerging experience, we will begin discussions in early 2004 with the professions, patient organisations and the NHS to develop a framework for independent prescribing by pharmacists.**

Diagnostics and Monitoring

- 2.12 There is further scope for pharmacist involvement in diagnostics and monitoring. Scientific advances, particularly the new genetic knowledge, are revolutionising diagnosis and therapy. The genetics white paper *Our Inheritance, Our Future* published in June 2003 (www.doh.gov.uk/genetics/whitepaper.htm) identifies the potential for the choice and dose of medication to be tailored to a person's genetic make-up. A suitably trained pharmacist, supported by genetic testing facilities, could select the best option. And some pharmacists may wish to develop a special interest in genetics, providing advice on pharmacogenetics to the local health community.

Medicines and pharmacy within NSFs

- 2.13 National Service Frameworks set standards and help reduce unacceptable variations in service quality. We are committed to ensuring that emerging NSFs address the effective use of medicines as an important and integral part of high quality patient care. In developing the diabetes, renal, and long term conditions NSFs, we are drawing together existing guidance and good practice to provide practical support on medicines management. And the Children's NSF will highlight the role of community pharmacists in supporting and advising parents and children on self-care for minor ailments. Hospital pharmacists, in promoting the safe and effective use of medicines, also make an important contribution to the care and treatment of children. Pharmacists in all sectors, working as part of the clinical team, have an important role in ensuring consistent standards of care across the NHS.

PCTs and Primary Care

- 2.14 In primary care, pharmacists are increasingly active in promoting the clinical and cost effective use of medicines and in managing the entry of new drugs, including those covered by National Institute for Clinical Excellence (NICE) guidance – services traditionally provided by hospital pharmacists. Many pharmacists are working proactively with GP practices to influence prescribing, in undertaking medication reviews for targeted patients, and managing services such as hypertension clinics.
- 2.15 PCT pharmaceutical advisers make a significant contribution to local prescribing strategies. In addition, they are involved in commissioning drug treatments, including for specific groups of patients such as those with cancer and multiple sclerosis. Increasingly they are working with hospital chief pharmacists and community pharmacists to plan local pharmacy services. They will have a key role in the effective implementation of the proposed new community pharmacy contractual framework.

CHIEF PHARMACEUTICAL OFFICER'S 10 KEY ROLES FOR PHARMACY

- To provide convenient access to prescription and other medicines
- To advise patients and other health professionals on the safe and effective use of medicines
- To be a point of first contact with healthcare services for people in the community
- To provide medicines management services, especially for people with enduring illness
- To promote patient safety by preventing, detecting and reporting adverse drug reactions and medication errors
- To contribute to seamless and safe medicines management throughout the patient journey
- To support patients as partners in medicines taking
- To prescribe medicines and to monitor clinical outcomes
- To be a public health resource and provide health promotion, health improvement and harm reduction services
- To promote value for money in the use of medicines and to reduce wastage

3 Community Pharmacy

3.1 Community pharmacy should

- Be – and be seen to be – an integral part of the NHS family in providing primary care and community services
- Support patients who wish to care for themselves
- Respond to the diverse needs of patients and communities
- Be a source of innovation in the delivery of services
- Help deliver the aspirations within National Service Frameworks
- Help tackle health inequalities

3.2 In achieving these objectives, community pharmacy has two huge assets. The skills, expertise and experience of community pharmacists and support staff and its presence in the community with a tradition of ready access to all – with around 6 million people visiting community pharmacies every day.

A clear NHS identity

3.3 But too often community pharmacy is seen as separate from the NHS, as part of the retail sector rather than as a vital element of healthcare delivery. Yet 80% of the average pharmacy's business is derived from the NHS.

3.4 Perceptions are important. Introducing the NHS identity to pharmacies providing NHS services will help the public to identify these as an integral part of the NHS and as an access point to a range of NHS services. We are exploring ways to help pharmacies use the NHS logo.

