



Commissioning for Choice, Quality and Outcomes

Enabling community pharmacy to contribute to better integrated primary care

SUMMARY AND RECOMMENDATIONS

- ▶ The White Paper *Pharmacy in England: building on strengths – delivering the future* presents a range of policies that could radically improve primary and community care quality and outcomes. Improving local service integration is an important goal. But achieving better health and increased satisfaction with the NHS will also demand maintaining and extending choice within primary care.
- ▶ Seamless care provision does not require the formation of large local organisations that will restrict choice. Nor should funding reforms intended to promote better service integration and – where it benefits patients – more collaboration and co-operation between GPs and community pharmacists be allowed to ‘lock out’ constructive competition and curtail the ability of pharmacies to offer new services.
- ▶ ‘Next stage’ success for the NHS will require primary and community care remuneration systems that provide more incentives for GPs and community pharmacists to work productively together to identify health risk factors and early stage illnesses, improve access to treatment for minor and common conditions and support better medicines taking. One option is to adapt the Quality and Outcomes Framework (QOF) in the GP contract in order to provide shared payments. An alternative way forward will be to create a separate pharmaceutical care QOF or wider pharmacy based health care budget.
- ▶ Extending pharmacy access to NHS electronic care records is another key priority for enhancing choice and improving quality and outcomes. Until recently there has been inadequate high level appreciation of the importance of this opportunity. Health care records ought normally to be seen as belonging to the person to whom they relate. NHS ‘customers’ should be able to give permission for pharmacists and when appropriate other care providers to see their information.
- ▶ Life expectancy in the UK has increased by ten years in the sixty years since the NHS was established. It has therefore become progressively more important to offer the whole population health checks to help promote informed self care and where possible prevent later life disabilities. Providing vascular checks and NHS LifeCheck services will enable pharmacists to offer community oriented pharmaceutical care, aimed at meeting the needs of both individuals and populations.
- ▶ Internet based and other computer supported health and self care support services have an important potential to complement personal care, without substituting for it. Future developments in areas such as health risk identification and life style planning, improving medicine taking and long term condition management will all require multi-level inputs, tailored to meet individual and group requirements.
- ▶ English community pharmacies now conduct about a million Medicine Use Reviews (MURs) a year. To ensure these produce optimal benefit, pharmacists must make full use of the information available to them to identify patients in most need of their help. GPs ought to be prepared to refer suitable patients to their pharmacists. ‘Enhanced MURs’ (MUR Plus) involving full therapeutic reviews should be made available through pharmacies to selected individuals.
- ▶ The introduction of ‘directed enhanced’ pharmacy services (DEPS) will offer a valuable short term way of extending pharmacy based health care provision. But this is no substitute for developing ‘world class commissioning’ to allow PCTs, Practice Based Commissioners and/or integrated care organisations to develop robust local approaches to incentivising primary care excellence and extending individual NHS user choice. Good quality primary care is the key strength that all ‘higher level’ future solutions for delivering secondary and tertiary care must rest upon.
- ▶ Government policies on further developing pharmacy as a clinical care resource demand that the undergraduate and postgraduate education of pharmacists is funded to reflect this shift and that there is appropriate investment in continuing professional development

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INTRODUCTION

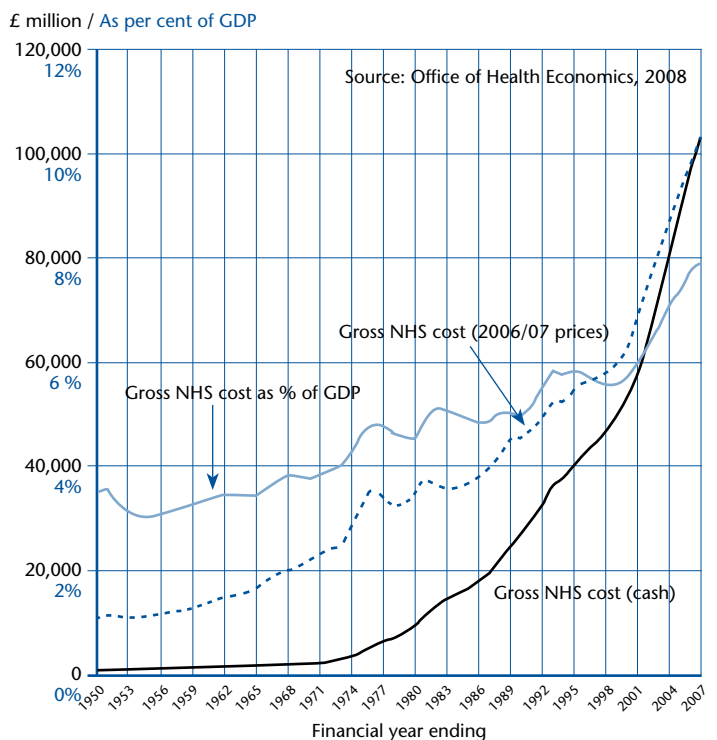
During the six decades in which the NHS has existed, the health of the British population has radically improved. Diseases such as tuberculosis and polio have been controlled or eliminated, and since 1948 average life expectancy has increased by ten years. The range of surgical, medical, pharmaceutical and other interventions available for treating not only infections but disorders such as heart attacks and heart failure has also been dramatically extended, from the pioneering antibiotics of the 1940s through to today's antithrombotics and medicines for conditions such as raised blood pressure, hypercholesterolaemia, diabetes, asthma and the cancers.

As technical understanding of the biomedical aspects of ill-health has grown, so too has social and psychological insight into health related behaviour. This in turn is opening up further opportunities for health promotion and disease prevention, in fields from smoking and obesity reduction to living with mental health problems and enabling individuals and groups to use their medicines safely and more effectively.

However, against this positive background health professionals such as pharmacists, doctors and nurses are having to face new challenges associated with trends such as population ageing, more critical and questioning public attitudes and the increasing complexity of many forms of health and social care. The fact that, although Britain is healthier than ever before, the country is also spending more of its total wealth on the NHS than ever before – see Figure 1 – is one source of tension. There are also concerns that the NHS has not improved care for people with serious conditions like strokes and cancers as rapidly as some other health care systems, while access to timely and convenient treatment for common and minor conditions may also be relatively unsatisfactory. This seems most likely to be the case in inner city areas, and particularly in London. The capital has historically lacked a strong primary care base, in part because of the dominant strength of its hospital sector.

