The *White Paper* will give pharmacists new opportunities to redefine pharmaceutical care provision — if they are prepared to embrace the challenge

The Government White Paper *Pharmacy in England: building on strengths, delivering the future*, published last April, should auger exciting developments for the pharmacy profession. Michael Holden and Deborah Evans are involved in supporting the changes needed to deliver the planned outcomes within the White Paper and they describe here its remit and some challenges that lie ahead for pharmacists.

Introduction

In April 2008 the Government announced its *Pharmacy White Paper,*[1] which highlights pharmacy's place in the NHS and its role as a leading clinical profession delivering better access to high quality services for patients and the public. While the focus is mainly on community pharmacy, its context is wider including hospital pharmacy, commissioning of services, professional regulation, and education and training.

The Government has a number of aims for community pharmacy. These include:

- a shift from dispensing to clinical services
- a wider range of services, exploiting opening times and location
- greater use of clinical skills and pharmacy staff.

To achieve these aims pharmacies will:

- become 'healthy living' centres — promoting health, well-being and self-care
- be the first port of call for minor ailments and supply common medicines
- support patients with long-term conditions.

Context

Over the last few years there have been a number of professional, regulatory and commercial changes (illustrated in Table 1) and these continue to impact on community pharmacy in England. These present many challenges for community pharmacy, which must become much more integrated within the primary health care team and have greater involvement in the delivery of health and well-being solutions. Managing these changes, overcoming the challenges, dealing with the insecurities and threats and optimising the opportunities have been met with varying degrees of success by the NHS and the profession. The key issues driving change include:

- the need to address health inequalities and secure improved health and well-being for all
- the impact of current NHS reforms; improving quality, access and choice for patients

Table 1. Changes impacting on community pharmacy

- Review of the contractual frameworks and funding arrangements in all home countries
- Category M
- NHS financial recovery
- Pharmacist prescribers
- All Party Pharmacy Group (APPG) inquiry
- Galbraith report
- New distribution arrangements
- World Class Commissioning
- Vascular risk assessment, reduction and management
- Responsible pharmacist consultation and planned changes in supervision
- ABPI guidelines and MHRA regulations
- NHS re-configuration
- Pharmacists with a special interest
- Electronic prescription service
- Clarke report
- Practice based commissioning (PBC)
- Pharmaceutical Price Regulation Scheme (PPRS) review
- Darzi NHS review and primary and community care strategy

Medicines use reviews (MURs) will remain a high priority area for the NHS.

- a focus on better commissioning of services to meet local needs
- the need to make better use of resources to deliver the best outcomes and harness new technologies.

As the NHS moves away from provision and further towards a pure commissioning role, the roadmap for pharmacy is becoming clearer; it needs to be, and be seen to be, a clinical profession providing quality health care services, not just a supplier of medicines.

The *White Paper*

The *White Paper* has been positively received by most within the profession although some questions remain concerning implementation, resources to deliver and a funding framework. The strengths within pharmacy are acknowledged and underpin the developments that will happen, which are outlined below.

Build on pharmacy's accessibility and expertise in medicines use to improve access to medicines and promote their safe and effective use

The main points here are:

- Medicines use reviews (MURs) will remain a high priority area for the NHS with:
  (i) Improvements in MUR quality eg. peer review, CPD, research and audit
  (ii) Primary Care Trusts (PCTs) may decommission MURs from those failing to meet quality standards based on new outcome metrics.
- Increase implementation of repeat dispensing to deliver benefits.
- Reduce medicines waste through improved management and adherence.
- Overcome the challenges associated with accessing medicines out-of-hours.
- Dispensing doctors may sell over-the-counter (OTC) medicines linked to broader reforms for dispensing doctor contracts.
- Improve access to medicines and information between secondary and primary care interface and the establish 'health community clinical pharmacy teams'.
- Commission safe services for delivery of oral chemotherapy within community pharmacy.
- Safe medicines practice embedded in primary care to reduce unplanned hospital admissions related to medicines.