Planning and Delivery of Local Services

3.5 But we want to see far more than symbolic change. We want to see community pharmacy fully engaged with PCTs in the planning and delivery of local services. And those services should be more clearly integrated with the work of other primary care professionals – particularly GPs. This can be achieved in a number of ways. Community pharmacists can make a valuable contribution as members of PCT professional executive committees. PCTs can also encourage the greater involvement of community pharmacists in drawing up local development plans.

Improving Access to Non-prescription Medicines

3.6 The traditional role of pharmacies as a readily accessible source of advice and medicines continues to be an essential part of our overall vision for primary care. **We intend to enhance this role by continuing to expand the range of medicines which pharmacies can supply without a prescription.**

The availability of a wider range of effective over the counter medicines, in a safe environment with access to professional advice, will increase patient choice, support improvements in public health, and make fuller use of pharmacists' professional skills and knowledge.

Community Pharmacy: Essential Services

3.7 We also want to see community pharmacies providing a greater range of services. As set out in the statement on the proposed new contractual framework, there are some essential services that we expect to see generally available through pharmacies, such as

- Dispensing
- Repeat Dispensing
- Disposal of medicines
- Promotion of healthy lifestyles
- Promotion of self-care for patients with minor ailments
- Signposting for patients to other healthcare provision

All pharmacies would be required to put in place clinical governance systems and support continuing professional development

Community Pharmacy: Enhanced Services

3.8 The provision of enhanced services will require the accreditation of the pharmacist – usually with additional training – to provide the service. Enhanced services might also encompass quality measures relating to pharmacy premises such as a consultation area. There is an early focus on medicines review but other services might be included once accreditation standards are set

Community Pharmacy: Additional Services

3.9 A wide range of services are continuing to be developed locally by pharmacists and PCTs to meet identified need and to improve patient care. These include:

- Supply of medicines under patient group directions to improve access to care such as emergency hormonal contraception and smoking cessation
- Monitoring of patients and recommending alteration of doses. For example, for people taking medicines that require careful monitoring such as warfarin or lithium
- Medication reviews where there is clinical need. For example, as required in the Older People NSF, for patients taking a complex range of medicines, or for people with specific conditions such as coronary heart disease.
- Free supply of medicines for minor ailments, where significant numbers of patients consult their GP, which eases unnecessary burdens on GPs, improves access and is more convenient for patients.

- Medicines management support for people who experience difficulty with their medicines, for example with poor compliance or side effects. And this might include home visits to help people with their medicines.
 - Supplementary prescribing within an agreed clinical management plan, particularly for people with enduring conditions such as asthma, hypertension or diabetes
 - Smoking cessation services – with PCTs commissioning appropriately trained pharmacists to provide one-to-one advice.
 - Diagnostic or monitoring services, for example for hypertension or diabetes, as part of an integrated local service.
 - Substance misuse services, for example, needle exchange schemes and supervised consumption.
- 3.10 We want to encourage such developments through the new contractual framework. As well as nationally determined essential and enhanced services, we want to facilitate local PCT commissioning of additional services. For some additional services, we expect to specify actions and outcomes within the new contractual framework. This will help those PCTs, who have not already done so, to commission services locally and to develop other services that meet specific needs.
- 3.11 There are some local, additional, services that we would not expect to see provided everywhere. Indeed, some might be provided relatively rarely, by pharmacists with expertise in a particular service and where the PCT determines a need for such a service. **We will consider with the PSNC and the NHS Confederation as part of our discussions on the new contractual framework, a scheme to designate ‘pharmacists with a special interest’ so that those providing services using particular expertise can be appropriately recognised.**
- 3.12 Other additional services will be provided more widely, capitalising on the ready accessibility of pharmacies. However, all additional services will have the common feature of making better use of the skills and experience of pharmacists.

