

## Fair Playing Field – for the benefit of patients

### Royal Pharmaceutical Society response

The Royal Pharmaceutical Society (RPS) is the professional body for every pharmacist in Great Britain. We are the only body that represents all sectors of pharmacy in Great Britain.

The RPS leads and supports the development of the pharmacy profession within the context of the public benefit. This includes the advancement of science, practice, education and knowledge in pharmacy. In addition, it promotes the profession's policies and views to a range of external stakeholders in a number of different forums.

Its functions and services include:

**Leadership, representation and advocacy:** promoting the status of the pharmacy profession and ensuring that pharmacy's voice is heard by governments, the media and the public.

**Professional development, education and support:** helping pharmacists to advance their careers through professional advancement, career advice and guidance on good practice.

**Professional networking and publications:** creating a series of communication channels to enable pharmacists to discuss areas of common interest.

The RPS welcomes this opportunity to provide our initial thoughts on a fair playing field and we plan to develop a substantive response to the second part of your review process.

Pharmacists are the experts in the use and optimisation of medicines. The prescribing and supply of medicines is by far the most frequent intervention made within the NHS. The expenditure on medicines dispensed through community pharmacy continues to increase with the total spend in 2009 of over £8.5 billion<sup>1</sup>. The cost of medicines is the greatest area of expenditure, following staff costs, within the NHS. Pharmacists can not only make significant savings to the prescribing budget but can also help ensure that patients understand and take their medicines in an appropriate manner. This will reduce the amount of medicines wasted as well as the number of unplanned admissions to secondary care caused by patients not taking their medicines correctly. Pharmacists have ensured the quality, safety and efficacy of medicines within the NHS for many years and this should be a central aspect of the Quality, Innovation, Productivity and Prevention (QIPP) agenda. The Bow Group report '*Delivering Enhanced Services in a Modern NHS: improving Outcomes in Public Health and Long Term Conditions*' concludes that "*enhanced pharmacy services are an under-utilised resource that can deliver innovative, cost-effective services to patients in a highly accessible manner, whilst facilitating the NHS to achieve its QIPP objectives*".

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<sup>1</sup> Data taken from NHS Information Centre

## **1. Corporation and value added tax**

**1.1:** Currently items that are purchased and dispensed to patients via a community pharmacy are not subject to VAT. Conversely, medicines purchased and dispensed to patients are subject to VAT. This is clearly inequitable and is having a direct affect on commissioning patterns and the provision of care.

**1.2** In the last two or three years many hospitals have significantly increased the provision of services provided in patients' homes. Again, the main driver for this is the inequitable application of VAT outlined in 1.1. We fully support the recommendations made in the Hackett Report<sup>2</sup> and are keen to support and assist their implementation.

## **2. Information and IT**

**2.1** For all providers to be able to provide an equitable service they all require access to relevant information about the patient. Currently, community pharmacy has no access to a patient's electronic record and in hospital pharmacy access is varied and mainly reliant on having web-based systems in place. This places pharmacists and other healthcare providers at a serious disadvantage when tendering for services as a qualified provider. All qualified providers must have the same access to data and the same level of support to provide services.

**2.2** Appropriate access to enabling technology for all providers would ensure more consistent care and improve patient safety. All relevant healthcare professionals should have appropriate access to patient records to inform their discussions with patients and to update the record with decisions made that affect subsequent treatments by other practitioners. It is possible that access to all relevant patient information could be set out as a condition of providing care. The information provided to people to enable them to make informed decisions needs to be comparable and provided in a variety of ways e.g. electronically, paper based. It needs to be understood by patients and the public so that they can make informed choices.

**2.3** Additionally, community pharmacy may hold significant patient information of key interest to other practitioners such as general practitioners. It is essential this information is integrated into a centrally held patient record to ensure the provision highest levels of patient safety and care and also reduce costs to the NHS.

## **3. Costs of capital**

**3.1** While we support the principle of the 'any qualified provider' model there must be a level playing field for all providers, with equal opportunities for all and an understanding of the different cost models in place for all providers. Many private sector healthcare providers invest in equipment and training to deliver a service and require a long enough period of time in any specific contract to ensure that initial capital outlay is recouped.

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<sup>2</sup> <http://cmu.dh.gov.uk/homecare-medicines-review-group/>

#### **4. Tendering and commissioning behaviours**

**4.1** The RPS is concerned about the lack of scrutiny built in to the new systems for commissioning local services. The RPS feels there must be clearer division between commissioners and providers. It will be crucial to ensure that that all GP commissioners have the required expertise and patient-centred multidisciplinary input to commission effectively.

**4.2** Care pathways need to be developed that include all the relevant professionals and providers. There need to be systems in place that compel providers to work together.

Changes to the national contracts for professions should be considered to incentivise and promote new methods of collaborative working.