Recent NHS policy documents such as the White Paper *Pharmacy in England: building on strengths – delivering the future* (Cmnd 7341) and *Our NHS, Our Future* (the interim report of the NHS Next Stage Review – see Box 1) reflect an awareness of such problems, and a desire to establish more integrated – or more broadly better quality – local and where necessary larger scale regional service provisions. In the case of community pharmacy, there

Figure 1. NHS spending UK, 1950 – 2007.



are important opportunities for service improvements which stem in part from ongoing changes in the structure and work of general medical practice.

The policy direction established by *Pharmacy in England* is towards combining the safe, accessible and reliable supply of medicines with an extended set of clinical roles. These link together pharmacists' knowledge of medicines with skills relating to treatment provision and facilitating health behaviour changes. They in part focus on managing therapies and helping pharmacy customers to take their medicines appropriately, but also include other forms of care provision, such as minor illness treatment programmes aimed at reducing GP practice workloads

Box 1. Lord Darzi and the NHS Next Stage Review – Our NHS, Our Future

In 2006 the then Professor Sir Ara Darzi, a celebrated Imperial College surgeon who had previously offered advice at Prime Ministerial level, was appointed by NHS London to review health care in the capital and offer recommendations for its improvement. His final report, *Healthcare for London: A Framework for Action*, was published in the summer of 2007, at around the same time that Gordon Brown moved to 10 Downing Street. This identified problems such as the apparently excessive use of hospital emergency services in London, poorly developed primary care in some localities and large numbers of District General Hospitals (DGHS). At the same time there are weaknesses in public access to appropriate care in contexts such as the acute treatment of strokes. Sir Ara's recommendations in part centred on the establishment of relatively large 'polyclinics' (or community hospitals – modelled on both German and US examples of integrated primary and secondary care) that could serve – it was argued – to raise the standards of general medical practice in the capital, improve support for people with long term conditions and open the way to some DGH closures.

A Framework for Action was not without critics. The King's Fund, for instance, questioned the level of savings that might be associated with the proposed changes. Some GP representatives also raised issues related to this country's unique strengths (as compared with German and American medical traditions) in the area of primary care. Seen from a historical perspective, Sir Ara's analysis touched on health policy controversies dating back to the nineteenth century and long standing tensions between hospital based doctors and those in the community whose professional origins, like those of modern pharmacy, lie with the apothecaries. The latter were long regarded as the people's doctors, as opposed to being a part of high level medical and wider political elite.

However, the NHS London report was in the main well received. Nationally, it may have been seen as cutting through unproductive debate to offer definitive solutions to long standing problems. Gordon Brown promoted Sir Ara to the House of Lords, where he became a health minister responsible for health care improvement. It is in this role that Lord Darzi has led the NHS Next Stage Review. This initiative was announced in the House of Commons by the Secretary of State, Alan Johnson, in July 2007. An interim report was published in October of that year. Amongst other things, this recommended that GPs' surgery hours should be extended.

The final report is due for publication at beginning of July, to coincide with the 60th anniversary of the NHS's functional establishment. It will touch on all aspects of the NHS's future development. But from the perspective of this report the key areas of interest relate to the recommendations it will make on primary care provision and the extent to which it will build on not only Lord Darzi's work in London but other sources, including *Pharmacy in England*. A new Department of Health strategy on primary and community care will also be published at around the same time as Lord Darzi's review. The view taken here is that although improving primary, secondary and where necessary tertiary care integration is an important priority, this should not be achieved at the expense of other aspects of health care quality. These include maintaining and where possible extending directly experienced service user choice and building on the established – personalised care related – strengths of independent primary care practice in England. Aligning the financial incentives and service values of competing care providers may well prove more important than creating larger organisations housed in bigger buildings.

and enhancing service quality. The provision of vascular disease checks and other risk factor and early stage case finding programmes ought in addition to complement established forms of pharmacy based care, and allow community pharmacists to contribute further to achieving better public health.

WORKING TOGETHER

Leading members of the medical profession have warned that '*pharmacists are not doctors*', and cautioned against policies that might reduce NHS patient access to trusted GP care when this is needed (Field 2008). There is good reason to respect the special expertise of doctors in areas such as differential diagnosis (Pruce 2008). Yet at the same time a properly informed, where appropriate collaborative, extension of community pharmacy services has a significant potential to promote self care, improve health outcomes and help contain future cost increases. While the public's interests in maintaining individuals' freedom to choose to consult their general practitioners should be defended, this does not mean that extending access to complementary services in alternative settings should not also be accepted as desirable.

This brief School of Pharmacy policy report, produced and published in partnership with Alliance Boots¹, considers issues relating to how strategies for enhancing primary care through the better integration of the work of the professionals and organisations involved in its delivery might best be structured. In particular, it also offers recommendations as to what needs to be done to ensure that the vision for service improvement contained in *Pharmacy in England* is translated into a substantive reality. The topics explored include:

- how health checks and tests can best be provided;
- how health behaviour changes relating to medicines taking and lifestyle more generally can be effectively supported;
- how pharmacists and general medical practitioners can be encouraged to work together more effectively; and
- how policy makers and commissioning bodies such as Primary Care Trusts should seek to facilitate, incentivise and support desired service improvements.

Developments in fields such as internet based health services and the provision of access to NHS electronic care records in ways which allow health professionals such as community pharmacists to (with appropriate service user and other forms of permission) see and amend individuals' records have a profoundly important potential to transform care provision and enhance service user choice in primary health care provision. This vital fact does not until recently appear to have been adequately understood by NHS policy makers, although it now appears that there will be movement in this direction.

Likewise, increased capital investment in new forms of health centre or hospital provision may in some instances prove an essential step towards achieving better care. But in this instance it is also salient to note that in an era when treatment (as opposed to preventive care) provision must in large part be focused on

1. This is the fifth in a series of joint publications on topics relating to pharmacy service development and public health improvement. It is concerned primarily with community pharmacy in England, although it also draws on Scottish and other UK, EU and US pharmacy experiences. Information about selected Alliance Boots initiatives is provided in some of the Boxes. However, readers should be aware that other community pharmacies of all sizes, from small independent concerns to other large chains, can also provide important examples of service innovations that could improve both customer satisfaction and public health.

meeting the needs of people with long term conditions, the preferences of older service users often tend towards the delivery of individually responsive personal care in familiar settings.