Innovation and responsiveness

- 3.13 We want to see community pharmacy continuing to be a source of innovative and responsive services for patients. That is why the new contractual framework will be flexible, allowing the updating and revision of service requirements and standards of provision. The content of each category may be adjusted – for example, with services moving from being “in the local” “additional” category to the “essential”.
- 3.14 The extent to which particular services are provided will vary from one place to another. The focus of pharmacy provision may be the health needs of a particular ethnic group, or older people or young mothers living in areas of poverty and deprivation. Or the focus might be on improving access to services where there are difficulties in getting to a doctor’s surgery; on serving local residents; or providing services to those who visit an area to work or shop.
- 3.15 Some areas may have integrated primary care services where pharmacists work alongside GPs and practice nurses to provide advice and to help patients with their medicines. In others, the local pharmacy may be the most accessible and convenient place for people to call in to discuss any health problems. Pharmacy services need to be as diverse and flexible as the communities they serve.

- 3.16 Some community pharmacies may choose to focus their services on the provision of highly efficient dispensing services. The hospital sector has shown that – with proper procedures and professional accountability – much dispensing can be carried out by technicians. By relieving other pharmacies of dispensing workload, such pharmacies will contribute to freeing up the time of pharmacists to undertake new roles. This is a welcome contribution to a diverse network of NHS community pharmacy provision.
- 3.17 The successful community pharmacy of the future will actively consider how it can contribute to meeting health needs and tackling health inequalities. It will help identify priorities for the PCT and demonstrate why and how these can be met through improved local services. And it will work closely with other health professionals to improve patient care.

4 Hospital pharmacy

“Medicines management in hospitals encompasses the entire way that medicines are selected, procured, delivered, prescribed, administered and reviewed to optimise the contribution that medicines make to producing informed and desired outcomes of patient care”

Audit Commission 2001: *A Spoonful of Sugar*

- 4.1 Hospital pharmacists are responsible for ensuring medicines are used safely, effectively and economically. They also have a key role in the effective communication of patients’ treatment when they are admitted to or discharged from hospital.
- 4.2 We want to see trust Chief Pharmacists delivering these responsibilities as part of a trust’s senior clinical and management structure and strengthening their strategic role in contributing to the better use of medicines across the local health community.
- 4.3 In hospital pharmacy, best practice is characterised by optimal use of staff, skill mix, robotics and information technology, enabling pharmacists to devote the bulk of their time to direct patient care, underpinned by efficient systems for the procurement and supply of medicines.
- 4.4 Hospital pharmacists have moved towards increasing integration into clinical teams and are continually developing specialised clinical roles. And there is active engagement with improving patient safety, the implementation of clinical guidelines and NICE guidance, and managing the economics of hospital prescribing. However, practice remains variable and more work is needed to ensure pharmacy services in all hospitals reach the standards of the best. Patients are entitled to expect the same high standards from medicines and pharmacy services regardless of where they are treated.

Hospital Medicines Management

- 4.5 Later in 2003, **we will be launching the second edition of our hospital medicines management framework.** This draws on experience since 2001 and will provide a tool for hospitals to assess their progress.
- 4.6 *Pharmacy in the Future* made clear our intention to set up a national collaborative programme to spread and share best practice. We have broadened the scope of the national medicines management collaborative to encourage fourth wave bids to explore the further improvements that can be made through partnerships between PCTs and local hospital trusts. In particular, focussing on the self-administration of medicines, using patients’ own drugs, dispensing for discharge and better communications about medicines. **We will also look at the collaborative to see how it can further support hospitals in developing their specific contribution to medicines management.**

Working across the health community

- 4.7 There is a need for greater flexibility in delivering pharmacy services to patients across primary and secondary care. Local pharmaceutical services (LPS) pilots are already delivering services to patients in novel ways. For example, community and hospital pharmacists are working together to support older patients discharged from hospital needing help with their medicines. A number of community pharmacists also provide advice and assist care homes in establishing and implementing best practice for medicines management.
- 4.8 More work is needed to strengthen communications between hospitals, community pharmacists and GPs about patients' medicines. Improving information flows will benefit patients, help reduce medication errors and reduce wastage. We look to trust chief pharmacists to work closely with PCTs, community pharmacists and GPs in developing shared ownership of the medicines agenda. Some localities, for example Peterborough, have appointed a joint chief pharmacist to the acute trust and PCT.
- 4.9 As in community pharmacy, we see the successful hospital pharmacy actively looking at innovative ways of meeting patients needs and making a stronger contribution to the development of local health strategies. It should work to deliver both improved medicines management and to develop specialised clinical services across traditional boundaries.

