

THE NATIONAL HEALTH SERVICE: AN OVERVIEW FOR PREREGISTRATION TRAINEE PHARMACISTS

INTRODUCTION

On qualifying as a pharmacist you will gain a range of rights and privileges. At the same time you will acquire a corresponding set of responsibilities and obligations. In the context of this paper two such areas of responsibilities are:

Responsibilities Towards Society: - In return for the privileges conferred by professional status, all professionals owe a duty to the society in which they practise. Society, in the form of its democratically elected government, therefore provides the statutory regulatory framework within which all health professions operate.

Responsibilities Towards 'Clients':- You will also have specific obligations to those who pay you for your work. In GB, most health care is commissioned and paid for by the state via the National Health Service. Most health care professionals, including pharmacists, will therefore have some form of contractual relationship with government via the NHS.

These responsibilities highlight the intrinsic relationship between government health policy and the scope and shape of professional practice. Understanding the NHS structure and the role of pharmacists within it is therefore fundamental in achieving effective professional status.

This paper sets out to provide you with some background information to the latest changes in the NHS and to identify the potential implications of these changes for your future practise:

Some of the key changes introduced by recent policies include:

- Changes to the NHS management and funding arrangements
- Greater emphasis of NHS quality
- Tackling health inequalities
- Focusing on Innovation and Improvement including the development of IT infrastructure and the development of non medical prescribers
- Emphasis on risk management and patient safety
- Greater involvement of public and patients in relation to decision making
- The development and implementation of national standards of care
- Introduction of a new General Medical Services (GMS) Contract and a new Pharmacy Contract
- Standard tariffs for hospital treatments (Payment by Results)
- The establishment of Foundation Trusts
- The introduction of Practice Based Commissioning

This overview deals mainly with the English system. Further documents will be produced that address the devolved countries of Scotland and Wales.

HISTORY OF THE NHS

Prior to 1948

Prior to the Second World War, health-care in the UK was provided by an unco-ordinated mix of private practitioners, charities and local-authority-run hospitals. Many of the major hospitals were dependent on charitable donations, and most were in financial difficulties. For most of the populations, good quality health care was either not available or was not affordable.

In the late 1930s the prospect of war prompted the government to bring all hospitals under temporary government control.

1948-1989

When the war ended the incoming Labour government decided that the pre-war situation was no longer acceptable and on 5th July 1948, the NHS came into existence. As a result all hospitals became publicly (NHS) funded institutions, managed and co-ordinated on a geographical basis by 14 Regional Hospital Boards. Primary care practitioners (GPs, Pharmacists, Dentists and Opticians) continued as independent practitioners who were contracted to local 'Executive Councils' to provide services to NHS patients.

Over the next 40 years, the NHS regularly reorganised with the intention of improving efficiency and effectiveness. Most notably, in the 1970s, an intermediate ('Area Health Authority') tier of management was added between Regional Hospital Boards and hospitals. However, the basic outline structure, as implemented in 1948, survived pretty much intact until the early 1990s.

During this time a disproportionate power and influence was gained by the acute sector. For a variety of reasons this sector was able to set much of the investment agenda and to consume a very large proportion of the increasing resource allocated to health-care by successive governments.

1989 – 1997

Attempting to counter the uneven distribution of power, influence and investment between primary and secondary care, and in an attempt to make the NHS more responsive to patient needs the early 1990s saw the most dramatic cultural change in the history of the NHS – the creation of an 'internal market'. Introduced by the then Conservative administration, this sought to replace the long standing national, centralised 'command and control structure with more local and responsive decision making based on competition between hospitals for patient referrals from 'GP fundholders'.

1997 – 2001

The incoming Labour government, elected in May 1997, was already committed to the abolition of the internal market. They considered it to be both bureaucratic and unfair to patients of non-fundholding GPs. In addition, competition between hospitals had resulted in wasteful duplication of services. Significant advantages, however, were perceived in the way that it had been able to move NHS 'centre of gravity' away from hospitals and towards primary care.

The White Paper 'The New NHS – Modern, Dependable' in Dec 1997¹ outlined the steps to replace fundholding, initially with Primary Care Groups (PCGs) which later

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developed into Primary Care Trusts (PCTs). PCTs are free-standing statutory bodies, taking over responsibility for significant areas of overall healthcare management, planning and budgeting etc. from the previous Health Authorities. Along with these changes came an emphasis on quality and patient choice in 'A First Class Service: Quality in The New NHS'² June 1998.

In March 2000 unprecedented additional resources were announced for the NHS. Attached to this investment, major change and improvement was planned for the way that the NHS operates. A number of key documents were published which set out this agenda for change. One of the most fundamental being 'The NHS Plan – A Plan for Investment – A Plan for Reform'³ July 2000. Relating to this plan a paper specifically outlining the agenda for pharmacists and pharmacy services in 'Pharmacy in the Future – Implementing the NHS Plan'⁴ Sept 2000 was produced. These two key documents are discussed further later in this paper.

2001 – 2006

In April 2001 further major change was announced which was aimed to empower frontline staff and patients and to ensure implementation of the NHS Plan. The shifting the balance of power (StBoP) programme announced in two consecutive documents^{5 6} outlined the role of Primary Care Trusts in running the NHS and improving health in their areas. This meant replacing the previous 95 health authorities with 28 new Strategic Health Authorities (SHA) covering a larger geographical area and having a more strategic role including performance management and building capacity and autonomy of the PCTs. In addition, the Department of Health was restructured to abolish the previous regional offices and to refocus to reflect the changes. 300 PCTs operated as free standing statutory organisations responsible for assessing need, planning and securing all health services and improving health for the population they serve. This included the commissioning of secondary services, the provision of primary care services and the administration and implementation of new professional contracts including the GP contract and the Community Pharmacy contract.