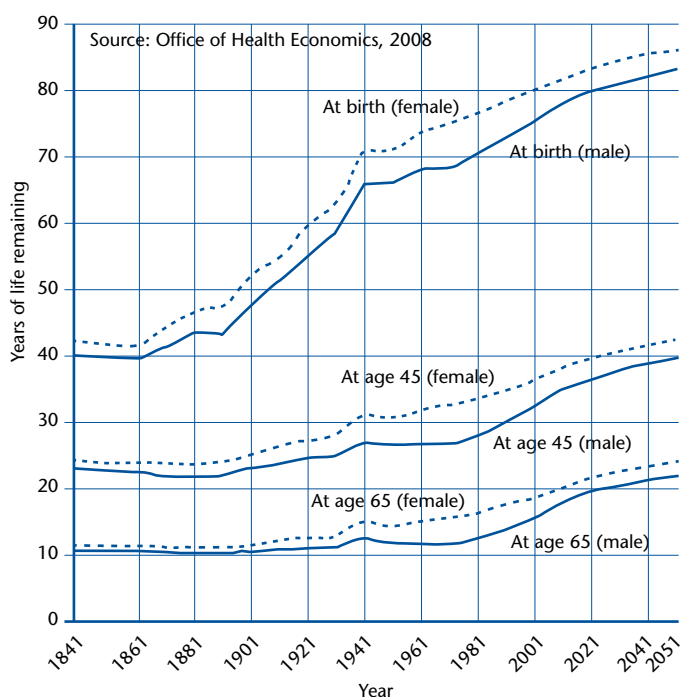
At a time when computer based information technologies are making 'virtual' integration increasingly easy, concentrating specialist and generalist resources on single physical sites – or even locality wide 'integrated care organisations' – will not in itself necessarily lead to better co-ordinated, more convenient or more efficient care. Commissioning new buildings may prove less important than investing in the development of coherent values and the healthy human relationships that allow physical resources to be used to best effect, and for public interest oriented competition and choice to be extended rather than curtailed.

The analysis offered here suggests that services which are planned and managed in a seemingly 'top down' manner are at risk of being regarded as inappropriate and de-motivating. 'World class' health care commissioners, like successful governments, companies and educational institutions, need to be sensitively aware of such human realities. They should seek to serve their communities (which encompass not only people with immediate health problems, but also health care professionals and the wider public) in ways fully consistent with the fact that respect for individual autonomy and choice is likely to be a central characteristic of systems and services that will successfully help twenty first century populations achieve good health.

IMPROVING HEALTH OUTCOMES IN A DIVERSE COMMUNITY – THE GROWING IMPORTANCE OF HEALTH CHECKS

Figure 2 details the increases in life expectancy enjoyed in Britain since reliable records were first introduced. Today, average life expectancy for men and women combined is 80 years. This is about twice that recorded at the start of the Victorian era. The most important driver of this change has been the decline in the infant death rate that commenced at the start of the twentieth century. At that time over 150 out of every 1000 babies born alive

Figure 2. Life expectancy in England and Wales, 1841 to 2051 (projected from circa 2006).



died before their first birthday. But the infant mortality rate (IMR) in Britain now is 5 per 1000. This compares with the 'world class' infant death rates of 3 per 1000 seen in Sweden and Hong Kong, and the disturbing fact that in Afghanistan and Sierra Leone the recorded IMRs still stand at 150 per 1000.

By contrast, increases in survival in later life have not been as great as is sometimes assumed. People who reach 65 can, on average, presently expect approaching 20 years more life, as compared with 13 years at the time the NHS was created and 10 years when Victoria was on the throne. Nevertheless, the proportion of the population aged 65 and over currently stands at 25 per cent, as opposed to 15 per cent in 1948. In absolute terms, there are now 5 million UK citizens aged between 65 and 74 and a further 6 million aged 75 and over. These numbers, the equivalents for which in 1948 were 3.6 million and 2 million, are projected to rise by a further 25 per cent by 2020. It is amongst these groups that per capita health care needs and costs are highest (Figure 3).

The processes of demographic and epidemiological transition underpinning such changes in the public's health and longevity have been described in other School of Pharmacy publications. An additional point to stress here is that although the total population of the UK has been relatively stable during the lifetime to date of the NHS, it is projected to expand much more rapidly in the years leading up to the middle of the twenty first century. Between 1948 and 2008 it grew by about 10 million, to a total of 60 million. Yet by 2051 the British population is expected to be almost 20 million higher than it is now. This trend is partly associated with the fact that some minority groups tend to have larger families than the national average.

From an NHS perspective changes in the ethnic composition of the British community have brought new challenges, alongside those of overall population ageing. For instance, Figure 4 indicates that cardiovascular disease death rates amongst people of African, Irish and South Asian origin are relatively high, for both genetic and cultural reasons. People of Indian, Pakistani and Bangladeshi racial origin are, for example, twice as likely to develop diabetes during their lives as white Western Europeans. This to an extent complicates the traditional picture of health inequalities being primarily associated with social class, although the latter remains a powerful differentiator. In the case of infant mortality, for example, the observed rate is now only about 3 per 1000 among babies born to parents with professional and managerial roles, while the equivalent amongst people with routine and unskilled occupations is around 7 per 1000.

Such data, although less dramatic than those sometimes – and on occasions misleadingly – quoted in relation to health inequalities, underline the continuing importance of preventing premature death in British society. There is a continuing need to address its causes in every group. However, balance of distress and lost personal and social opportunity caused by ill-health has during the lifetime of the NHS tended to move away from early death, towards living on into old age with physical and mental diseases and disabilities. Having a long standing illness should not automatically be taken to mean that someone is socially or otherwise handicapped. But General Household Survey findings indicate that six out of ten people aged over 65 have a long standing condition. This compares with three out of ten working age adults aged 16-64, and two in ten children and younger teenagers.

Figure 3. NHS spending on hospital and community care by age group, 2004.