Antimicrobial Prescribing

- 4.10 Hospital pharmacists are active in promoting the rational use of antimicrobial agents to prevent and treat infections. We recognised their contribution in *Getting Ahead of the Curve* (2002) – our strategy for combating infectious diseases – www.doh.gov.uk/antimicrobial-resistance/keydocs
We are investing £12 million over the next three years specifically to build on pharmacists' present involvement in antimicrobial prescribing and usage, so helping to ensure that these drugs are used prudently and monitored to reduce the hazard to public health posed by microbial resistance.

Hospital Manufacturing

- 4.11 Hospital pharmacy has a traditional role in the procurement, manufacture and supply of medicines for patients. It is important not to neglect these essential, underpinning, functions. **Over 2002 –2006, we are taking forward a major programme of investment and reform of hospital manufacturing and preparation of medicines.** This programme, supported by unprecedented resources of £46 million, represents the largest ever capital investment in hospital pharmacy and will help secure NHS capacity to provide essential medicines – particularly specialised products not available commercially – for patients. Chief Pharmacists and hospital managers will help deliver a modern manufacturing service with the highest quality standards. The implementation plan is available at www.doh.gov.uk/hospitalmanufacturing/index.htm

Harnessing New Technology

- 4.12 Hospital pharmacists are active in using modern technology and we see this trend accelerating. Automation and modern information management will improve patient safety, increase efficiency, and enable pharmacists and their staff to focus on delivering clinical services and more direct patient care.

- 4.13 Many of the future developments and opportunities for hospital pharmacy will be enabled by harnessing new technologies. Automation and robotics will remove the burdens of mundane and repetitive tasks and release time for more direct patient care. The continuing development of hospital pharmacy services, including specialist clinical pharmacy, the introduction of supplementary prescribing and the bridging of medicines management across local health communities will all be underpinned by the use of modern technology.

5 Making the Vision a Reality

5.1 To make the vision a reality, we need

- Effective and appropriate arrangements for managing and paying for the work that pharmacy does for the NHS
- More staff working in different ways
- Better information management and technology
- A robust supporting infrastructure and
- Strong professional leadership

Managing and Paying for Community Pharmacy

5.2 The framework for the new contract reflects our vision for a diverse, flexible community pharmacy sector. Although built around a national core service, the framework offers choice to PCTs in the services they commission from community pharmacy to meet local needs and priorities. The framework is flexible, allowing for development over time, and it sits alongside LPS. This, in turn, allows for even greater flexibility, enabling PCTs to have more influence on the delivery of pharmacy services – for example, in or around new primary care developments or in response to gaps in service provision. It is PCTs – not the centre – that make decisions about services; and these must be services that count and really matter for local people. The contractual framework supports discussions to provide community pharmacy services that meet needs today and tomorrow.

5.3 In the future, we believe the way in which pharmacy services are funded, managed and paid for should fully support the new contractual framework and local arrangements. With publication of the framework, the Department of Health, the NHS and community pharmacy need to consider together whether the current system continues to reflect the most appropriate approach.

5.4 At present, community pharmacy receives the vast majority of its funding from the centre via PCTs. £800 million – or an average of £70,000 – goes in fees and allowances to each NHS pharmacy for the services it provides. The cost of the medicines dispensed by community pharmacies is met from PCTs' unified budgets. However, this is only one element – albeit a critical one – of community pharmacy services. With the introduction of LPS, which is also funded from unified budgets, for the first time PCTs have the opportunity to assess fully the value and cost effectiveness of the services provided.

