

5th October 2010

White Paper Team

Room 601

Department of Health,

79 Whitehall,

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Equity and Excellence: Liberating the NHS White Paper

Response from the Guild of Healthcare Pharmacists

Thank you for the opportunity to respond to this consultation. The Guild of Healthcare Pharmacists represents UK wide around 4,000 pharmacists including the majority of hospital pharmacists, pharmacists employed by Primary Care Trusts (PCTs) and pharmacists employed by other public bodies such as the Commission for Social Care Inspection and the Healthcare Commission. The Guild is part of the health sector of the union Unite.

Our response to main questions regarding the draft standards are as follows:

1. Liberating the NHS 1.1–1.28

An NHS that is available to all, free at the point of use and based on need not the ability to pay is a fundamental principle to GHP members. The values of shared access to collective healthcare and a shared responsibility to use resources effectively to deliver better health care will also chime with our members who as medication managers see better utilisation, informing patients on risks and benefits to improve decision making and collective multi-disciplinary work in secondary and primary care as their core role. We also welcome the focus on outcomes rather than inputs, outputs and process measures and the stronger emphasis on quality. We too recognise the successes of the NHS and equally areas of poor outcomes. However we are unconvinced that basic tenets of greater competition will deliver the excellent vision outlined as history tells us it will increase fragmentation, insularity and potentially lead to increased costs and due to the required bureaucracy to support a competitive market and a multiplicity of commissioners and providers.

2. Putting patients and the public first 2.1–2.4

The GHP fully supports the Government's ambition of achieving world class health outcomes and daily our members work to fully-inform patients on the alternative options for appropriate medication treatment assisting them to jointly decide with other clinicians on a suitable pathway of care that most fits their individual needs. For the NHS Commissioning Board's (NHSCB) role to champion patient and carer involvement it should have expert advice from clinicians including pharmacists and many of our members as front-line clinicians have experience and expertise of commissioning and ensuring the effective utilisation of medication as the most common clinical intervention is core to service delivery.

2.5–2.17

Pharmacists were one of the leading professions in adopting the first information revolution to produce clear and effective labelling with appropriate decision constraint systems to prevent obvious errors.

We fully support the government's moves to provide accurate, relevant and informative data for patients to help inform them about their choices of care. We also support the need for patients to be able to communicate with all healthcare professionals providing their care. Healthcare professionals must also be able to communicate with each other about treatment decisions. Our members are committed to involving patients in their treatment decisions and lifestyle choices as evidenced by a clear move and emphasis from adherence and compliance with medication regimes towards concordance.

We would support the use of patient surveys and real-time feedback and openness about mistakes and errors. However to achieve this openness it is essential that the coalition government deliver on their commitment on the selective treatment of dispensing errors under section 64 and 85 of the Medicines Act. Our members are faced with an invidious choice of being required to disclose errors as part of their contract but conversely leaving themselves open to prosecution under strict liability legislation where there is no mind to undertake a criminal act.

Although our members within the NHS have access to hospital records we can see the advantage especially on admission and discharge of shared records both between all providers in primary and secondary care and patients themselves. This would enable the completion of NICE/NPSA PSG 001 (medicines reconciliation) for all healthcare providers.

We do however have concerns that the Government needs to be selective in its data collection to avoid increased bureaucracy by focus not on the data that supports commissioning especially at the periphery as increased resources on data collection for accountancy and contractual purposes can lead to a loss of resources from direct patient care. Information systems should provide high-level assurance of contractual compliance

but detailed information should be at the clinical level to improve patient safety.

2.18–2.23

The Government rightly identifies patient choice as a key element to service provision within the NHS. However, this choice must be supported by all clinicians in different professions and the funding stream as stated must support this choice. We also recognise that in certain high risk and complex treatment programmes e.g. oral anticoagulation, it may be more appropriate to focus on continuity of service to ensure patient safety rather than risk “holes” in the system by utilisation of multiple of “any willing providers”

2.24 –2.26

The GHP and its members are committed to the fact that standards of service provision will be raised with the introduction of an enhanced but equally importantly an informed patient voice. There should be systems to ensure this is a true voice not just those of committed and organised lobbies. The incidents at Mid Staffordshire and Airedale show that it is important that the expectations and responsibilities of healthcare professionals are clear and their voices are listened to when concerns are raised about service quality. The recent advice on whistle-blowing arrangements are thus to be welcomed.

3. Improving healthcare outcomes

3.1–3.4

We totally support the new Government in continuing the work of Lord Darzi, focusing on quality outcomes and general quality improvement to enhance patient safety. We welcome the core purpose as a focus on improvement of quality and healthcare outcomes as the primary purpose of the NHS and commend to the Government in England the work in Northern Ireland that has shown how investments in integrated medicines management services has improved patient safety, experiences and outcomes in terms of readmissions and length of stay.