2006 onwards

From October 2006 another wave of major NHS change was introduced. Strategic health Authorities and Primary Care Trusts were merged and their roles changed. The previous 28 Strategic Health Authorities were reduced to 10. The aim of this merge was to

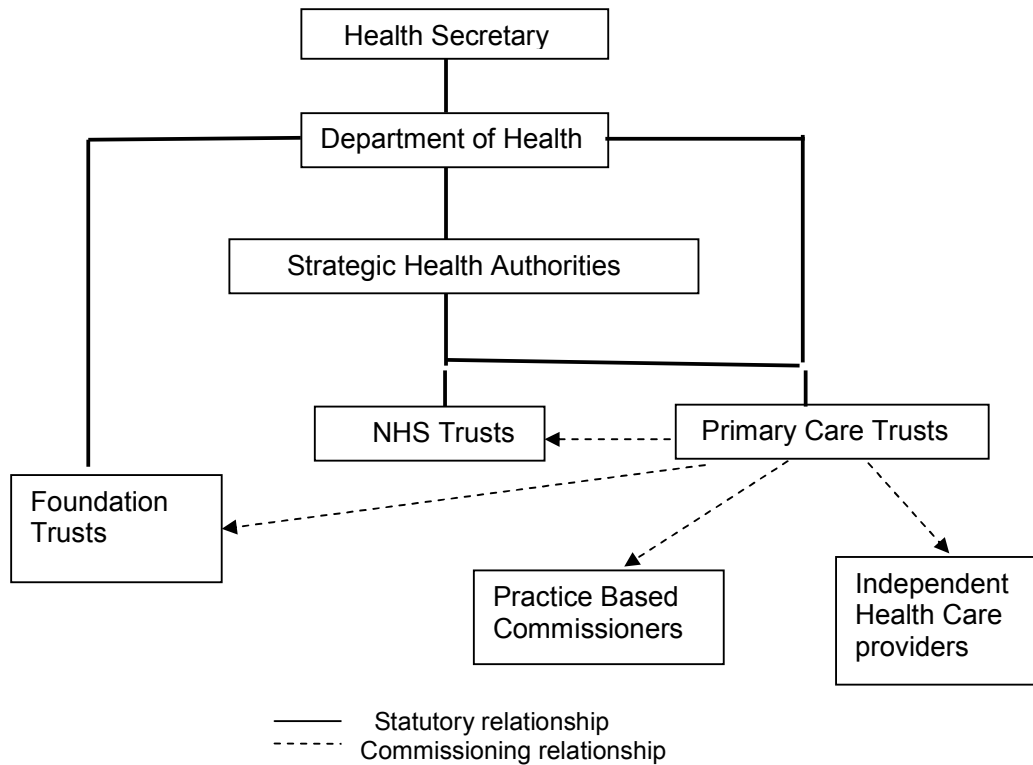
- Strengthen the architecture of the local NHS.
- Save money by streamlining management and administration to provide better value for money so greater resources can be dedicated to patient care. This is another step towards creating an NHS which is patient-led.
- Cut out unnecessary bureaucracy by bringing together administration services and reducing the duplication of administration, human resource functions, accounts and hospital contract negotiation teams.

The new configuration of SHAs means they are better placed to oversee and support the development of more strategic PCTs and the move towards more NHS Foundation Trusts. In addition, through almost complete co-terminosity with Government Office of the Regions' boundaries, joint working between health and local government agencies should improve significantly.

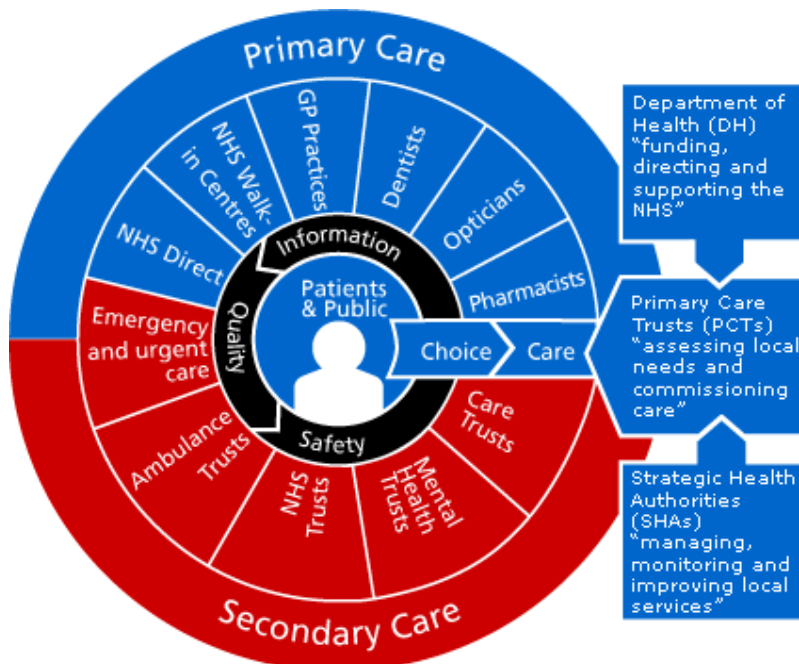


Under this the 300 PCTs were merged to form 152 new PCTs. The PCT performs its commissioning function through empowering, supporting and coordinating a comprehensive system of practice-based commissioners; who in turn are responsible for the care of their registered patients. Practice Based Commissioning Groups may be individuals, group or localities of GPs and the rules and regulations surrounding these are outlined in the Department of Health document: *Practice Based Commissioning: Technical Guidance*⁷. The number of Practice Based Commissioning Groups (PBC) around the country will vary as negotiations take place between PCTs and their constituent GPs as to exactly what services they will take responsibility for in their area. PBC groups are therefore likely to evolve over the next few years. The emphasis is now on plurality with services being provided not only from PBCs but also from other providers: PCT funded, privately funded or through other routes.

CURRENT NHS STRUCTURE and FUNCTIONS in ENGLAND



Below is a diagram which aims to clarify the relationship between various NHS bodies and professional groups. This along with the text that follows explains how the NHS in England works.



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Health Secretary

The current Health Secretary (also known as Secretary of State for Health) is a cabinet minister and accountable to parliament for the overall running of the NHS. The role is one of the most politically sensitive because of the high public profile of the NHS.

