Pharmacists have been warned not to underestimate their primary care trust’s ability to change funding arrangements once pharmacy’s global sum is devolved to them in April this year. The warning came from a group of dispensing doctors during the 2010 conference, which took place this week in Shanghai, China. Responding to the warning, Mike Dent, head of finance for the Pharmaceutical Services Negotiating Committee, assured pharmacists that their funding was not at risk, at least in the short term.

After the global sum is devolved, Mr Dent confirmed, dispensing fees and practice pay- ments will be absorbed into PCTs’ budgets. The global sum currently accounts for about a half of pharmacy’s NHS income. He admitted the situation might, in the long run, give PCTs an incentive to reduce the number of pharmacies in their area. However, he offered the following assurance: “Fees and allowances will still be negotiated centrally; they’ll still be in the Drug Tariff so your PCT’s control is limited.”

Lisa Silver, a GP and PCT adviser from Henley, Oxfordshire, offered a blunt prediction for the future of pharmacy funding. “The income stream now, for you guys, comes down centrally — it arrives at the PCT and gets dissipated out,” she said. “From April, that income stream will sit with the PCT. It will be in their baseline. Forget about it being ring-fenced.” Her predictions were backed up by several other dispensing doctors attending the conference, including Nick Chapman, board member of the Dispensing Doctors’ Association.

Contracts similarity

Dr Silver highlighted the similarity between GP and pharmacy contracts — ie, the provision of essential services along with advanced or enhanced services. She suggested that when their contract was renegotiated in 2003, GPs were given assurances that nationally agreed service payments would not be altered. However, such assurances became redundant once PCTs had control of local budgets, she said. Dr Silver warned pharmacists against assuming that the same thing would not happen to them: “[PCTs] can and will engender some very great changes upon you. I know the PSNC will do their best but once we’ve got local determination, PCTs will bring about changes swiftly.”

PCTs, will try to save money any way they can, added Dr Silver, given the financial pressure they are under. “If I were a PCT . . . I would [ask GPs] to write six-month scripts for thyroxine, annual scripts for contraception and three-month scripts for hypertension,” she said. “These patients are stable; why do you need to write monthly scripts? It doesn’t matter what national negotiations there has been because they would not be twisting the rules.”

Mr Dent accepted there was an issue surrounding quantities on repeat prescriptions but confirmed that the PSNC was working with the Department of Health to prevent this potential problem. Present, a three-tier solution has been proposed, he explained, the first of which involves sending a clear message to PCTs on the consequences of changing prescription durations. The NHS finance director will write to all PCT chief executives asking them not to alter the period of treatment prescribed for long-term conditions because this could increase medicines waste, cause supply shortages and risk destabilising the viability of local pharmacies, he confirmed.

The second and third tiers involve penalising PCTs financially for tampering with prescription durations and providing financial support to pharmacies that are affected, respectively. Finer details could not be provided, said Mr Dent, because the proposals have not received ministerial approval. However he accepted that, in the long term, the concept of increasing treatment periods for repeat prescriptions could free pharmacists’ time to offer other services.

Dr Silver criticised pharmacists who were unfamiliar with the draft regulations on pharmaceutical needs assessments (PNAs), which are currently the subject of consultation. “PNAs are the single biggest change that’s going to affect your working lives,” she said. One audience member pointed out that primary care trusts will be expected to consult with relevant stakeholders when writing their PNA but Dr Silver said that PCTs would only engage with “those who put their hands up”.

She also advised pharmacists to be aware that they will need to submit documents to PCTs to prove they are capable providers of advanced and enhanced services. Failure to meet deadlines issued by PCTs for providing such documentation could result in funding being withheld, she warned. Furthermore, services such as the provision of methadone could be offered to other healthcare professionals, she suggested. “If you consider that you are the only provider of pharmacy services, think again.”

Knowing the local population

Dr Silver advised all pharmacists to get hold of their PCT’s joint strategic needs assessment — a document that separates the local population into several smaller areas (known as wards) and provides a demographic breakdown of each one (eg, how many elderly people and how many children live there). PCTs determine the need for services by examining this assessment, she said. Therefore, for example, the provision of emergency hormonal contraception services might only be offered in wards with an above-average percentage of young people. “When a PCT rolls out enhanced services, do not assume that they will roll them out to all of you,” she explained. “They will only roll them out in specific areas where there is a need.”

Although the suggestion that pharmacists and GPs should work closer might have started to sound like a broken record, it was mooted many times during the conference. Dr Silver advocates the concept of local medical and pharmaceutical committees negotiating together with PCTs when services are shared out. For those LPCs that are struggling to engage with their LMC, her advice is simple: “Try harder.”

Are pharmacy funds safe with PCTS?

Gareth Malson reports concerning news from a conference in China that funding arrangements for community pharmacies in England could change, possibly for the worse, after the global sum is devolved to primary care trusts in April.