Five years of the pharmacy contract

The latest community pharmacy contract for England and Wales was introduced on 1 April 2005. To mark the contract’s fifth anniversary, Dawn Connelly asks contractors and pharmacy organisations which aspects have worked, which have not worked and what needs to change.

Fin McCaul, chairman of the Independent Pharmacy Federation, believes that one of the most beneficial aspects of the 2005 contract is the recognition within it that pharmacy has a wider role to play in public health. “It has allowed pharmacy to be recognised by some primary care trusts for its ability to engage with hard-to-reach populations,” he says.

Mr McCaul argues that not only has the contract lifted pharmacy’s profile as a member of the healthcare team within PCTs, it has had an impact on the way the profession operates. “Pharmacists are beginning to change the way they work — they recognise that they are part of a team and are not working in isolation,” he says.

Ash Soni, a community pharmacy contractor and professional executive committee chairman at NHS Lambeth, believes that establishment of a three-tier contract and recognition of elements of the cost of services has worked well. He adds that, for those patients who have had them, medicines use reviews have been a success and a lot of GPs have appreciated their value and benefit.

Mr Soni also highlights that the contract has brought clearer recognition of the role of pharmacists within the healthcare team. “In a lot of cases, patients have started to understand the training and skills that pharmacists have and some PCTs have seen skills and value and have commissioned additional services from pharmacists.”

Professional image

Rob Darracott, chief executive of the Company Chemists’ Association, points out that there has been a lot of investment to deliver MURs and as a result the quality of pharmacy premises is much better now than it was five years ago.

Tony Schofield, a pharmacy owner in South Shields, Tyne and Wear, agrees that the professional image of pharmacies has improved since the introduction of the 2005 contract. “This is a good thing and I think the public values us now as more than suppliers. Smoking cessation services, supply of emergency hormonal contraception and minor ailments schemes have helped.”

However, Mr Schofield adds that the individual accreditation requirements of different PCTs mean that there is a postcode lottery for patients to access such services. “It has also become difficult for locum pharmacists to meet accreditation requirements in every area they work,” he says.

Patchy commissioning

John Turk, chief executive of the National Pharmacy Association, believes that the three-tier architecture of the contract is sound but points out that NHS investment locally has been patchy, while at a national level funding has been unreliable due to erratic clawbacks. “As a result, this has not been the dynamic and transformative contract that was hoped for in the early days,” he says.

Patchy commissioning of services is also raised as a concern by Mr Darracott, who puts the problem in part down to poor data capture. “There remains a huge hole in data which prove that what pharmacy is doing is making a difference,” he says. He points out that successful services like those on the Isle of Wight ([PJ, 31 January 2009, p99 and PJ, 28 November 2009, p584]) have built in mechanisms for capturing data on outcomes.

Mr Schofield also comments on the lack of local commissioning. He says that, although there has been some interesting pilots, for example, hepatitis B and C screening, the initial promise for local commissioning of enhanced services has been disappointing. “It will be no surprise if, even with excellent outcomes, such services are commissioned patchily,” he believes.

Mr Soni argues that there has been a reluctance across the board to develop pharmaceutical services and care. “The contract
hasn’t evolved as designed with advanced services becoming essential and new advanced services being developed for national rollout.” Neither has consistent development of enhanced services happened, he adds. “For example, there are lots of minor ailments services but they are variable. Also, since there is clear evidence of the benefit, why haven’t they been commissioned by all PCTs?”

Mr Darracott highlights the importance of effective implementation of services, noting that pharmacy appears to struggle with this. “Delivery is crucial to future development and commissioning of services,” he argues, adding that models of locally commissioned services that do work seem to put a lot of effort into implementation.

Mr Schofield questions the political will to manage long-term conditions in community pharmacy when and where they arise. “This is not a case of waiting on the community to come adequately via local commissioners,” he adds. “We must now strive to encourage the wider commissioning of invaluable pharmacy services, including public health and well-being programmes, and adherence support as envisaged in the White Paper. Commissioners must be encouraged to make the best use of pharmacy’s considerable potential, and to work with pharmacies to ensure that services are commissioned in as considered and sustainable a way as possible.”

He stresses that it is crucial that the Government invests in sustainable pharmacy funding, recognising the major efficiency savings pharmacists can deliver for the savings as well as the high quality care they can provide to patients.

Contract negotiator’s view

Alastair Buxton, head of NHS services at the Pharmaceutical Services Negotiating Committee, says: “There’s no doubt that the pharmacy contract has laid a path for progress; without it, and the changes in practice that followed, I don’t believe it would have been possible for the Government to publish the White Paper.”

Mr Buxton believes that medicines use reviews have demonstrated community pharmacists’ capacity to provide high quality NHS services at the heart of their communities, effectively supporting patients to self-manage their long-term conditions. “The majority of pharmacies are now providing this extremely popular service, and we expect to see 1.8 million MURs provided this year.”

“Unless the Government puts a moratorium on 100-hour contracts in the next few months, that figure is likely to grow,” he adds.

Leading lights

Mr Darracott would like to see pharmacy building on its successes nationally and locally through sharing experiences of successful clinical services and how these have changed day-to-day activities in the pharmacies providing them. “I believe that there is a gap between people’s understanding of why the contract is moving towards more clinical services and what this means on a day-to-day basis,” he says.

Mr Darracott is keen to highlight that in some areas local commissioning of services is working well, citing the Isle of Wight, City and Hackney, and Birmingham as examples. He believes that these “leading lights” should be used as models for the future development of services nationally.

So, it seems that the 2005 contract has brought benefits for both patients and pharmacists in terms of provision of MURs and, in some areas, other clinical services. It has enhanced pharmacy’s image as part of the wider healthcare team and improved standards within premises. But the over-riding message is that more consistent commissioning of enhanced services and investment in sustainable pharmacy funding is needed before pharmacy’s true potential can be realised.