Supporting the Health Secretary are five Ministers of Health who are also appointed by the government and are either MPs, elected by the public or are Members of the House of Lords. The ministers support the Health Secretary with different areas of responsibility in the Health Service. The current members of the ministerial team are:

Alan Johnson	Health Secretary <i>Responsibilities include:</i> NHS and social care delivery, system reforms; finance and resources and strategic communications.
Andy Burnham	Minister of State for delivery and reform: <i>Responsibilities include:</i> Finance including financial recovery, allocations, Comprehensive Spending Review. Capital Development including PFI, NHS LIFT and Community Hospitals. NHS efficiency and productivity. Income generation and cost recovery. Delivery of targets. System reform including reconfigurations, commissioning, choice, plurality, Independent Sector Treatment Centres, contestability, Payment by Results Foundation Trusts. Unscheduled and emergency care. ID cards, East Midlands and East of England SHAs.
Ben Bradshaw	Minister of State for Health Services: <i>Responsibilities include:</i> Emergency preparedness including pandemic flu; counter fraud, cancer, cardiac services, diabetes and renal services, mental health. North West and North East SHAs.
Lord Philip Hunt of King's Heath, Minister of State for Quality	<i>Responsibilities include:</i> Safety and quality. Patient safety and the NPSA. Professional regulation, clinical negligence, Research, Pharmacy and healthcare products, including MHRA. NICE pharmaceutical industry, R&D, NHS IT/Connecting for Health. NHS workforce issues including numbers, planning, education, training, pay and, pensions. South Central and London SHAs.
Dawn Primarolo	Minister of State for Public Health <i>Responsibilities include:</i> Public Health White Paper implementation, including Health Bill; health inequalities, drugs including drug treatment; tobacco and smoking; alcohol; physical activity; diet and

nutrition SHAs on the South East Coast and West Midlands.

Ivan Lewis

Parliamentary under Secretary of State for care services

Responsibilities include: social care finance, performance and workforce issue, commissioning for Social Care Inspection, Social Care Institute for Excellence, children's health, maternity services, child and adolescent mental health services. Yorkshire and the Humber and South West SHAs.

Department of Health

The Department of Health (DH) is one of the largest government departments operating from offices in London and Leeds. It aims to improve health and well being through its strategic responsibility and accountability for the health and social care system in England. It does not directly run the National Health Service, manage individual hospitals or directly employ doctors, nurses or dentists. Rather it sets the national standards for patient care and regulates health provision through a variety of regulators such as: Strategic health Authorities; the Healthcare Commission; Executive Agencies such as the Medicines and Healthcare Products Regulation Agency and Special Health Authorities such as the National Institute for Clinical Excellence (NICE).

The Health Care Commission inspects health services. When problems occur, the Department of Health is meant to put things right.

The DH also sets priorities and targets, including those for improving cancer and heart disease treatment and reducing hospital appointment waiting times. It works to improve public health, for example by reducing smoking, and stopping alcohol and drug abuse. It also seeks to improve mental health and the care of those with mental illness.

The DH also provides specialist guidance to health practitioners and social workers, and supports research to improve the quality of health and social services.

It is staffed by approximately 5000 civil servants and headed up by the Chief Executive of the NHS, currently David Nicholson, who reports directly to the Health Secretary. He is provided with specialist expertise and advice through a number of National Clinical Directors and Key Specialists. These individuals provide expert knowledge in specific fields. One of these is the Chief Pharmaceutical Officer for England who is currently Dr Keith Ridge.

Executive Agencies

Executive agencies are organisations that undertake a particular business function for the NHS and are accountable to the DH. These include:

- **Medicines and Healthcare Products Regulatory Agency (MHRA)**
- **NHS Connecting for Health**
- **NHS Purchasing and Supply Agency**

Medicines and Healthcare Products Regulatory Agency (MHRA)

The MRHA is the most relevant to pharmacists. It was formed from the merging of the Medicines Control Agency (MCA) and the Medical Devices Agency (MDA). The MHRA is the government agency which is responsible for ensuring that medicines and medical devices work, and are acceptably safe.

Amongst its responsibilities is the Licensing of Pharmaceuticals, the regulation of clinical trials, the issuing of relevant safety warnings and the provision of advice and guidance on medicines and medical devices. More information is available on their website: www.mhra.gov.uk

NHS Connecting for Health

The role of Connecting for Health is to deliver new, integrated IT systems and services to help modernise the NHS and ensure care is centred on the patient by implementing the National Programme for IT. This vast programme of NPFIT includes creating an NHS care records service with individual records for every patient in England, coordinating an electronic hospital appointment booking service (choose and book) and most importantly for pharmacists the implementation a system for the electronic transmission of prescriptions (ETP). ETP should make prescribing and dispensing safer, easier and more convenient to patients. More information is provided at www.connectingforhealth.nhs.uk

NHS Purchasing and Supply Agency

This agency deals with all issues relating to procurement within the NHS at local, regional and national level. More information is provided at www.pasa.nhs.uk

Special Health Authorities and Independent Public Bodies

An increasing number of these types of bodies have been set independently from the NHS to provide specialist advice about a particular area of work. In some cases they have replaced previous Executive Agencies. For independent bodies work can therefore be carried out by them without the direct influence of government or government departments.

Special Health Authorities are still independent but are subject to ministerial direction in the same way as other NHS bodies. These are outlined below Further details on those which are most relevant to pharmacists are provided in the text that follows. The following is a comprehensive list of all the Special Health Authorities and Independent Bodies:

Special Health Authorities

- Health Protection Agency (HPA)
- The NHS Institute for Innovation and Improvement
- Mental Health Act Commission

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- National Institute for Health and Clinical Excellence
- National Patient Safety Agency
- National Treatment Agency
- NHS Appointments Commission
- NHS Blood and Transplant
- NHS Business Services Authority
- NHS Direct
- NHS Litigation Authority
- NHS Professionals Special Health Authority
- The Health and Social Care Information Centre
- The NHS Institute for Innovation and Improvement

Independent Bodies:

- The Health Care Commission
- Commission on Human Medicines

Special Health Authorities

The **NHS Institute for Innovation and Improvement** has replaced the NHS Modernisation Agency, which had merged with the NHSU (NHS University), as well as replacing the NHS Leadership Centre. Its mission is to improve health outcomes and raise the quality of delivery in the NHS by accelerating the uptake of proven innovation and improvements in healthcare delivery models and processes, medical products and devices and healthcare leadership. Further information is available at their website: www.institute.nhs.uk

Programmes originally offered by the NHSU are now offered throughout the NHS through host agreements. The NHSU Core Programmes has now become the Core Programmes for the NHS. It maintains and develops these programmes and is hosted by the South Yorkshire SHA on behalf of all SHAs. The Widening Participation Programme has been taken on by Skills for Health (mentioned later).