We know from Audit Commission work that the medication pathway is complex, slow and error strewn despite the best efforts of our members and other healthcare professionals. The evidence shows that with investment the financial and economic returns are enhanced but more importantly the safety of individual patients is improved. Our members have been frustrated that their efforts in this area are hindered by chronic vacancies due to inequitable salaries and we are concerned that with the current financial pressures, employers will take the short-term decision to dis-establish these posts rather than address the underlying problems.

It is right that patients are asked to measure outcomes and that standards of services are monitored. This information must be used in conjunction with clinical outcomes when these services need to be re-commissioned so that previous standards of care can be taken into

account.

We support the assertion that healthcare outcomes “improve most rapidly when clinicians are engaged, and creativity, research participation and professionalism are allowed to flourish”. However, many pharmacy clinicians do not participate in research due to a lack of protected time for such activity within their clinical role. Healthcare outcomes would therefore benefit from the allocation of funding for pharmacists to undertake training to increase clinical research, similar to that available to their colleagues in the healthcare team.

3.5–3.11

We support the emphasis on outcome based performance in setting the direction for the NHS, public health and social care recognising that this requires work in collaboration across these organisations. The two must be clearly distinct and supported by principles or criteria that show what should be delivered by which organisation locally, but also highlight the benefits to patients and the cost savings of collaboration.

3.12–3.15

We accept that progress on outcomes will be supported by quality standards but these authoritative standards have to be both achievable and deliverable within the accompanying financial framework. It is clear that many of our members feel the stress of delivering existing standards in an environment of staff shortages and there is a need for an effective and realistic capacity-planning framework to accompany these requirements. We welcome the expanded role of NICE but request that quality standards are clear and unambiguous if resources are not to be diverted and wasted on meeting a new series of inappropriate targets and compliance is not a major data collection exercise again diverting resources from direct patient care.

3.16

The Government’s commitment that research remains a core function of the NHS is to be welcomed. We would seek our managed sector pharmacist members having equal access to NIHR funding streams as their colleagues in medicine, dentistry, nursing, midwifery and allied health professions

3.17-3.23

Our members in Foundation Trusts have seen some benefits from the transparency of effective payments systems and its ability to address issues that may have been unresolved particularly in relation to services across the interface. We support the introduction of best practice tariffs rather than average price which encourages competition on quality rather than price. The imposition of penalties is supported but must be handled carefully in that it should be about service quality rather than data provision if resources are not to be sidetracked into data collection. The recent experience on value based rebate schemes from commercial companies are a classic example where compliance requires major investments

in data collection systems to achieve the funding at no benefit to patient care.

Successful commissioning needs to take outcomes, cost and availability into account when deciding upon which service should be commissioned. A co-ordinated scrutiny process needs to take all three aspects into account to monitor and measure commissioning effectiveness. It will be very difficult to measure outcomes and cost when they are monitored by different bodies. This will need to be underpinned by the free and transparent flow of information and we would see this as a clear role for the Health & Social Care Information Centre. Pharmacists already play a vital role in optimising medicines and there is evidence of the major effects that our members employed in PCTs and SHAs have had on both improving the clinical and financial utilisation of medication. We have major concerns that the changes proposed with the potential dissolution of these supporting structures may lead to a loss of this expertise to the detriment of the NHS and more importantly patients. We await information on how the Government proposes to replace and improve these structures within its new commissioning framework.

4. Autonomy, accountability and democratic legitimacy 4.1-4.9

No one can disagree with a healthcare service freed up to deliver healthcare to patients but we return to the fact that any commissioning body will need to have a degree of expertise at the appropriate level. We also believe there should be robust governance arrangements in place which ensure the 'any willing provider' model is fully supported and that GP consortia consider all providers in a transparent manner and so are not seen to favour their constituent practices. It is essential that these consortia are not solely constituted by GPs and/or nurses but take in the expertise on an equal basis from a wide range of healthcare professionals. As the new, proposed system of primary healthcare is introduced, we highlight the fact that it is essential to capture the expertise existing within PCT pharmacy teams. These teams working commissioning arms provide essential pharmaceutical input into local strategic decision making as well as prescribing advice and work on medicines usage and formulary management. The effective utilisation of this expertise will be pivotal in the future success of primary healthcare and through collaboration with secondary care colleagues achieve the required improvements across the existing interfaces.

Given the sizable primary care medicines expenditure and the risk associated with a lack of pharmaceutical oversight, we would like to see the skills of PCT based pharmacists being protected in this transitional period and will work to ensure that they are embedded into the new NHS. These pharmacists ensure that drug budgets are within acceptable levels and that locally introduced formularies are suitable for the communities they serve. It is also currently unclear how specialist services, which are currently commissioned across PCT boundaries, will be commissioned in the future. Pharmacy specialist services which include the delivery of medicines information, medicines assurance and medicines usage and safety are currently commissioned across SHAs. The majority of these services are provided to organisations and we believe that these services need to be commissioned at a national or regional board level through the national and regional mechanisms in order to reduce the

problem of variability and to ensure that quality standards are applied equally across the NHS.

4.10–4.19

We would wish to see further proposals on the role of the commissioning boards on how it provide effective and inclusive leadership to hospital and public health pharmacists and how the local democratic mandates are achieved before commenting further.