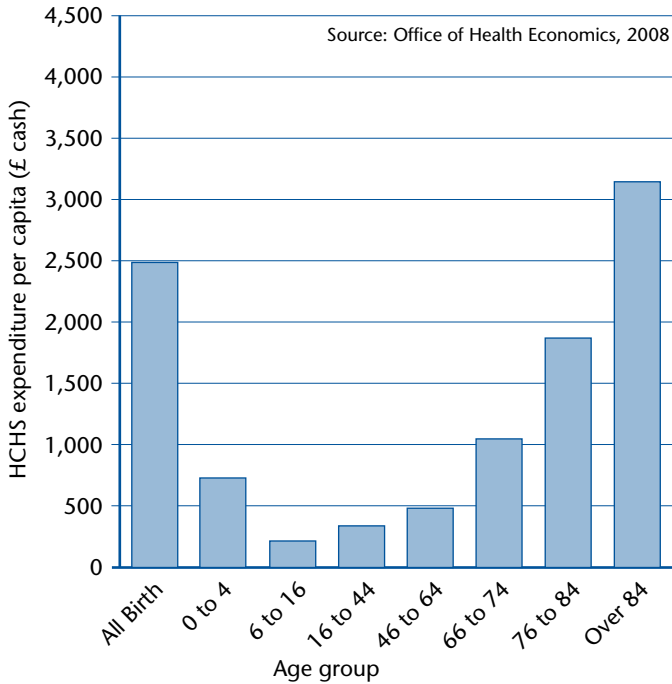
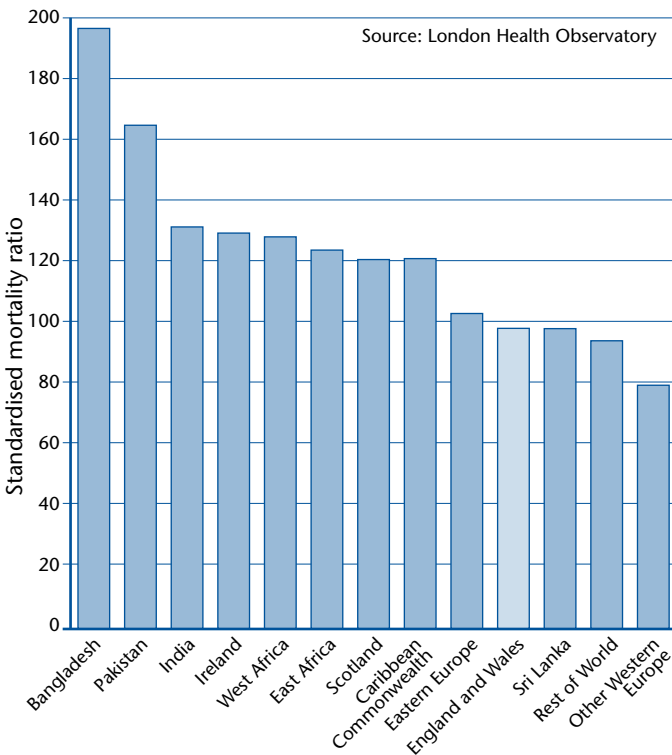


Figure 4. Standardised mortality ratios for circulatory disease by the ethnic background of people aged 20-69 dying in England and Wales, 1999-2003.



Box 2. The Growing Importance of Medicines Use and Pharmacy

Data presented in the recent Pharmacy White Paper show that current NHS spending on medicines in England (including both hospital and community use) has grown to approximately £11 billion, about three quarters of which is accounted for by GP prescribing and community supply. Such figures emphasise the value of the role pharmacists can play in ensuring economy in medicines use. Yet it is also worth emphasising the growing importance of medicines use (and research) in communities such as the UK.

As a proportion of total NHS spending the cost of the general pharmaceutical services (which exclude hospital drug costs, but include community pharmacy fees) has in fact fallen rapidly in recent years, from around 13 per cent in 2000 to approximately 10 per cent today. Despite some media stories of rising pharmaceutical costs, the percentage of NHS money devoted to the general pharmaceutical services is actually lower today than it was forty years ago, in 1968.

However, in volume terms the number of prescriptions dispensed in England has risen from 250 million in 1968 to over 800 million today. The equivalent figures for the UK as a whole are 300 million and over 1,000 million. Such figures are indicative of a greatly increased workload for, and contribution to health care by, community pharmacy.

A key driver in this trend has been the increase in the population aged over 60 years. People in this age group receive almost 60 per cent of all prescription medicines dispensed. But even here the extent to which medicines consumption has increased should not be exaggerated. In age standardised terms per capita prescribing for the over 60s has actually fallen in recent decades. The change in the volume of medicines used has been a function of the absolute number of individuals surviving to and living on in retirement, which is itself partly a function of the growing efficacy of modern pharmaceutical care.

HEALTH CHECKS

Figures like these help to explain the growing use of medicines in modern communities – Box 2 – and increasing political level awareness of the potential importance of health checks for the entire population. Commentators such as Sir Derek Wanless (2004) have emphasised the importance of encouraging younger, healthy – or at least symptom free – people to engage positively in maintaining good health and where possible preventing habits and conditions such as excessive alcohol use, diabetes and raised blood pressure from causing them avoidable disability.

During the twentieth century ‘metabolic syndrome’ related conditions and factors (such as smoking and obesity, associated with lack of exercise and over-eating) offset the health benefits brought by advances in pharmaceutical treatment and medical care. The hope for the twenty first century is that combinations of health related behaviour change and further advances in medicines use (which pharmacists are well placed to offer together) will further reduce avoidable ill health, and open the way to continuing extensions in individuals’ disability free (and working) life spans. The government’s recent proposals for the further development of community pharmacy, and the delivery of vascular disease checks and NHS LifeCheck services, should be understood within this nexus of ideas.

Early in 2008 the Prime Minister spoke at King’s College London of the importance of further reducing the incidence of heart

disease and strokes and diabetes and its sequelae, such as kidney failure. Such disorders are directly responsible for over a fifth of all hospital admissions. The services being developed to support this strategic aim in England are:

- **NHS LifeCheck**, the concept of which was first discussed in the 2006 White Paper *Our Health, Our Care, Our Say*. This in essence will involve a medically 'low-tech' approach, based on the use of self assessment questionnaires designed for people at life stages such as the start of adulthood and the beginning of middle age. These may be supported by 'self-diagnostic investigations', such as measuring waist and hip sizes, calculating body mass indices and using facilities located in pharmacies (see Box 3) or surgeries to measure blood glucose levels and blood pressure; and
- **Vascular disease checks**. This initiative was first publicly described in 2008 in *Putting Prevention First*, which was made available immediately after the publication of *Pharmacy in England*. These checks are to be provided to everyone aged between 40 and 75, to help further ensure the comprehensive, population wide, measurement and recording of risk factors such as lipid levels and the early stage identification of conditions such as diabetes and its precursors.

The emphasis of this second programme appears to be based more on a traditional model than is the case with NHS LifeCheck, with its more explicit focus on self care promotion. But as the vascular disease check programme evolves in pharmacy or other settings it could act as a 'second level' complement to the LifeCheck approach. Other issues to be resolved in taking forward these two important initiatives relate to how they can be linked to existing provisions for monitoring patients' health in general practice, how unproductive repeat testing in alternative settings can be avoided, and how payments for providing such services should be made.