Expand existing pharmacy services and develop new services to support healthy living and better care

Pharmacies will:

- be repositioned, recognised and valued by all as healthy living centres
- change their focus to an expanded range of clinical patient services
- support patients with LTCs including a new service for the newly diagnosed.

To enable these points outlined above there will be a number of initiatives, which are:

- a work programme for 2008–10 to accelerate pharmacy's contribution
- electronic capturing of interventions

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- more pharmacy staff to be health trainers
- minor ailments scheme to be incorporated into contractual framework
- partnership between pharmacy stop-smoking services and local NHS services
- national template for commissioning of *Chlamydia* screening
- expand pharmacy-based contraceptive services
- include pharmacies in the delivery of the vascular risk assessment programme
- enhance the role of pharmacy in the care of patients with diabetes
- support for patients on new treatment for the management of LTCs
- put systems in place to support early detection and prevention of some cancers
- appointment of two clinical leaders — one hospital, one community pharmacy.

In December 2008 the Government announced that it would not be making any changes to the dispensing arrangements for doctors and in January 2009 an interim report on the feedback from the consultation was published without offering any specific recommendations at that stage. Subsequently the government published the *Health Bill 2009* which contains provisions on market entry, a new quality and performance regime and amendments to legislation on LPS contracting.

Pharmacies are well placed within the communities they serve to support the national and local public health strategies with a focus on maintaining good health. There are, however, a number of structural enablers that must happen to support the shift in role, and these will need cooperation across the whole health care system. These include strengthening PCTs' commissioning of pharmacy services as part of the World Class Commissioning programme by:

- rewarding pharmacy contractors adequately for their investment
- fostering a shift away from pure dispensing and towards clinically focussed pharmaceutical services

- providing better rewards for those embracing change and delivering the vision
- encouraging innovations that meet local needs
- commissioners recognising that pharmacy is an essential part of clinical service delivery.

Other structural enablers were described including:

- a major consultation in autumn 2008 on the control of entry system including 100-hour pharmacies, dispensing doctors and appliance contractors
- update pharmaceutical needs assessments (PNAs), involve pharmacists in local planning processes and integrate their work into care pathways for patients
- develop local pharmaceutical service (LPS) solutions
- PCTs are to be directed to commission certain services (directed enhanced services) according to local needs, such as minor ailments, vascular checks, LTC support, *Chlamydia* screen and treat, and contraception.

There is also a need to:

- set more robust standards for essential and advanced services
- harmonise accreditation
- introduce financial incentives and penalties with sanctions for poor performance
- develop easily measurable metrics to demonstrate quality of outcomes.

Additional requirements

This *White Paper* highlights some additional actions that must happen to enable and sustain the change to ensure that patients and the NHS fully benefit. These are described below.

Communications and relationships

If pharmacy is going to realise its true potential then patients have to know about the full range of services that can be accessed and the choices that they can make. These include:

- A communications programme. This is needed to deliver messages to patients, the public, NHS and other stakeholders on the breadth of services and skills available within pharmacies.
- Improved inter-professional relationships, particularly between pharmacists and GPs.

Research and innovation in practice

Pharmacy practice should be based on sound evidence and decisions for patients based on appropriate clinical information.

- Research and innovative practice with sound evidence base will be supported
- Further work is needed to consider giving pharmacists access to patient summary care records.

The pharmacy profession

The pharmacy profession needs to be brought in line with other professions and this means:

- A new regulatory body is needed (to be established in 2010 — the General Pharmaceutical Council; GPhC).
- There is a need for a strong professional leadership body.
- Changes in education and training for undergraduates and post-qualification
- Legislative changes to optimise deployment of the whole pharmacy workforce, eg. regulations concerning supervision and responsible pharmacist.
- New professional, clinical and leadership competencies must be developed to deliver services.