**4.3** It should be a requirement for Clinical Commissioning Groups (CCGs) to deliver against the relevant Joint Strategic Needs Assessment (JSNA). We believe that a reduction in health inequalities must be a priority for local NHS services and the NHS as a whole. There must be robust and meaningful input from patients and other health and social care professionals (as well as GPs) in the development of NHS systems and processes. The RPS accepts that absolute fairness is impossible to achieve in a system where funds and services will be limited. However, we are concerned that the NHS reforms could significantly disadvantage some groups. We entirely support the principle of local decision making based on locally –assessed need. However, we wish to flag up the risk of a so called ‘postcode lottery’ emerging as decision making moves from 152 PCTs to approximately 210 CCGs within the revised NHS architecture.

**4.4** Specialist pharmacy services are in general, commissioned across large geographical areas and several different organisations. We are concerned that they won’t be continued as part of the NHS reforms as the current focus promotes localised commissioning. Pharmacy specialist services include the delivery of medicines information, pharmaceutical quality assurance and medicines usage and safety are currently commissioned across Strategic Health Authorities (SHAs). These services deliver expert advice and high-level support for the commissioning, provision and assurance of complex or novel medicines-related services for NHS patients. There is experience of commissioning specialist pharmacy services through a specialised commissioning mechanism for 4 out of the 10 SHAs in England. The NHS Commissioning Board (NHSCB) potentially offers a mechanism to commission specialist pharmacy services to a consistent definition and in a coherent manner across England. Commissioning at a national level will reduce the problem of variability and will ensure that quality standards are applied equally across the NHS. Pharmacists also play a vital role in the procurement of medicines and this must not be forgotten as the proposed new structures develop.

**4.5** Commissioning must be undertaken to deliver care to all within a community. An alternative range of healthcare providers must be used to ensure healthcare is delivered to those sectors of the community who are most disenfranchised and do not seek healthcare from general practitioners.

#### **5. Teaching and training for clinical staff**

**5.1** The RPS believes that there should be equitable access for all healthcare providers to local training and education via the Local Education and Training Boards (LETBs).

**5.2** The RPS considers it essential for all healthcare professionals to have ‘protected time’ for education and training. This should be supported with funding to cover locum costs whilst healthcare practitioners undergo continuing professional development or compulsory training.

## **6. Payment systems**

**6.1** Alongside more national services the RPS understands the need for a localised NHS with services commissioned by locally accountable bodies. In order for these services to be easily commissioned and to provide measurable and comparable outcome data there should be a set of national service frameworks acting as a menu from which local needs can be met. The RPS will play a key role in the description of good standards and outcomes, as well as the competencies required by pharmacists and pharmacy support staff involved in service provision. This will avoid the current problems of pharmacists being unable to provide enhanced services in neighbouring PCTs without multiple accreditations. Such processes have in the past proved to be a barrier to the delivery of quality services to patients

**6.2** We encourage the national contracts for healthcare professionals to be more aligned with one another and we would support the development of a quality and outcomes based contract for pharmacy. We believe this could raise the standards and equity for all professionals

### **Pharmacy specific statements:**

1. We would like to see the evolution of integrated care pathways that offer the most cost-effective as well as the best quality outcomes for patients. This will require all healthcare professionals to work together in the development of these pathways with jointly agreed referral mechanisms in place. The use of medicines is a component of almost all disease pathways, and we believe pharmacists, as medicines experts, should have input into the creation of all relevant pathways.
2. We wish to see the promotion of a joint leadership programme across all professions involved in healthcare provision. We believe this would enhance the ‘level playing field’ for all providers

The RPS has some concern that the role of Monitor has not been clearly defined and may impact upon almost every one of the 10,000 community pharmacies in England that provides additional services outside the remit of the core pharmacy contract.

The function of pharmaceutical supply is clearly stated as not being within the remit of Monitor. However, it is not clear if other service provision by a pharmacy, such as diagnostic testing, clinics involving the testing of blood samples e.g. NHS Healthchecks, anticoagulation clinics, will require licensing with Monitor.

### **In Summary:**

The RPS suggests that the following eight issues need to be tackled to ensure a level playing field within Primary care:

1. A consistent series of metrics with which to measure all professions and providers: patient outcomes, cost, speed of delivery.
2. Open access to relevant data for patients and providers, utilising appropriate security measures to preserve patient confidentiality.
3. Stability of circumstances for providers delivering care services: consistency of reporting information, duration of reporting process, length of contract etc.
4. Consistency of levels of support. Some providers receive funding for IT, equipment and staff costs and paid time away from service provision for continuing professional development. Others do not.
5. Full information on patients and the public seeking care.
6. An understanding that some providers, whilst able to deliver services, may have no experience of producing tender documents or even participating in the commissioning process. They will require support to do this.
7. The use of service specifications that do not favour abilities or working practices of any single provider.
8. A clear and transparent commissioning process that is clear to all when contracts are being tendered and the decision-making process around selecting a provider.



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