Although there is at this stage a considerable amount of additional work to be done to establish appropriate delivery protocols, Box 3 offers an initial outline of what could be developed. Relevant priorities and options include extending access to NHS care records to pharmacies to allow them to see, at least in summary form, what is already known about each individual's health status and treatment. As the All Party Pharmacy Group has previously pointed out (APPG 2007), this would allow pharmacists to update records and open the way to – as and when appropriate – their changing or starting new treatments. It may also be that in future the system for incentivising clinical care quality improvements in general practice (the Quality and Outcomes Framework, or QOF) could (where necessary with linked changes in the community pharmacy contract) be modified to permit shared payments to practices and pharmacies for conducting health checks and other forms of joint activity.

Another way forward could be to institute a QOF or 'pharmacy based health care' budget specifically for community pharmacy. This could be run independently of that for general medical practice, albeit that it should be designed to complement the doctors' QOF. It might in part do this through encouraging pharmacists to focus on areas where GPs and their practice based colleagues are not specifically incentivised to work. Where community pharmacies and general practices offer alternative services, the total sums of money involved nationally and locally could be rebalanced as their workloads change with shifting patterns of consumer choice.

Additional ideas relating to enhancing collaboration and co-operation between general practice and community pharmacy wherever this is desirable, and structured competition when and if this is in the public's interest, are considered below. However,

Box 3. Health Checks in Pharmacies

Boots pharmacies have been offering pioneering cardiovascular health checks on a private basis since 2004. The company's work in this field has demonstrated that providing such checks are (when they are well designed and delivered) an effective use of the time and skills of pharmacy team members and that such services have the potential to contribute to better health outcomes in ways that do not threaten or undermine service users' relationships with their GPs. Pilot schemes have included the use of a computer-based risk assessment programme (*Heart Healthcheck*) and a monitoring and management service for people who already have a diagnosed cardiovascular condition (*Know Your Heart*). Current work is in part focused on the further specification of high quality testing programmes that link factors such as waist circumferences and body mass indices with cholesterol, blood glucose and blood pressure measures and also lifestyle and other background risk assessments.

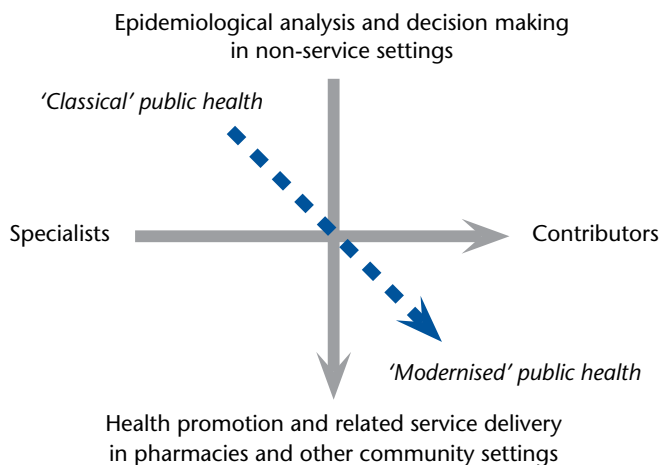
With the recent announcement of the NHS vascular disease check programme and the ongoing development of NHS LifeCheck (see main text), the lessons gained via such investments should soon become applicable in publicly funded community pharmacy settings provided by Boots and other pharmacy service providers. From a public health improvement perspective particular effort should be made to attract people who are not in contact with their doctors, and whose cardiovascular and related disease risks have never, or at least not recently, been assessed.

Such people might often most effectively be reached by the offer of health checks in high street and shopping centre locations separate from GP surgeries or large health centres that may be difficult to access. There is evidence, for example, that men are likely to use the former in encouragingly high numbers (Van den Berg and Donyai 2007). Boots is in some suitable localities providing premises for GP surgeries. For example, in Halifax the local Spring Hall Medical Practice has recently opened a satellite surgery in a Boots store, following the establishment of an NHS Healthcare Centre in the company's Poole premises in 2007. By contrast, in Collumpton near Exeter there is a Boots pharmacy in an NHS primary care centre offering a wide range of holistic therapies alongside more conventional medical treatments. This provision is in part aimed at supporting self testing and diagnosis and promoting informed self care (Dixon 2008).

Alongside such innovations, Boots is also developing privately funded 'health check' services for insurance company customers and employers wishing to offer their staff health related benefits. The interface between publicly and privately funded care must in this (as in all other) context be appropriately defined and managed. Nevertheless, it is in future possible that privately purchased health checks should also be made available on an extended basis to people who are below the 40 years old age threshold proposed for NHS vascular checks (in which population a significant proportion of undiagnosed early stage illness now probably exists). They may also be required by NHS users who wish to have more frequent and convenient checks than the health service might be able to provide.

from a public health perspective a point to highlight here is that the development of a more structured approach to monitoring health risks and encouraging behavioural changes and better medicine taking in pharmacies could prove a significant milestone in the translation of public health theory into English primary care practice – see Figure 5.

Figure 5. Developing Public Health Service Delivery



To a degree, it could help the latter emulate the approach being taken in Scotland, where there is already an established track record of both positive co-operation between GPs and community pharmacists and more independent clinical pharmacy development. For community pharmacists in England, providing vascular checks and NHS LifeCheck will provide fresh opportunities for them to offer not only individual care but to in future lead the establishment of what may be termed ‘community oriented pharmaceutical care’. That is, in achieving pharmacy service patterns that are sensitive to not only the immediate medication and related clinical needs of individuals, but are also capable of supporting medicine use and behavioural choice in ways designed to affect health at a population level (Box 4).

IMPROVING MEDICINES TAKING

It is commonly estimated that between 30 and 50 per cent of medicines are not taken in the way their prescribers and dispensers intended. The harm and financial losses this causes should not be exaggerated. Yet even so there is significant reason for concern. Hence in the last ten to twenty years there has been growing interest in the role that professionals such as pharmacists can play in helping to enhance medicine taking and support other forms of health behaviour change, like stopping smoking.

The best known UK example of this probably remains still the work of the Royal Pharmaceutical Society on concordance (as opposed to compliance) in medicine taking (RPSGB 1997) and its subsequent dissemination into practice. This drew professional attention to the importance of understanding health service users’ preferences and intentions and establishing realistic agreements as to what treatments should and should not be prescribed and taken.