The **Health Protection Agency (HPA)** was formed in 2003 as an Executive Agency and bringing together expertise from the Public Health Laboratories Service, the National Poisons Centre and public health staff responsible for infectious control, emergency planning and other protection support, as well as other agencies. In 2005 it merged with the National Radiological Protection Board and became an independent Public Body. It is dedicated to protecting people's health and reducing the impact of infectious disease, chemical hazards, poisons and radiation. Its role includes anticipating and preparing for emerging or future threats and includes a programme of research and development, education and training. More information is available on their website: www.hpa.org.uk

The **National Institute for Clinical Excellence (NICE)** works on behalf of the National Health Service and the people who use it. The organisation provides national guidance and makes recommendations on promoting good health and in preventing ill health through the use of treatments using the best available evidence. All pharmacists should be familiar with the NICE website and the types of recommendations made in it. www.nice.org.uk

The **National Patient Safety Agency (NPSA)** was created as a Special Health Authority in July 2001 to co-ordinate and to encourage the reporting of incidents and near misses related to medicines and to identify learning opportunities arising from these. The national Reporting and Learning System (NRLS) provides the NPSA with

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anonymous data that can be analysed to identify national trends and priorities. It also issues advice and provides recommendations in areas of high risk e.g. the use of potassium chloride in hospitals and methotrexate in both primary and secondary care. This is another body that all qualifying pharmacists should be familiar with along with some of its recommendations www.npsa.nhs.uk/

The **National Treatment Agency (NTA)** aims to increase the availability, capacity and effectiveness of treatment for drug misuse in England. The associated web site includes details of the NTA's work programme, as well as publications and guidance for those in the drug treatment sector. Regional teams provide support to Drug Action teams to ensure resources are spent to best effect on a full range of service that meets the needs of local people. It also works with other organisations to provide training for new and existing staff. www.nta.nhs.uk

NHS Direct provides a telephone and online health advice service for patients and the public. As part of their service they may signpost individuals to their local Community Pharmacy. www.nhsdirect.co.uk

NHS Litigation Authority (NHSLA) indemnifies NHS bodies in respect of both clinical negligence and non-clinical risks and manages claims and litigation under both headings. The Authority also has risk management programmes in place against which NHS trusts are assessed.

NHS Professionals Special Health Authority works in partnership with NHS Trusts to provide high quality flexible staff to Acute, Primary Care and Mental Health organisations across England. It takes a national approach to managing flexible staffing for the NHS and is one of a series of initiatives designed to strengthen and support the NHS workforce. www.nhsprofessionals.nhs.uk/

NHS Business Services Authority was formed on April 1st 2006 this Authority performs functions previously carried out by the Prescriptions Pricing Authority as well as those of the Dental Practice Board, NHS Counter Fraud and Security Management Service and NHS Pensions Agency. It is the main processing facility and centre of excellence for payment, reimbursement, remuneration and reconciliation for NHS pharmacists, dental practitioners NHS pensioners and other affiliated parties patients, employees and affiliated parties. www.nhsbsa.nhs.uk

Independent Bodies

The **Health Care Commission** is the independent inspection body for both the NHS. It works to drive improvement of standards in both NHS and independent (private or voluntary) sector healthcare organisations. They work with the National Audit Office, the Audit Commission and the Commission for Social Care Inspection to promote improvement in patient care and efficiency in the NHS and public health.

The Healthcare Commission is responsible for assessing and reporting on the performance of both NHS and independent healthcare organisations and has published to famous performance (star) ratings. It produces a report to Parliament annually on the provision of healthcare by or for NHS bodies. It is also responsible for reviewing formal complaints about the NHS that have not been resolved locally by the NHS organisation or independent health care provider. For more information visit their website www.healthcarecommission.org.uk



The **Commission on Human Medicines** was created on Oct 1st 2005 and replaces the former Committee on Safety of Medicines, combining its functions with that of the Medicines Commission. It advises the UK Licensing Authority on the quality, efficacy and safety of medicines and includes the production of "Pharmacovigilance". It is partially responsible for the Drug Safety Bulletin of the MHRA and Commission on Human Medicines. The change was in response to a perceived requirement for a greater degree of expert scientific judgment at the earlier stages of specific product developments and a need for a more transparent structure. The changes therefore removed the entitlement of industry to be represented on the Commission, updated the handling of, conflicts of interest and increased lay membership."Further information available on the MHRA website www.mhra.gov.uk/home

STRATEGIC HEALTH AUTHORITIES

England is divided into 10 Strategic Health Authorities (SHAs). A map of the old and new strategic health Authorities is available on the Department of Health website www.dh.gov.uk/assetRoot/04/13/37/44/04133744.pdf

SHAs should provide leadership for local leaders in responding to patients in the health care area, reform services and develop rules for this. It will intervene when required to in the interests of patients or the taxpayer.

The key responsibilities of the SHAs are:

Strategic leadership: providing vision for NHS reform policy including specific national transformation projects e.g. Connecting for Health, developing strategic partnerships at regional level and providing strategic oversight of PCTs as well as contributing to the DH policy and Strategy Directorate

Developing organisations and the workforce: developing PCTs so that they are fit for purpose, encouraging the move to foundation Trusts status and ensuring that all aspects of workforce development including education, training and workforce planning best support service demand

Ensuring local systems operate effectively and deliver improved performance: and that they take account of national guidelines and rules. This is done mainly by assessing and performance managing PCTs including benchmarking against other areas. Performance management of Trusts will continue prior to achieving Trust Foundation status.

In discharging these functions SHAs must work in partnership with PCTs, regional organisations and government offices for the regions. They hold PCTs to account for their performance but in turn are accountable to the Department of health for ensuring their local systems operate effectively and in line with government policy

To meet their responsibilities the SHAs will undertake several specific roles, they will;

- hold reserves on behalf of PCTs
- have responsibility for meeting overall surplus 'control totals' in their areas
- manage performance on behalf of the Department of Health
- have responsibility for the development of PCTs and NHS trusts in their areas, making use of the development programmes
- have overall responsibility for ensuring the full implementation of system reforms
- minimise intervention with individual organisations, but they will have authority to arbitrate between NHS trusts and PCTs
- ensure effective processes of engagement and consultation with patients, users and local people. They will oversee any merger proposals between NHS Trusts, including safeguarding choice for patients.

