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Pharmacy in England: building on strengths – delivering the future – Draft regulations under the Health Act 2009: Pharmaceutical Needs Assessments RPSGB response

Background

The Royal Pharmaceutical Society of Great Britain is the professional and regulatory body for pharmacists in England, Scotland and Wales. It also regulates pharmacy technicians on a voluntary basis, which is expected to become statutory under anticipated legislation. The primary objectives of the Society are to lead, regulate, develop and represent the profession of pharmacy. The Society leads and supports the development of the 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. Following the publication in 2007 of the Government White Paper Trust, Assurance and Safety - The Regulation of Health Professionals in the 21st Century, the Society is working towards the demerger of its regulatory and professional roles. This will see the establishment of a new general Pharmaceutical Council and a new professional body for pharmacy in 2010.

The Society welcomes the opportunity to respond the Department of Health's consultation on the Draft regulations under the Health Act 2009: Pharmaceutical Needs Assessments.

1. **Do the requirements for PNAs adequately reflect the likely needs for pharmaceutical services locally? If not, what other needs for pharmaceutical services should be reflected?**
   It is not clear if social need, as distinct from health need, has been adequately addressed as part of the PNA. We would also like to ensure that innovative practice is included in PNAs and that this type of practice continues to be supported and is not stifled.

2. **Are there any other elements which should be included? If yes, please let us know what should be included and why?**
   We feel that there should be a requirement in the regulations that the PNA is linked to the Joint Strategic Needs Assessment rather than just have regard to it as we believe that the JSNA is integral to the production of the PNA. This would ensure that relevant data, such as public health data, was used to help form the PNA.

   We would also recommend that there is an obligation to meet the World Class Commissioning competencies when applying PNAs to the commissioning process.

3. **Draft Schedule 3A sets out the mandatory information PCTs need to include in their PNAs. Do you have any comments on these categories?**
   We would agree with the categories but we feel that they do not go far enough to build an accurate picture of the local health profile and consequently the pharmaceutical needs for a particular area. If dispensing doctors are consulted it needs to be made clear about why they are there.

   We would strongly recommend that ‘a necessary’ service is defined as otherwise it will be left to local interpretation and lead to more variation.

4. **Are there any other areas which should be mandatory? If yes, please state the information you consider needs to be included and why.**
   We would also recommend that there is an obligation to meet the World Class Commissioning competencies when applying PNAs to the commissioning process

5. **Are all relevant interested parties included in consultation requirements in draft regulation 3F? If not, please let us know who should also be included and why.**
   It is not clear how PCTs should consult with patients in relation to PNAs. It is recommended that patients are consulted with but it is not a requirement. Details on who needs to be surveyed i.e. hard to reach groups, disenfranchised groups etc and the percentage of patient responses recommended should be further defined as inadequate numbers could be challenged. We would recommend that the core elements of a patient survey are set at a national level; this will assist in cross –boundary issues between PCTs.

6. **Is a minimum 60 days adequate for consultees to make their responses to the relevant PCT? If not, what would be reasonable?**
   This depends on the quality of data being sought. The more in-depth the data the better quality the PNA and the more robust and cost- efficient pharmacy services. Most consultations have to be conducted over a 12 week period and so we would query why this process differs from the norm.

7. **Is there further information required on the consultation process? If yes, please provide examples.**
   We would recommend that Strategic Health Authorities (SHAs) have a role in reviewing the PNAs produced by the PCTs in their area as they will be able to look for consistency etc across the patch. Comparison of PNAs should be at SHA level if competency four of world class commissioning, '*lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service design and resource utilisation'*, is to be achieved. Stakeholder engagement with specialist institutions would also aid the process leading to improved patient care.

8. **Is it clear what the scope of a PNA is and when it should be revised? If not, how could we make it clearer?**
   There should be more information on the level of detail that is required to be included in the PNA and there would need to be sufficient funding linked to the PNA to support this. The PNA has to be robust enough if challenged but Department of Health is advocating that the initial focus is to support the commissioning agenda although the PCTs seem to be focusing on the future requirement around 'control of entry' requirements. The purpose of the PNA needs to be made clearer, as the first PNA published may be fit for

one purpose i.e. commissioning and then that purpose is changed after a short period of time e.g. to control of entry tool and a new PNA would then need to be undertaken.