Subsequently investigators such as Horne, Barber and Weinmann (Horne 2007, Horne et al 2005, Barber et al 2005) have sought to understand the factors underlying poor medicine taking in greater depth. The latter can be divided into intentional (in Horne’s terminology, preferences) and non-intentional (practicality related) reasons for non-adherence. The intentional – cognitive – drivers of medicine taking behaviour can be further divided into those that involve positive perceptions of how necessary and beneficial it is to take medicines, as opposed to those which relate to fears about side effects and other negative outcomes.

Box 4. Community oriented pharmaceutical care – the Asheville Project and recent progress in England

At a national policy level the NHS is now leading the world in seeking to develop the role of community pharmacists. However, there are already many small scale international examples of pharmacists expanding their roles in the ways that *Pharmacy in England* envisages. One celebrated example is that of the Asheville Project in North Carolina in the US. This dates back to 1994, when community pharmacists in the town of Asheville led a voluntary initiative aimed at helping people with diabetes to use their medicines better and care for themselves more effectively. There is today a substantive body of research showing that their interventions led to marked improvements in both markers for health outcomes and service user satisfaction and quality of life. The Asheville model has now won funding from its users’ health insurers.

The US context, with its less developed primary care services and a lack of uniform universal access to care, is very different from that of the modern NHS. Yet illustrations such as that provided by the Asheville Project are encouraging for community pharmacy and the proponents of concepts such as community oriented pharmaceutical care (see main text). The central element of the latter is the co-ordinated use of medicines and pharmacy team provided interventions to affect health at a population level, as well as to enhance individual choice and wellbeing.

Relevant examples of key services provided by Boots and other pharmacies in England include, in addition to the heart check service already outlined:

- smoking cessation support. Boots is the UK’s largest provider of NRT;
- influenza vaccinations. This service could be expanded to encompass other forms of immunisation, when and if judged appropriate;
- Chlamydia screening. This service was in the community pharmacy context pioneered by Boots in collaboration with the Department of Health, and is currently available in most localities on a private basis; and
- weight loss.

To take the latter as an illustration, the Boots service is aimed at complementing rather than obviating the need for much larger scale measures aimed at helping to control and where possible reduce obesity rates. That is, it should ideally be seen by PCTs or other health service commissioners as part of a multi-level strategy. It is provided via Patient Group Direction based protocols in selected English pharmacies, and is intended for customers with a body mass index of 30 or over. (If there has already been a relevant CVD or other diagnosis, the BMI threshold is dropped to 28.) Pharmacist led consultations are initially conducted at one, three and six months (or more frequently if required) and service users are provided with the medicine orlistat, together with health related behaviour change support.

The primary goal of the programme is to facilitate a five per cent body weight reduction in the first three months. There is evidence that this combined ‘medicinal product plus pharmaceutical care’ approach can effectively promote weight loss in circumstances where alone individuals have been unable to succeed in achieving this. As such it provides a potentially important model for the future of effective health promotion and individual protection.

Based on such research, integrated 'multi-level' programmes aimed at enhancing medicines taking are being developed. These include elements ranging from reminder systems like automated phone calls and texting services to help counter non-intentional non-adherence (which is often the most significant cause of poor medicines use) through to mass media messaging and group or personal counselling aimed at correcting misinformed fears. From a pharmaceutical care perspective, such approaches have the potential to be applied to other areas of health behaviour change. These include, for example, encouraging exercise taking and programmes for supporting alcohol use control.

MEDICINES USE REVIEWS

Such developments (especially when backed by additional services like internet based advice and care – see Box 5) offer the prospect of an increasing range of powerful 'self care support plus product' based approaches to improving health through pharmacies. Whether funded via the health service or individual purchasing, these could contribute to the delivery of both effective forms of health promotion and better support for people with long term conditions. There is mounting evidence regarding this last area that patient centred models involving the multiple level use of personalised information and reminder systems, remote and near patient monitoring and service co-ordination by known, accessible, individuals can help achieve better outcomes (Kings Fund 2007). To the extent that they can also facilitate greater service user choice, they are also likely to promote greater involvement and enhanced satisfaction.

However, with regard to the agenda set out in *Pharmacy in England* and the NHS's emerging focus on the establishment of better integrated local care, a more immediately important issue to focus on here is arguably that of Medicine Use Reviews. The latter were introduced in England in the wake of the 2004 community pharmacy contract. They are funded as an advanced service. Each pharmacy – staff members of which must be accredited to undertake MURs – can conduct up to 400 such interventions per annum in return for an item of service fee of a little under £30. Their costs are in effect met from an earmarked national fund. Approaching 1.5 million MURs were conducted by community pharmacists in the period between June 2005 and June 2008. Approximately a million more will be undertaken in the coming year.

Despite initial problems and concerns about the number and depth of the reviews being undertaken, many pharmacists report that they are of value in identifying difficulties in medicine taking and other threats to health. Against this, however, some GPs question their present utility. *Pharmacy in England* stressed the importance of ensuring that MURs are delivered in ways which ensure that they are most likely to be of benefit to people and communities at most risk. The 2008 White Paper argued that Primary Care Trusts should seek to prioritise their provision in accordance with local need.

Few commentators would doubt the desirability of such recommendations, although in practice optimising the value of MURs may well depend more on enhanced collaboration between individual GPs and community pharmacists than it will on PCT level interventions. One way forward is for pharmacists to ensure that they make the best use possible of the information already available to them in the form of pharmacy held patient medication, repeat dispensing and (where available) non-prescription medicine use records.

Others include encouraging GPs to select and refer patients to pharmacists for MURs (as appropriate, in contexts such as preparation for annual clinical reviews) and improving the reporting mechanisms back from pharmacists to general practice.

Box 5. Internet supported health care

Information technology (IT) based 'solutions' to extending public access to health related information, testing, treatment and support should not be seen as replacing personally delivered services where service users want and benefit from them. But they can usefully augment other forms of care, and create new options. Boots.com is already one of the largest such service providers in Great Britain. It has over twice the daily number of 'hits' attracted by, for example, NHS Choices. This statistic highlights the capacity of web based services provided by trusted companies like Boots to contribute to the achievement of public health improvement objectives, alongside public sector and other private providers. Providing health information that effectively supports self-care and patient involvement is important. The health website 'ask boots' – www.boots.com/askboots – was launched last year in partnership with The BMJ Group. It offers free access to high quality information on over 180 different everyday conditions and provides clinical evidence-based advice on subjects ranging from children's sleep problems to coronary bypass operations.