In exceptional circumstances the SHA may request that DH allows new rules to operate in areas where issues arise, however these will be temporary.

(http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPAMPGBrowsableDocument/fs/en?CONTENT_ID=4130756&MULTIPAGE_ID=5707414&chk=46uxpz).

NHS TRUSTS

1) Primary Care Trusts

A map of the old and new Primary Care Trusts is available on the Department of Health website

www.dh.gov.uk/assetRoot/04/13/50/84/04135084.pdf

PCTs are now at the centre of the NHS and control 80 per cent of the NHS budget. As they are local organisations, they are in the best position to understand the needs of their community, so they can make sure that the organisations providing health and social care services are working effectively.

The key roles of the 152 PCTs are:

Engaging with the local population to improve health and well being: includes reducing health inequalities in partnership with LAs, and developing a robust system of emergency planning

Commissioning a comprehensive and equitable range of high quality, responsive and efficient services, within allocated resources. This is done primarily through empowering, supporting and coordinating a comprehensive system of practice-based commissioners, who in turn are responsible for the care for their registered patients. Commissioning for primary medical services is not devolved but retained by the PCT. Where appropriate, services may be commissioned jointly with local authorities or for specialist services, jointly with other PCTs. The 5 key commissioning roles are:

- *Assessing needs, reviewing provision & deciding priorities*
- *Designing services:* in partnership with practice based commissioners. Drawing on evidence of cost effectiveness and best practice
- *Shaping the structure of supply* through stimulating provider interest, going to tender and placing contracts. Ensuring that patient choice and competition between providers is promoted and that services are joined up for patients along the way
- *Managing demand* within its cash limited allocation of resources
- *Performance managing providers* ensuring that contract requirements are met e.g. on national targets, quality and equity of access and taking systematic account of patient and practice feedback

Directly providing high quality responsive and efficient services where this gives best-value.

Practice Based Commissioning (PBC)

At the centre of current NHS organisational thinking for primary care is the creation of Practice Based Commissioning (PBC)⁷. Under PBC groups of practices and other primary care professionals will take responsibility from their PCTs for commissioning of services that meet the needs of their local population. In order to do this front line clinicians are being provided with the resources and support to become more involved in these will commissioning decisions. They receive clinical and financial information on how their patients use health services including referral data and budget breakdown as well and prescribing data and budget breakdown. This information can then be used for the redesign of services by front line clinicians for the benefit of patients.

Commissioning practices or groups of practices will have the following main functions:

- designing improvements in patient pathways
- working in partnership with PCs to create community based services that are more convenient for patients
- responsibility for a budget delegated from the PCT, which covers acute, community and emergency care
- managing the budget effectively

The key perceived benefit of PBC is that it gives clinicians greater freedoms and flexibilities to tailor services to the needs of the local community. In theory, the quality and choice of services should improve and patients will benefit from more services being provided with greater convenience in the community. In particular, patients with long-term conditions will be able to benefit from more personalised care.

Whilst active involvement of PBC in redesigning services remains voluntary the government required 100% coverage of practice by end of December 2006 in terms of providing them with relevant information and offering them support from the PCT to enable this to take place.

PBC is funded through a Directed Enhanced Service (DES) under the new GMS contract involving a two stage payment. It is intended that through service redesign and increased efficiencies PBCs will then be able to free up additional resources that they must reinvest in patient care through an agreed plan with the PCT.

More information on PBC can be found on the department of Health Website:

www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Commissioning/PracticeBasedCommissioning/

Several resources have been made available on this website to assist in developing PBC including tools and templates for implementation. Practical guidance has also been set out in the DH publication Practice Based Commissioning. “Early wins and Top Tips”⁸ and “Practice Based Commissioning. Practical Implementation”⁹.

Additional useful resource material on PBC has been made available through the organisation Primary Care Contracting (www.primarycarecontracting.nhs.uk), who has produced a series of PBC bulletins. Of particular interest to pharmacists are:

- Bulletin 3 – Multiprofessional involvement in PBC Feb 2006
- Bulletin 5 – Pharmacy and PBC June 2006

PBC provides a new opportunity for health professionals such as pharmacists pharmacy to get involved in service delivery and newly qualifying pharmacists in primary care would be well advised to become familiar with the PBC configurations and interests in their locality so that they are ready to help shape the direction of pharmacy services in the future.

2) Ambulance Trusts

Ambulance trusts have also undergone major recent reorganisation with 29 trusts being merged into 12. The changes mean that they will be able to work more closely with organisations such as the NHS and police and fire services. The aim is to ensure more efficient use of resources and better opportunities for staff.

3) Care Trusts

Over 2002 and 2003, eight demonstrator sites were set up as Care Trusts with the purpose of better-integrating health and social care. These trusts combine both NHS responsibilities and local authority health responsibilities under a single management, and are therefore in a position to increase continuity of care and simplify administration. They are able to commission and to provide both Health and Social Services, acting under delegate authority from local councils and in this way services to users, patients and carers may be delivered more effectively and appropriately.

Currently Care Trusts are as follows:

- Bexley Care Trust
- Bradford Care Trust
- Camden and Islington Mental Health & Social Care Trust
- Northumberland Care Trust
- Manchester Mental Health and Social Care Trust
- Northumberland Care Trust
- Sandwell Mental NHS and Social Care Trust
- Sheffield Care Trust
- Witham, Braintree and Halstead Care Trust

4) Acute Trusts - provide acute care in the Hospital setting.

5) Mental Health Trusts – provide in-patient and community based care for patients with mental health problems. They work closely with local authorities and voluntary organisations.

These trusts are subject to an annual health assessment from the Health Care Commission which through a system of “self declaration” and unannounced spot checks assesses amongst other issues how well they use resources and how well they are meeting a range of core national standards. This replaces the former STAR ratings for Trusts which were found to poorly reflect standards of clinical care. NHS Trusts obtain their income through a combination of service agreements with PCTs, provision of undergraduate and postgraduate training, private healthcare and limited commercial activities (e.g. car parking).