5.5 Within this vision for the future, we ask whether those pharmacy costs that are paid for by the centre should transfer to PCTs' budgets. There may be distinct advantages. It would

- give PCTs a direct financial interest in the value of all the services community pharmacies provide for patients.

- encourage community pharmacies to focus more clearly on their total service provision – on its efficiency and effectiveness. This would be wholly in line with the statement of 10 key roles for pharmacy which calls on all pharmacists to promote value for money in the use of medicines.
- reinforce community pharmacy as an integral part of NHS provision.

- 5.6 Consideration of the future funding of pharmacy services also raises a further important issue. The “terms of service” for community pharmacies are at present set out in regulations, and therefore determined by the Secretary of State. In practice, the responsibility for ensuring that pharmaceutical services are provided lies with PCTs. However, LPS schemes are set out in contracts between PCTs and community pharmacies. Where PCTs commission additional services, these too are set out in contracts. If, in future, NHS pharmacy costs were to switch to being fully met by PCTs, it appears sensible to consider whether the national “terms of service” should continue in their present form or also be subject to contracts. The centre would continue to set minimum standards and safeguards, as already happens with LPS, and with other aspects of NHS primary care provision.
- 5.7 Both the above developments reflect changes that are already occurring in relation to doctors and dentists. Implementation would require primary legislation and, therefore, would be unlikely before 2005. And any change will follow implementation of the proposed new contractual framework – which we hope to begin to introduce from April 2004. We recognise that this would represent considerable change but take the view that these developments are consistent with changes to the management and funding arrangements across primary care that have or are already taking place. We would like to discuss these possibilities in more detail with community pharmacy representative bodies and the NHS. And, for them, it is important that there is an opportunity to consider these proposals and to seek views from their members.
- 5.8 Local Pharmaceutical Services are still at an early stage of development, compared with Personal Medical Services. As primary care develops in new ways, a further question arises on whether there should be a new form of contract that will cover both medical and pharmaceutical services (and, possibly dental services). This could offer the prospect of a more integrated service delivery and a better patient experience.
- 5.9 Our view is that it is maybe too soon to be considering this but that we should not miss the opportunity to look at it again when the time is right. This might involve combining PMS and LPS schemes once LPS has moved beyond the pilot stage. In the case of LPS, this cannot be until the current schemes have been running long enough for a view to be taken on whether this is desirable. **We shall therefore consider this in more detail by the end of 2004.**

More staff working in different ways

- 5.10 Analysis, drawing on the recent RSPGB pharmacy workforce census, confirmed a shortage of pharmacists, with heavy reliance on locum pharmacists and on pharmacists older than the normal retirement age, especially in community pharmacy. Although the number of pharmacists in training is increasing, and new schools of pharmacy are opening, it takes 5 years, including a one year pre-registration placement, to train pharmacists. Significant growth in the pharmacy workforce will take time.
- 5.11 And in response to developments, new roles for pharmacists are emerging constantly, further increasing demand. We must therefore make better use of the available workforce.

Making better use of skill mix

- 5.12 In doing so, we must not lose sight of the importance of the pharmacist's traditional role. And it is clear from National Patient Safety Agency pilot work that pharmacists play a vital role in protecting the public. This will continue. But we also need to be very clear about where a pharmacist's personal role adds value, and where there is scope for work to be carried out by others.
- 5.13 A pharmacist has professional and legal responsibility for everything that goes on in the pharmacy – whether as a pharmacy superintendent, manager, owner, or trust Chief Pharmacist. This will continue.
- 5.14 In September 2002, *Pharmacy Workforce in the New NHS* prompted discussion on making better use of the pharmacy workforce. Its principles received broad support from organisations and individuals. Most respondents welcomed our proposal to increase the role of technicians, including the ability, under certain circumstances, to dispense and sell medicines in the absence of the pharmacist.
- 5.15 Since then, the RPSGB has announced its intention that all technicians should be registered from January 2007, with voluntary registration from 2005. We support this move, which is a clear indication of the responsible role which properly trained pharmacy technicians are qualified to undertake, and the prospect of registration makes us even more confident in proposing changes to the current arrangements.
- 5.16 Recognising that patient safety must remain paramount at all times, we propose
- The pharmacist retains overall responsibility for ensuring that appropriate procedures for dispensing and sale of medicines are in place, including arrangements for checking the appropriateness of the prescription and providing advice to patients or carers at the time the medicines are dispensed or supplied.
 - That, at all times, a registered and appropriately qualified technician need not be supervised personally by a pharmacist. However, there will need to be a pharmacist with responsibility for each pharmacy, and who is contactable and able to advise at all times.
- 5.17 **We will consult formally on the details of this proposal by early 2004, including the additional qualifications, over and above registration with the RPSGB, which might be required for technicians who work in this setting. This will also take account of any necessary legislative changes.**