Progress to date

In August 2008 the consultation on the *White Paper* proposals for legislative changes[2] was published and then informed by a series of listening events. This document excluded possible future payment mechanisms but provided more information on a number of proposals for structural change as follows:

- A stronger focus on commissioning for quality including changes to the control of entry system based on PCT's assessment of local needs to promote choice, competition and quality. This includes sanctions for poor performers.
- Changes to the current exemption criteria for 100-hour contracts
- Introduction of supplementary lists for individual pharmacists and compliance with the *Safeguarding Vulnerable Groups Act* 2006
- Reforms of arrangements for doctors providing dispensing services including a single regulatory entry system for pharmacies and dispensing doctors
- Legislative changes required to allow the sale of OTC medicines by some dispensing doctors
- Reforms to bring arrangements for appliance contractors in line with pharmacy contracts
- Amendments to the *NHS (Pharmaceutical Services) Regulations* 2005 and to provisions governing local pharmaceutical services contracts.

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The two national pharmacy 'tsars' have now been appointed to drive through the key objectives. The clinical director for primary care and community pharmacy is Jonathan Mason at City and Hackney PCT and the clinical director for hospital pharmacy is Martin Stephens at Southampton University Hospital Trust. They will report to Dr Keith Ridge, Chief Pharmaceutical Officer at the Department of Health. In addition, the National Public Health Leadership Forum is working on several elements and ongoing negotiations are taking place between the Pharmaceutical Services Negotiating Committee (PSNC) and NHS Employers on service specifications and potential changes to the contractual framework.

Discussion

It should be remembered that although there is much detail to be agreed this is a command paper and events described within it will happen. The challenge is

to pro-actively enable the change. This needs the sort of engaging and compelling vision provided by the *White Paper*, requires the profession to accept that we must re-engineer our practices and an honest acknowledgement from all sides that we will need proper support to do so. To continue to do what we have always done means that pharmacy will get what it has always got…or more likely, less! New ways of working will result in successfully combining a safe, high-quality and efficient dispensing service with new clinical and public health activities.

Change also requires a different way of thinking, feeling and working. Organisations cannot change in isolation so we need to consider the key principles of change management in order to bring the grassroots of the profession with us. There are many experts in the field of change management. Stephen Covey[3] says that we should begin with an end in mind and John Kotter[4] highlights the need to put the appropriate steps in place beginning with a sense of urgency and the establishment of a guiding team to create a clear vision and strategy, which are effectively communicated to empower others to act. Beyond this we should create some quick wins, not let up and embed change in all that we do.

We strongly urge all sectors of the profession to work together at both a national and local level. Primary care pharmacists are well-placed to act as a facilitator between general practice and community pharmacy with patients' needs firmly embedded at the centre of collaborative activity. PCTs and Local Pharmaceutical Committees (LPCs) can lead the change by establishing a 'guiding team' involving community, primary care and secondary care pharmacists and commissioners. This team must develop an action plan with clear accountabilities, timelines and measurable outcomes and recognise the change individuals will need to go through.

Top tips for enabling change

- ☐ Give people some time to adjust; listen to their concerns and feelings
- ☐ Increase urgency; reduce complacency
- ☐ Explain the reasons for change; consult and involve
- ☐ Ask all sectors for their ideas about making the change work
- ☐ Answer questions honestly and openly
- ☐ Create sufficient trust for others to be open
- ☐ Understand what the change would mean to all stakeholders
- ☐ Learn actively from the change experience

Conclusion

The opportunities outlined within this *White Paper* are unprecedented and give community pharmacy in particular the chance to redefine how pharmaceutical care and public health is provided to patients. A vision is not, on its own, enough. Realisation of that vision will only come with investment, strategic planning and, most importantly, targeted action. Cultural change requires the right environment; it needs stability, confidence, a road-map to a well defined destination and proper levels of support. All are crucial, yet few if any of these critical success factors are in place. We all have an important role in making this happen. ✣

The future will require pharmacists and their teams across all sectors to embrace the opportunities within the *White Paper* and the developments in education and training that will equip them for their new clinical roles in patient care.

Declarations of interest

The authors are working with a number of stakeholders to support the change required to deliver the planned outcomes within the pharmacy *White Paper*.

Michael Holden and **Deborah Evans**, directors of balance, an independent pharmacy consultancy. Contact: info@balancesolutions.org.uk

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