6) Foundation Trusts

Foundation Trusts were first introduced in April 1st 2004. These organisations are legally established as independent “Public Benefit Corporations”. They are still part of the NHS but have greater freedoms to develop in the way that local people and staff feel is appropriate. The theoretical aims of foundation trust status are linked with decentralisation and democratisation. Firstly they have some freedoms from Whitehall control and direction from the secretary of state, and secondly they form a new kind of social ownership where health services are owned by and accountable to local people rather than to central government. The model is one of a cooperative or mutual society. NHS Foundation Trusts are subject to the same NHS standards, performance ratings and systems of inspection as conventional NHS trusts but are performance managed by Monitor, an independent body set up for this purpose and to make sure they are well managed and financially strong. All trusts including acute trusts, mental health trusts, ambulance trusts and primary care trusts can apply to have foundation trust status but they need to be in financial balance and to be able to demonstrate that they are performing to a high standard before this will be granted.

The new Pharmacy Contract

Launched in April 2005 this mirrors the structure of the GMS contract with three levels of service. It is intended to improve access to pharmacy services and to raise the quality of services. Essential services are provided by all community pharmacies, advanced services are provided by accredited community pharmacists and pharmacies and enhanced services are locally commissioned by PCTs to meet local needs.

Essential services include: dispensing of medicines; repeat dispensing; signposting patients to other health providers; support for people with disabilities; medication waste disposal; health promotion and support for self care. In addition all pharmacists are expected to put in place systems for clinical governance and are to participate in Continuing Professional Development.

Advanced services include: medication use review and prescription intervention service. Accreditation of the pharmacist to provide these services is provided by many universities and premises suitability is by self certification and subsequent PCT verification.

Enhanced services: services commissioned locally by the PCT and could include:

- minor ailment management,
- disease specific medicines management service,
- concordance services,
- domiciliary assessments,
- needle exchange,
- palliative care services,
- Enhanced Hormonal Contraception services
- Smoking cessation service
- Headlice management service
- Substance misuse service
- Diabetes screening
- Gluten free food supply
- Services to schools
- Out of hours service
- CHD screening / healthy living
- Home care and intermediate care services
- Anticoagulation services
- Supplementary prescribing
- Patient Group Direction Service
- Full clinical medication review

It is expected that over time some services may move between categories for example some currently enhanced services may be re-categorised as advanced and currently advanced services being re-categorised as essential.

Essential and advanced services are nationally specified. Model service specifications are also available for most enhanced services although PCTs may be able to alter these to meet particular local needs and negotiate these locally. Costing may be determined using an enhanced services costing toolkit available from the PSNC.



Qualifying pharmacists in both primary and secondary care are advised to determine what enhanced services are being commissioned locally. The flexibility provided in the new Pharmacy and GMS contract are intended to assist contractors in being able to meet both national and local public health and public service targets.

To progress issues in the new contract all PCTs are required to do a local assessment of Community Pharmacy Services in their area and a toolkit for PCTs the use is available from NtPaCT at www.natpact.nhs.uk/pharmacy

Further information regarding the new Pharmacy Contract is available from the Pharmacy Services Negotiating Committee (PSNC) website www.psn.org.uk

NHS POLICY AND PRINCIPLES

The NHS Plan

The NHS Plan, announced in July 2000³, set out the original blue print for radical reform within the NHS. The key aims of the Plan were to redesign the NHS around the needs of the patient by making a large number of changes to the detail of how the NHS ran and how the professionals within it work. It constituted the biggest change to healthcare in England since the NHS was formed in 1948 and determined a 10 year program of reform and redesign. The core principles of the NHS were stated in the Plan.

The NHS will:

- provide universal service for all based on clinical need, not ability to pay
- provide a comprehensive range of services
- shape its services around the needs and preferences of individual patients, their families and their carers
- respond to different needs of different populations
- work continuously to improve quality of service and to minimise errors
- support and value its staff
- work together with others to ensure a seamless service for patients
- help keep people healthy and work to reduce inequalities
- respect the confidentiality of individual patients and provide open access to information about services and performance

Sections within the Plan related to NHS facilities and staff, cutting waiting times, improving health, changes for doctors and other staff. Further details are provided on the Department of Health website

The NHS Improvement Plan: Putting People at the Heart of Public Services

The NHS Improvement Plan in June 2004¹⁰ builds on the principles set out in the NHS Plan and sets out the way in which the NHS needs to change to become truly patient-led. The changes suggested are profound and affect the whole system and the way individuals and organisations behave. It states that the previous 5 years were about building capacity and capability but that the next will be about improving quality. Key NHS Priorities for the years 2004 – 2008 are highlighted.

Some of the key themes set out within this document are:

- The delivery of quality based on clinical need
- Continued reduction in waiting times for patients
- The right of to choose where they will be treated from 4 or 5 different health care providers
- The emphasis on long term conditions
- Support for patient self care and self management
- Disease prevention and public health
- Health inequalities

In operational terms the document highlighted various initiatives to support this agenda. These include:

- Greater flexibility in the way services are provided with a 15% target for procedures to be provided by independent providers by 2008
- Greater flexibility for PCTs to commission services from a range of providers
- Flexibility in NHS staff with new the development of skills and a new pay structure
- Electronic information systems including Choose and Book, NHS Direct on line and NHS Digital Television and the introduction of a individual personal care record
- The introduction of financial incentives including payment by results
- Continued movement of power towards PCTs and Foundation Trusts
- Reduced beaurocracy and fewer national targets

Subsequent documents provided further information about key areas of delivery and change arising from the NHS Improvement Plan. These include

Creating a patient- led NHS: Delivering the NHS Improvement Plan¹¹

This describes the major changes underway to develop a truly patient led NHS.

Commissioning a patient – led NHS¹²

This sets out how commissioning will be addressed throughout the whole of the NHS structure and announces the latest changes in function for SHAs and PCTs. The three main areas to concentrate on for the future are highlighted as:

- Promoting health improvement and reducing inequalities
- Securing safe and high quality services for their population
- Emergency Planning

Our health, our care, our say

This key white paper published in January 2006 ¹³ covers a range of government initiatives designed to shift the balance of services from secondary care to primary care settings. The paper aims to: improve health and wellbeing; improve access to high quality services; provide support for those in greatest need; and ensure care is provided in the most appropriate setting close to home.