Agenda for Change

- 5.18 Hospital pharmacy has made great strides in developing the workforce and expanding the role of support staff. *Agenda for Change* rewards staff, taking on extra responsibilities and acquiring new skills, with incentives to change traditional ways of working in order to improve patient care. Recognising the concerns raised by the profession, **we will use the early implementation sites to test out and refine the application of the job evaluation scheme to pharmacists, pharmacy technicians and other pharmacy staff.**
- 5.19 Pharmacists are successful in developing clinical and specialist roles in hospitals. **We want to build on this success through the establishment of consultant pharmacist posts.** These will enable clinical excellence and leadership to be recognised. Consultant pharmacists may be supplementary prescribers or become independent prescribers or other clinical specialists. They should support medicines management in hospitals and play a leading role in training pharmacists and other health professionals locally. They should also be well placed to influence the use of medicines across the wider local health community.

Training Capacity

- 5.20 In increasing training places for pharmacists and pharmacy technicians, we need to ensure there is adequate capacity to deliver these programmes properly. In particular, the need to deliver the necessary clinical teaching within undergraduate pharmacy courses and to secure sufficient pre-registration pharmacy trainee and student pharmacy technician places. All pharmacy employers have a responsibility to support the training of tomorrow's pharmacists and pharmacy staff. We will ensure that pharmacy is played fully into the work on practice placements that is underway following the review of the Multi Professional Education and Training levy. And we will continue to discuss how best to maximise training capacity with key stakeholders such as providers of education and training, funding bodies, employers and the regulatory body.

Professional Development

- 5.21 The Centre for Pharmacy Postgraduate Education (CPPE), based in Manchester, supports community pharmacists in a number of ways through workshops, distance learning and increasingly through e-learning. The CPPE has also extended its programme to hospital and prison pharmacists and, in the future, is also looking to support pharmacy technicians.
- 5.22 The NHS University First Contact Programme aims to broaden health professionals' skills to include assessment and diagnosis in support of minor ailment services. We expect some pharmacists to come forward to join this programme.

More Efficient Dispensing: Using Patient Packs

- 5.23 The increased use of patient packs offers potential support in the delivery of two key aims – getting the most from the skills and experience of pharmacists and ensuring that patients get the best from their medicines. We support their use but have reservations about the appropriateness, practicalities and costs of moving to a situation where complete packs are the only form in which medicines are prescribed by doctors or dispensed in community pharmacies.
- 5.24 Therefore, we intend to build on the package of measures outlined in August 2002 in the Medicines and Healthcare Products Regulatory Agency's consultation document (MLX285). We are considering rounding from 28 to 30 or vice versa. We will ask the National Prescribing Centre to explore with key prescribing stakeholders those areas where it would be possible to make an early move to rounding.
- 5.25 This will inform discussions with the PSNC on simplifying the rules governing the reimbursement of medicines. We will also ask the National Prescribing Centre to recommend ways to support prescribing in full packs, where this is appropriate. We will then consider what, if any, statutory changes are necessary and how we can best support prescribers, pharmacists and PCTs in implementing those recommendations.