Computer based programmes are of proven value in a range of self care contexts, including not only physical conditions but also mental health problem management. Future options that Boots.com might in its next stages be extended to provide include new forms of carer support and the provision of a personal health record service. The importance of this last is in part that it could help enhance awareness that 'customers' (or in traditional health service terminology patients) should ultimately own their personal records and be empowered – taking into account the legitimate needs of care providers for record continuity, coherence and usability – to decide who should and should not be able to see and add to them.

A key message of this report is that a more open NHS approach to permitting community pharmacists appropriate access to electronic records, coupled with the intelligent provision of internet based services to complement personally delivered care, has the potential to transform health care delivery and public health outcomes in the early twenty first century. This is true not only for younger individuals and those with what they may experience as embarrassing or stigmatised conditions, like urinary incontinence, 'neurotic' depression or erectile dysfunction, who may on occasions value anonymity and impersonal advice. It is also true for people with long term and/or multiple conditions who simply need better information and convenient access to ongoing support.

The latter should arguably involve a minimum of bureaucracy and unduly lengthy report writing. A number of pharmacists interviewed during the preparation of this report additionally argued that the impact of MURs could be strengthened by the introduction of higher level, extended, interventions. That is, full therapeutic reviews for selected patients, which could perhaps be termed 'MUR plus' or enhanced MURs. This is once again an area where the development of shared payment systems across the internal primary care boundary between community pharmacy and general practice, designed to ensure population as well as individual level monitoring of and support for appropriate medicines taking, could usefully be developed.

GENERAL PRACTICE AND COMMUNITY PHARMACY – COLLABORATION AND COMPETITION?

General medical practice has been central to the working and, many commentators have argued, the most significant successes of the NHS. For most patients, their GP or practice group remains the single most important provider of NHS care, especially in circumstances that are seen as serious and personally threatening. Despite the conflicts that have on occasions been apparent between doctors' representatives and previous governments, there is strong governmental acceptance of this fact (Colin Thomé 2008).

At senior levels in the NHS the value of general practice is well recognised. But it is perhaps understandable that not all GPs believe this to be the case. The reasons behind concerns for the future of primary care may range from attacks relating to the allegedly excessive levels of doctors' payments awarded by the Department of Health, through to the recent debate about establishing relatively large 'polyclinics' that some observers see as a threat to general medical practice. The apparent inconsistency of policies relating to issues such as GP fund-holding and the more sophisticated 'multi-fund' model developed during the last Conservative administration through to the subsequent evolution from Primary Care Groups through to PCTs and Practice Based Commissioning since 1997 may also have dismayed some practitioners.

In fact, the standards of care achieved by GPs and community pharmacies in contexts such as assuring the safety and economy of medicines use in the community are already high in international terms. Much of the research available suggests that where problems exist they are most likely to occur within secondary care institutions and at the boundaries between the latter and the outside world (Jafri 2008). However, this is not to say that the existing primary system could not be further improved, or that well intentioned future changes might not paradoxically serve to undermine NHS patient interests.

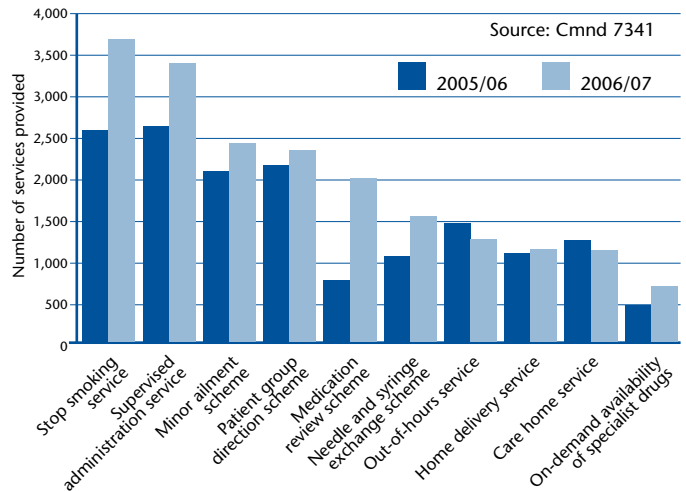
Given such concerns, there is a relatively strong case to the effect that service users' rights to choice and competition between alternative providers of care need to be more coherently defined. At present people are free to use the community pharmacies they prefer, as and when they feel the need to do so. Yet on entering the more formal NHS system local arrangements can in practice tightly restrict the options available for seeking satisfactory care. It may in future be particularly important to ensure that developments such as the establishment of 'polyclinics' or integrated local care organisations (LCOs – NHS Alliance 2008) do not stop 'non-medical' service providers like community pharmacies from being able to make new service offers that would benefit the public.

Concentrating too much local funding in single provider organisations could have this effect. Innovations such as the electronic transmission of prescriptions (the system for which has been designed so that prescriptions will in the main be directed, via patient instructions made in GP surgeries, to preferred pharmacies) should also be monitored and managed in ways which help to ensure fair competition between community pharmacies.

Looking in more detail at the relationship between pharmacy and general practice, it is perhaps only to be expected that some doctors might object to policies and service developments (see Box 6 and Figure 6) that will allow pharmacists to provide more clinical care even when this may improve health outcomes. There is, for example, evidence that there is only 'selective acceptance' of pharmacist prescribing by general medical practitioners

(Blenkinsopp et al 2008), even though nurse prescribing in practice settings is widely accepted. Similarly, a proportion of GPs have objected to extending pharmacy access to patients' electronic care records.

Figure 6. The Ten Most Frequently Commissioned Local Enhanced Pharmacy Services in England, 2006/7.



More pharmacists may in future wish to practice as clinical pharmacists in GP practices and other settings. Yet on the present pharmacy 'side', some contractors fear that the emergence of more polyclinics, health centres and group practices with integrated dispensing pharmacies will undermine the viability of the community pharmacy network. This is presently physically accessible to the great majority of the population. It is in the public's interest that rationally structured pattern of pharmaceutical care availability should be preserved. Such concerns raise a number of long term public interest questions and policy dilemmas which cannot be easily resolved. But it is worth stressing that, given mutual good-will and a genuine commitment to serving NHS users' interests as efficiently and effectively as possible, there is no inherent reason why workable ways forward should not be found.

To a very substantial degree, the opportunities now open for the further development of community pharmacy (not only in the UK, but also in the US and the EU – Taylor et al 2007) stem from changes which are central to the development of medicine itself, and are integral to the thinking underpinning the NHS Next Stage Review. Figure 7 illustrates this point. In summary, population ageing and an increasing emphasis on delivering complex medical care in community and near-community settings is focusing the work of primary care doctors and their practice and social care colleagues in helping people with relatively serious health problems to live as normally as possible in the community.