Greater integration between health and social care, patient choice and empowerment and the delivery of more services in GP surgeries, clinics and community hospitals are among the underpinning themes of in the paper

Key recommendations include:

- Patients to have greater choice of general practice but registration with only one practice
- Longer practice opening hours
- The Quality and Outcomes Framework of the GMS contract to be refocused for greater prevention, self care and management of long term conditions
- Introduction of a 'life check' at different ages with those people needing intervention referred to health trainers
- Development of new care pathways; more development of intermediate and joint care
- National procurement of services in areas where they are identified as being insufficient or below standard.

More capacity and contestability will be introduced throughout primary care with new providers including social enterprise and commercial companies encouraged - though there is no requirement for PCTs to divest themselves of provision. The social enterprise model with more '3rd sector' providers who reinvest any surplus in services is highlighted as a key option for providers.

PCT freedoms to provide or procure additional services or to fill gaps in services will be developed further, with input from local authorities.

QOF will also develop 'strong incentives' for self care with the role of the GP in promoting self care identified as one of the 'highest priorities' of the future contract. By 2008/9 the QOF is expected to have new measures to focus on health and wellbeing with a new national reference group on health and wellbeing having a key role in determining priorities.

The paper outlines key issues around workforce development in delivering the agenda outlined. It highlights that new strategies are needed for workforce development with staff increasingly equipped with skills to work across both hospital and community settings and in new environments. Education and career frameworks need to be integrated across both health and social care to facilitate these changes.

Organisations will plan around competencies, identifying the skills needed to suit multi-agency environments with common tools and processes

Choosing Health

Choosing Health¹⁴ is a key Public Health white paper is based on the principle that the NHS is about disease prevention as well as the treatment of illness. The principles behind this new approach to public health are:

Informed choices – people want to make their own decision about choices that affect their health and to have good quality information to help them do so

Personalisation – support to be tailored to the realities of the individual lives

Working together – progress depends on effective partnerships across communities

Measures in the paper include:

- Ban on smoking in the workplace in restaurants and in pubs
- An overhaul of sexual services
- Clear labelling of the nutritional content of food
- Action to curb the promotion of unhealthy foods to children
- NHS health trainers to provide advice to individuals on how to improve their lifestyles
- Specialist obesity services within every PCT

RELEVANT PHARMACY POLICIES AND PUBLICATIONS

Pharmacy in the Future

Responding to the NHS Plan the document “Pharmacy in the Future”⁴ set out its vision of how pharmacy could play a full part in delivering the new NHS agenda. It is probably the most important document relating to pharmacy and pharmacists in the last 50 years and you would be advised to obtain a copy.

Three challenges highlighted for pharmacy in this document were:

- Meeting patients changing needs by making sure that people get medicines or pharmaceutical advice easily and in a way, at a time and in a place of their choosing.
- Responding positively to the competitive environment where people demand a greater variety of ways of accessing services at a time convenient to them.
- Ensuring that public confidence in the profession is maintained and enhanced.

Pharmacy in the Future identified how pharmacy services could support the NHS Plan in four key areas.

Better Access to Medicines and Advice

- Supporting ‘self care’ of patients with more OTC medicines and more switches from POM to P
- Easier access to out of hours medicines
- NHS Direct referral to pharmacies
- Pharmacies in one-stop primary care centres
- Repeat dispensing
- Electronic prescribing
- Increased pharmacist input to public health initiatives such as smoking cessation where appropriate through the use of ‘Patient Group Directions’

Helping patients get the most from their medicines

- Investment in medicines management initiatives.
Two government funded initiatives have been set up. One is run through the PSNC and the other through the National Prescribing Centre. All PCTs were expected to have set up medicines management schemes by 2004
- Investment in a partnership approach to medicines

Redesigning Services

- Local Pharmaceutical Services pilot schemes
- Rewarding quality services not prescription volume
- A review of contract restrictions
- Performance framework for hospital pharmacy
- Pharmacist prescribing

Getting the most from staff

- More preregistration training places
- Better use of pharmacy workers
- Undertaking a thorough review of workforce requirements
- Addressing issues of skill mix in the pharmacy
- Resources for Community Pharmacy Clinical Governance
- Giving commitment to the requirement for lifelong learning

A Vision for Pharmacy

This consultation document¹⁵ set out proposals for a programme of continuing development for pharmacists to implement Pharmacy in the Future and provides a vision for future Community Pharmacy services. Some of the key elements within this were used in developing the new Community Pharmacy contract.

The document lists ten key roles for pharmacy which have been identified by the Chief Pharmaceutical Officer and are listed below:

- To provide convenient access to prescriptions 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 health care services, especially 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's journey
- To support patients as partners in medicines taking
- To prescribe medicines and monitor clinical outcomes
- To be a public health resource and provide health promotion, improvement and harm reduction services
- To promote value for money in the issue of medicine to reduce wastage

Building a safer NHS for patients: Improving medication safety¹⁶

This Department of Health publication sets out some of the causes of medication errors and gives examples of good practice to reduce medication errors. This document is aimed at pharmacists and pharmacy services and has important implications for practising pharmacists.

Changes in professional regulation

The government recognised that systems of health professional regulation were uncoordinated and inconsistent between the professions; hence a Council for The Regulation of Health care Professions was set up in 2003. However, since this time the name of the organization has changed to reflect its role and purpose, and it is now called the **Council for Healthcare Regulatory Excellence** (<http://www.chre.org.uk/>). This role of this statutory overarching body (covering all of the United Kingdom) is to promote best practice and consistency in the regulation of healthcare professionals. All individual regulatory bodies (including the RPSGB) are now accountable to this council and the result is that the requirements for education, training, continuing professional development, revalidation and fitness to practice are, to a significant extent, standardised. Arising from this change all professionals including pharmacists are expected to demonstrate

- A commitment to, and participation in, continuing professional development (CPD)
- Fitness to practise in their specialist field

Some form of regular 'revalidation' is also likely to be expected in the fullness of time.

THE NHS PLANNING FRAMEWORK

Every 2 years the Chancellor of the Exchequer undertakes a review of all public service bodies and the outcome is a Public Service Agreement (PSA) which sets out what the service is expected to achieve within the new allocation of resources. As part of this process the document “National standards, Local action”¹⁷ sets out a standards-based planning framework to be used in planning, commissioning and delivering health services.