Information management and technology

- 5.26 As members of clinical teams, hospital pharmacists have access to patients' medical records in hospital. This access enables informed decisions to be made about individual patient's medicines.
- 5.27 Almost all community pharmacies keep records of the medication dispensed to individual patients. But these records are confined to the dispensing activity of that individual pharmacy or, where patients

consent, to the branches of a pharmacy group. Many patients regularly use the same pharmacy, but others do not. Even where patients do use the same pharmacy they may well change when they move home, or visit another pharmacy while they are on holiday.

- 5.28 As community pharmacy expands, the healthcare services it provides (such as medicines use review, supply of medicines under minor ailment schemes and patient group directions), it may need access to more healthcare information about a patient to be able to provide a safe, effective, service. It may also be important that other health professionals are aware of any intervention or supplies that may have been made by the pharmacist. This sharing of information will offer important benefits to patients, improving safety of medicines and by enabling contra-indications, adverse reactions, and other potentially harmful circumstances to be identified wherever medicines are dispensed, supplied, monitored or sold.
- 5.29 The sharing of patient information is sensitive and there will be concern by some people at the prospect of community pharmacist having access to all or part of their NHS records. As with other healthcare professionals, community pharmacists are bound by their Code of Ethics to respect patient confidentiality. (Similar requirements will apply to pharmacy technicians once they are registered.) With the development of shared records, there are further issues to be addressed around ensuring patient consent is obtained and confidentiality is maintained during data access and transfer.
- 5.30 Any personal information given or received in confidence for one purpose may not be used for a different purpose or passed to anyone else without the consent of the person providing that information. However, this should not inhibit the exchange of patient information between health professionals – as long as certain safeguards are applied to its use.
- 5.31 A key principle in sharing patient information is that health professionals only access the information they need to carry out their role in healthcare provision for a patient safely and effectively. We will be discussing with key stakeholders the need for pharmacists to access and share relevant information with other health professionals. **We will then be consulting on elements of patient information that community pharmacists may need to deliver appropriate healthcare services as part of their new contractual framework.**
- 5.32 As part of the National Programme for Information Technology in the NHS, an Integrated Care Record Service (ICRS) will be created. All patients will have a common electronic record with information and events that inform individual care decisions about patients. This will be complemented by detailed health records in local systems. We will use our discussions with stakeholders and consultation to inform whether, subject to complying with NHS security and confidentiality standards, the common record could be used to enable community pharmacists to have access to required information. The level of access would depend on the healthcare service to be provided.
- 5.33 Pharmacists acting as supplementary prescribers must share access to the same common patient record as the independent prescriber. Further ways in which IT can support this may need to be considered.
- 5.34 IT can also help relieve burdens on pharmacists and their staff; increase safety and increase convenience for patients. For example, at present much of the information on a prescription form has to be re-entered by community pharmacy staff on their computer systems to update their records and produce a dispensing label. This offers potential for errors. It is also time that can be better spent. Therefore, subject to supporting regulatory changes, we will be pressing ahead with arrangements for the electronic transmission of prescriptions – increasing patient safety and freeing up time.

- 5.35 There will also be increased convenience for patients who will no longer have to visit or make arrangements for the collection of their repeat prescriptions from their GP surgery. This will also provide the opportunity for more flexible repeat dispensing so that patients will no longer need to return to the same pharmacy for the lifetime of their prescription.
- 5.36 The ability to receive prescriptions electronically, requires community pharmacies to have computer systems that comply with certain standards and have appropriate mechanisms of connectivity. We will also want this connectivity to bring other benefits such as access to the Internet and e-mail. It will improve communications with pharmacies – for example, public health alerts – improve access to information such as the national electronic library for health, and enable pharmacists to contribute to the work of the National Patient Safety Agency and the Medicines and Healthcare Products Regulatory Agency.