9. **Is it clear what the scope of a supplementary statement is and when it could be produced? If not, how could we make it clearer?**
   Yes, the examples given clarify the processes that could occur in different situations. However, the supplementary statements made are often based on spurious comment rather than being based on substantial research or evidence. We feel that there could be an inadequacy of the statistics and scientific method which could render the supplementary statements meaningless.

10. **Are there any other relevant comments outside of the above questions?**
    The role and remit of the PNAS needs to be clearly defined. Is it a tool for commissioners or providers or both? It is stated that the PNA is a commissioning tool but there is an expectation that it will be used as a 'control of entry' tool in the future, following a consultation later this year. Anecdotal evidence is that PCTs are only engaging in PNAs as they believe it will be used as a control of entry tool in the future. When it becomes a 'control of entry' tool then there would need to be a process to appeal against the content of the PNA.

    If the PNA identifies gaps in service provision then the expectation would be that these services would be commissioned. Such expectations need to be managed as although this would result in a commissioning intention document there may not be the funding available to implement the recommendations. This needs to be clarified as it could be challenged in the courts.

    There should also be guidance on how to decommission services if there is over provision in a particular area.

    The issue of internet pharmacy also needs to be considered as these pharmacies cover a wide area and are not confined to one PCT.

    The role of the pharmacy champion at each PCT in the development of PNAs should be defined, in fact we feel there should be national guidance on what this role consists of as it has become apparent that often the 'pharmacy champion' is present in name only.

There should also be more clarity in how the PNA relates, in particular, to 100 hour pharmacies and how the future for these pharmacies is incorporated into the PNA.

We believe that the implementation of the current toolkit from NHS employers and PCC, published Sept 2007, has led to major variation in the quality of PNAs. The development of PNAs is critical to health outcomes, yet there is little scientific rationale and measure of health outcomes behind any of the recommended services which makes this exercise extremely difficult.

11. **Do you agree our estimate of the likely costs and benefits? If not, please indicate and provide evidence, where possible, of any areas of disagreement.**
    No because the benefits gained assume that services will be commissioned. Given the cuts in NHS spending that are expected over the next 2 years PCTs may not be in a position to commission any new services, nor have the manpower to do so. There is also some question as to whether the PCTs have the capability, the resources or the skills to carry out a robust PNA. Also, there is no substantial evidence behind the claims made as we believe the quality of the measures employed is poor. The variation of PNAs from PCT to PCT makes an estimate completely unreliable. A national template which requests certain specified data would make it easier to compare pharmaceutical services across PCTs.

12. **Are there matters not included in the Equality Impact Assessment for consultation which should be? If yes, please let us know what they are.**
    It is not clear if social need, as distinct from health need, has been adequately addressed as part of the PNA.

13. **What further information would support PCTs' own equality impact assessment of their PNA?**
    Thorough evaluation of commissioned services and of health trends using high specification JSNAs and inclusion of data from social services and local authorities.

14. **What data and other local information would PCTs use to reflect differing local health needs in terms of ethnicity, age, gender, disability or other specific equality issues?**

Local information - it may be prudent for neighbouring PCTs to discuss PNAs or as suggested in the answer to Q7 for the SHA to be involved. Patients that live on the border of two PCT areas may be disadvantaged by pharmaceutical services offered or desired by one PCT but not by the other. Whilst each PCT must determine the health needs for its population there will have to be a degree of overlap to avoid a postcode lottery effect.

The PNA needs to be correctly incorporated. If figures from secondary care could be correctly harvested against assigned postcodes (not GP surgeries) the quality of data obtained would allow the specific targeting of pharmaceutical services and allow precision measurements on health outcomes and cost-efficiency.

Yours sincerely

Lindsey Gilpin
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Royal Pharmaceutical Society of Great Britain