The framework of Health Care Standards “Standards for Better Health” forms a part of this publication. These standards are used by the Health Care Commission who have responsibility for assessing the quality of health and health care in England. Standards are divided into Core standards that are expected to be met by all organisations in order to be acceptable, and developmental standards which form the basis of measuring the progress of organisations within the NHS to meet increasing patient expectations. Annual guidance is also provided to supplement this and to give further detail on planning and action within year.¹⁸

Examples of some medicines related standards include: core standards for the need to record and learn from medicines related incidents (Standard C1a); the need to ensure that all medicines related alerts, safety notices and other communications are acted upon within timescales (Standard C1b); the need to ensure that all medicines are handled safely and securely (Standard C4d); and that organisations confirm to NICE technology appraisals (Standard C5a).

Taking this forward locally **Local Delivery Plans (LDPs)** are led by PCTs with the active engagement of all key stakeholders. These LDPs are three year strategic action plans covering NHS and Social care priorities. The Seven key national priority areas are addressed and they should describe the planned health and social service improvement in their areas to address each of these priority areas.

National priorities for 2005-2008

National targets have been set within the Health and Social care standards that cover four broad priority areas:

- **Improving Health of the population**
Health Promotion and disease prevention so that people are kept out of hospital as far as possible
Target: increasing life expectancy at birth to 78.6 years for men and 82.5 years in women with specific targets around cancer, mental health, smoking, obesity and sexual health
- **Supporting people with long-term conditions**
Promoting better self-care. Treatment in the community or peoples homes and avoiding hospital admissions
Target: offering personalised care to vulnerable people at risk and reducing emergency bed days by 5% by 2008
- **Improving Access to services:**
To reduce the issue of waiting.
Target: By 2008 no one has to wait more than 18 weeks from GP referral to hospital treatment with specific targets around problem drug users
- **Improving the Patient / user Experience**



Promoting patient choice and becoming more customer focused

Target: *Individuals are involved in decisions about treatment with additional targets around reducing MRSA levels in hospital and other organisations*

Services offered by pharmacists such as Medicines Management, Out of Hours Medicines, Health Promotion, Minor ailment schemes, Smoking Cessation services and supervised methadone administration could all contribute to various aspects of the national priorities and targets that have been set.

RELEVANT LEGISLATION

The legislative framework for the NHS in England and Wales is mostly set out in the National Health Service Act 1977. Several parts of this legislation have been amended quite substantially by various enactments. Four of the most recent are outlined below

Health and Social Care Act 2001¹⁹

This Act addressed many of the aspects of the NHS Plan that required primary legislation. It provided better protection around the use of patient information, strengthened the way that public and patients were involved in the way the NHS works, modernised pharmacy and prescribing services and changed the way long term care was funded and provided. One of the elements of this Act was to provide the legal framework for Local Pharmaceutical Services (LPS) within the NHS.

NHS Reform and Health Care Professions Act 2002²⁰

Put in place the legislation required to take forward the proposals in *Shifting the Balance of Power** and *Involving Patients and the Public in Healthcare**. It provided for the changes to the role of CHI and for the setting up of the Council for the Regulation of Healthcare Professionals.

Community Care (Delayed Discharge) Act 2003²¹

This Act is intended to overcome the problem of delayed discharges because people who are ready and safe to leave hospital are unable to do so because their care needs have not been addressed or their package of onward care has not been put together. This is done by introducing a reimbursement system for delayed hospital discharge, whereby the Local Authority (LA) must make a payment to the healthcare provider for each day of delay from hospital when the LA is responsible for that delay. In addition, it is also now possible in certain circumstances to remove local authorities' power to charge for certain community care and carer's services

Health Act 2006²²

This Act makes provision for the prohibition of smoking in certain premises, places and vehicles and for amending the minimum age of persons to whom tobacco may be sold. It also makes provision in relation to the prevention and control of health care infections and in relation to the management and use of controlled drugs. Finally it makes provision in relation to the supervision of certain dealings with medicinal products and the running of pharmacy premises.

BACKGROUND TO OTHER GOVERNMENTAL DEPARTMENTS SUPPORTING THE HEALTH SECTOR

Skills for Health

Skills for Health (SfH) is one of the 25 Sector Skills Councils, which make up the Skills for Business Network. These are licensed by the Secretary of State for Education and Skills in consultation with Ministers in Scotland, Wales and Northern Ireland.

The broad aims of all of these Councils are to:

- Address skills gaps and shortages
- Improve productivity and performance
- Increase opportunities to boost skills
- Improve learning supply

Skills for Health is funded through the four UK health departments, the Sector Skills Development Agency, regulatory bodies and the sector. They do not provide training directly; they see education and training providers as some of their key partners. Their remit is to help the health sector develop solutions that deliver a skilled and flexible UK workforce in order to improve health and healthcare. They cover the whole of the health sector (NHS, independent and voluntary employers) and work with a range of partners to:

Their aims are to:

- Develop and manage national workforce competences
- Profile the UK workforce
- Improve workforce skills
- Influence education and training supply
- Work with their partners

They have a network of Directors in Scotland, Wales and England. Their role is to act as a source of information and intelligence on skills issues, contributing to policy development and ensuring that SfH is sensitive to the specific regional and national needs of the health sector.

www.skillsforhealth.org.uk



SUMMARY AND CONCLUSIONS

The NHS is undergoing a massive programme of change, which will have a major impact on the way that pharmacy is practised in England. These changes offer perhaps the greatest opportunities for pharmacy in its history. However, in order to take advantage of these opportunities the profession must be prepared to change and modernise itself. In particular, the need for individual pharmacists to maintain and develop their skills throughout life will be crucial.

Rather than seeing the preregistration year as the final chapter in a five year training process, you must see it as the start of a process which will continue for as long as you continue to practise.

These are exciting times to be qualifying as a pharmacist.

Helen Liddell, Leeds - March 2007



RESOURCES AND REFERENCES

Useful Website Resources:

www.natpact.nhs.uk
www.primarycarecontracting.nhs.uk
www.dh.gov.uk
www.bma.org.uk
www.psn.org.uk
www.nhs.uk
www.nice.org.uk

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¹⁴ Choosing Health. Making Healthier choices Easier. Department of Health. Nov 2004. <http://www.dh.gov.uk/assetRoot/04/09/47/52/04094752.pdf>

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