Supporting infrastructure and professional leadership

- 5.37 The vision for pharmacy is a challenging one for pharmacists and for NHS organisations. Provision of the right support and leadership is vital to its success. In *Shifting the Balance of Power*, we placed PCTs firmly in the driving seat in delivering NHS reform. They are at the forefront in the commissioning and delivery of services. PCT pharmaceutical advisers and pharmacist members of PCT professional executive committees have a key role in taking this work forward.
- 5.38 More recently, the Department of Health has begun a change process to ensure that its focus is on framing key policies. As the local headquarters of the NHS, Strategic Health Authorities (SHAs) work with PCTs in managing the quality of prescribing and securing value for money from the £8 billion we spend on medicines each year. And SHAs can promote and encourage the strategic direction for changes in pharmacy set out in this vision paper.
- 5.39 To date some, but not all, strategic health authorities have appointed pharmaceutical advisers. We look to all SHAs to set in place arrangements for securing high-level pharmaceutical advice to support this continuing programme for pharmacy services, including the need to encourage pharmacists to take a more strategic approach to the health needs of their local community.
- 5.40 The National Prescribing Centre (NPC) based in Liverpool, supports NHS organisations, particularly on prescribing and medicines management issues, but also on wider pharmacy practice matters.

6 Conclusion

- 6.1 This paper sets out our vision for pharmacy for the years ahead. It rightly celebrates pharmacy's successes – achievements since publication of *Pharmacy in the Future* in 2000. During this time, there have been other far-reaching changes in the NHS and it is both timely and appropriate to look again at the future shape and direction of pharmacy.
- 6.2 In doing so, it is important that all those concerned – patients, the wider public, the profession and others working within the NHS – are able to inform and contribute to that vision. Below are a number of questions that we have drawn from the proposals set out in *A Vision for Pharmacy*. We hope that these will encourage further thinking about pharmacy today and ways in which this might develop in the future. We welcome responses to these questions but those responding may also wish to comment more widely.
- 6.3 However, we believe that there are certain roles and functions within pharmacy that should not change. We fully recognise that pharmacists are skilled health professionals providing expert advice and support in making the best use of medicines. Patients and the public place a high level of trust and confidence in pharmacists' knowledge and skills. The value of their role within the NHS cannot be overestimated and that must be retained.
- 6.4 But pharmacy can – and in many places already does – provide an ever-growing range of services and these, too, have a central part in the modern NHS. In this way, pharmacists contribute to improving patient services and, at the same time, take the opportunity to make better use of their skills and deploy these to better effect.
- 6.5 Community pharmacies are not just another shop on the high street or in the retail centre. We believe they should be clearly seen as places where patients are able to access readily an increasing range of healthcare services. They are a valuable resource for improving health and reducing health inequalities, especially for vulnerable and deprived populations. Community pharmacy can offer a fulfilling career for pharmacists and their support staff, attracting future generations of young people to the profession and encouraging those who have left to return.
- 6.6 Community pharmacy will need to make changes in order to provide the services that patients and the new NHS want and need. And it will do so in a more competitive retail environment. In doing so – and we are confident that it will – it will be fairly rewarded.
- 6.7 Hospital pharmacies are continuing to develop the specialised services that patients need, through the use of modern technology, the innovative and imaginative use of staff skills and the increasingly important role of specialist pharmacists, and through influencing effective and efficient medicines management strategies across local health communities.
- 6.8 More than ever, the last three years has demonstrated the unique and valuable contribution that pharmacy makes to patient care. We believe pharmacy's full potential is only now beginning to be realised. We believe it has the resources, the capability and the desire to go even further in the years ahead.

We have drawn the following questions from the proposals set out in this paper. We welcome your response to these questions but if you wish to comment more widely, please do so. We look forward to hearing from you by 17 October 2003. Your response can be sent to

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

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

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

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

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?

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

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

In what ways can good practice in medicines management and service provision be shared between individual hospitals?

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

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

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

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



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32646/A *Vision for Pharmacy in the New NHS* can also be made available on request in Braille, on audio cassette tape, on disk, in large print, and in other languages.