4.20 –4.25

We note the concerns on the constraints on Foundation Trusts imposed by the previous parliament that were designed to prevent a potential increase in the privatisation, defragmentation of the NHS and variation in service delivery with a increase in the so called postcode lottery of treatment. However it is unclear that the coalition government has recognised the obstacles and barriers that have ensured that only 50% of NHS Trusts have Foundation status and our members are concerned at the proposed changes and the drive to social enterprises that are outside the NHS.

4.26-4-30

GHP totally supports the inspection of providers as an important part of maintaining quality service provision, but we would like to see this inspection integrated with the existing inspection regimes to which all healthcare professionals are subject. Multiple inspection teams will cause expensive duplication, needless distraction and possibly a conflict in advice given to individual practitioners. We would like to see appropriate but effective regulation, rather than duplication, for the benefit of professionals and bearing in mind the cost of regulation to the NHS.

4.31

We welcome the commitment to empower, engage and support staff and we agree that these measures improve patient care. The commitment to the Boorman recommendations is also welcome and we would seek action on the stresses caused to our members through staff shortages. We are unclear how extending the principles of autonomy in education, staff training and pay will be undertaken whilst ensuring small professional groups are not overlooked, standards and inputs remain consistent and there is not wasteful duplication.

4.32–4.34

We accept the difficulties of centralised workforce planning and ensuring the decisions affecting workforce demand are matched to supply but with small workforces we have experience that employers who have a short term focus often driven by short term financial priorities see the education and training and workforce development as tomorrow problem and a soft target for reductions with subsequent long term boom and bust as they react to short term problems of their own making.

Therefore as we continue to have significant pharmacist vacancies we are keen to ensure that the current funding streams for the education of pharmacists and their support staff within the managed sector is carried forward into the new NHS. Due to the size and mobility of the profession and the consistency of the problem due to the external market forces within and outside England we would argue this is a national issue that requires a national solution on both pay and workforce planning. SHAs have been instrumental in the management and routing of national funding in this area, if this role is taken up by GP consortia it is unclear how they will have sufficient expertise to ensure the most appropriate use of such funds. We are also concerned about the level of expertise within the Centre for Workforce Intelligence to inform and analyse and provide information about the complex pharmacy sector without direct input from within pharmacy.

4.35 –4.37

Currently within pharmacy there are major pay differentials particularly at the entry levels of hospital pharmacy. Funding for the Community Pharmacy contract, which sets the funding levels for private employers is negotiated by the NHS employers. The Pay Review Body has for a number of years reviewed the evidence provided by staff side organisations like ourselves supported by Unite and that provided by NHS Employers. For the last two years it has recommended a national recruitment and retention premium for band 6 and band 7 pharmacists recognising the major vacancy problem affecting patient care and safety due to salary differentials with Community Pharmacy rejecting NHS Employers evidence. Ministers have rejected this recommendation without clear reason in favour of local action and the problem remains to be addressed, as local employers do not want to destabilise the local NHS employment market or create local pay spirals.

We too await the independent review of pensions chaired by Lord Hutton, as this is a major concern to many of our members who have invested in both the ethos of public service and financially in its delivery. We note that the recent NHS pension review was seen as affordable by the previous government and the risk to the taxpayer was minimised by placing a ceiling on employer contributions.

5. Cutting bureaucracy and improving efficiency

5.1- 5.11

It is self-apparent that the better use of healthcare professionals across an integrated care pathway will cause a reduction in public spending. More efficient use of healthcare professionals – utilising them for those sections of the care pathway for which they are most suited – will introduce real savings in healthcare. Earlier in our submission we identified the benefits of integrated medicines management both on the quality and economics of healthcare. The abolition of SHAs and PCTs and the subsequent reduction in management costs opens up opportunities to become a leaner NHS. However, it is essential that the expertise and achievements of front-line pharmacists in these organisations are not lost. There is a danger that GP consortia will only focus on the medication budget but not

recognise the infrastructure that is required to support the effective management from a patient safety as well as a financial basis.

5.12–5.17

We support the continuation of the QIPP agenda and the resultant improvement in patient outcomes. Pharmacists have a particular role in the QIPP agenda as medicines are often the most expensive aspect of a care pathway and medicines usage is part of the majority of care pathways. Any process that takes an innovative view of a service would benefit from the inclusion of pharmacists expertise. There is a danger that many of the savings required during the transition will be lost as staff employed in PCTs and SHAs faced with major re-organisation and an uncertain future seek other employment. 6. Conclusion: making it happen

The GHP has welcomed the Government's offer to contribute to the consultation on the NHS White paper for England and we will seek to play an active part supporting the changes we see as beneficial to patient care and safety and highlighting areas of concern raised by our members.

As the organisation representing pharmacists in the managed sector we hope you will accept this offer of expertise and advice as we work together to build a better NHS.

We hope these comments are of assistance

Our reply may be made freely available.

Yours faithfully

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