Community pharmacy has an opportunity to support this trend by extending its role further to include risk factor management, self care support and health care provision for common conditions. While arrangements to facilitate this should involve giving the public a wider choice regarding where they access some forms of information, testing and treatment – and hence extend regulated competition within primary care – they ought also to promote closer doctor/pharmacist collaboration when this is in service user interests.

Box 6. NHS community pharmacy development

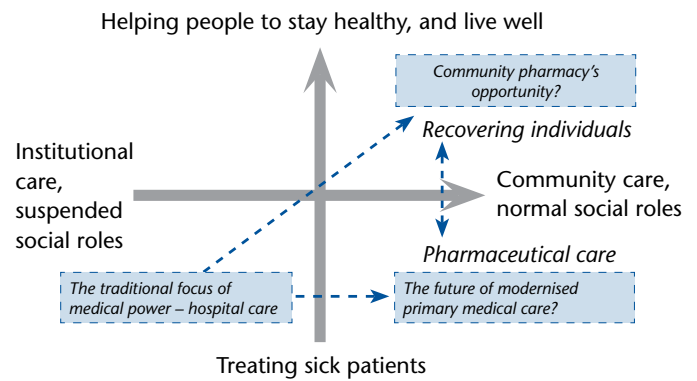
Pharmacy in England, which can be seen as the most important pharmacy policy document produced since the publication of the Nuffield Foundation's document *Pharmacy* in 1986, drew together information and thinking on a wide range of pharmacy related issues and policy options. It has served as an important prelude to the publication of the NHS Next Stages Review and the Department of Health's primary and community care strategy in July 2008. Examples of relevant developments that have taken place since the late 1990s include:

- continuing Prescription Only (POM) to Pharmacy (P) medicine re-categorisations. Progress in this area has been slower than many commentators have hoped for. But the changes achieved allow pharmacists to directly supply an increased range of effective medicines directly to the public;
- the introduction of Patient Group Directions (PGDs), which allow professionals such as pharmacists to treat patients with given conditions within frameworks agreed with medical practitioners. PGDs have been used in contexts such as obesity management, asthma care, cardiovascular disease prevention and treatment and emergency hormonal and other forms of contraception provision;
- new repeat dispensing arrangements, that despite limited take up to date can over periods of up to a year allow pharmacists directly to manage repeat prescription provision and offer enhanced care;
- funded Medicine Use Reviews which, as the discussion in the main text describes, have an important potential to enhance outcomes and also to reduce medicines wastage and;
- minor condition treatment schemes that, the pharmacy White Paper emphasised, can reduce GP workloads by 20 to 30 per cent while also improving the convenience of the services offered to a significant proportion of NHS users; and
- supplementary and independent pharmacist prescribing.

The latter should provide further opportunities for pharmacists to act as clinical care professionals. When taken together with the types of service provision indicated in Figure 6 and the additional community pharmacy care improvements seen recently in Scotland in areas such as long term condition support, the progress achieved since the current government came to power in 1997 has been very significant. But in terms of impacting on consumer experience of health care provision, the results of these professional service reforms have been less dramatic. To derive fuller value there needs to be further action to establish integrated incentives for the facilitation of seamless and effective community and hospital care, coupled with appropriate pharmacy access to care records – see main text.

If both GPs and community pharmacists can be encouraged to accept and build upon this basic understanding, there is good reason to believe that twenty first century health care will be significantly improved. From the perspective of this policy paper, pharmacy's professional leaders have a responsibility to defend the interests of the public in maintaining the availability of high quality, personally delivered, general medical care, while also continuing to raise awareness of the benefits of extending community pharmacy based health care.

Figure 7. The Direction of Health Care Change



THE NEED FOR WORLD CLASS COMMISSIONING

A key recommendation derived from the above is that although the boundaries within primary care will need to be redrawn as the twenty first century progresses, they also require definition. Success in achieving this and progress more widely will not hinge upon the efforts of health professionals alone. It will also depend on the quality of national and health service governance at all levels, from central policy making to local service commissioning.

Vigorous efforts are presently being made to raise the level of health service commissioning, and so to allow it to act as a more effective motor of service – and ultimately health – improvement (Britnell 2008). It would be beyond the scope of this brief report to attempt to analyse this work in depth. But in outline it involves defining commissioning competencies and promoting their development, in part through drawing on the existing skills of 'world class' management consultancies and US and other international health market insurers and providers.

Such work should deliver significant benefits, albeit that critics may suggest that if poorly executed it will add to rather than help move away from the impression of 'initiativitis' (that is serial, poorly thought out and fragmented change) that some senior primary care practitioners believe has in recent years slowed primary care development in England and indeed other parts of the UK. Avoiding this, and improving the overall quality and consistency of high level NHS policy making, should arguably be accepted as a vital part of achieving better commissioning standards.

It is also likely that more effective commissioning will require 'mindset' revisions that will allow a more productive balance between developing 'transformational' visions and building pragmatically on the strengths of existing services (Bevan 2007). If it is perceived by professionals that small numbers of people who are no more able than their peers are attempting to impose in an authoritarian manner plans that are not based on the realities of practice, their full co-operation and commitment will be hard to win.

INTEGRATED INCENTIVES

However, in the specific context of community pharmacy and the suggestions for its future contained in *Pharmacy in England*, the profession as a whole appears supportive of the changes proposed. They may be taken to represent a 'new charter for pharmacy' that it is in the profession's interest to seek to help implement, in partnership with others. There is also evidence that although the current use of newer health related services offered by pharmacists

is very limited (COI 2008), a majority of the public would welcome changes that will allow them to receive more treatments and health improvement services from community pharmacies (Taylor et al 2007).

Notwithstanding the need to ensure that GPs can also see the value of incremental steps towards this end, achieving progress will for the foreseeable future depend in large part on the rate at which service commissioners take the actions required to permit it. The introduction of 'directed enhanced' pharmacy services, which PCTs would be obliged to fund from their budgets when relevant local needs have been identified, could well prove a valuable way of moving forward. But this should not in the long term serve as an alternative to developing informed (evidence based) pharmacy and wider commissioning in every locality. Nor will it reduce the need for well integrated national payment systems that will more effectively incentivise GPs and community pharmacists to work together to deliver better health care.

As argued earlier, adapting the GPs' QOF to mandate or require defined payments to pharmacies in relation to the achievement of (practice) population wide health monitoring and medicines management goals might prove a vital step forward. In the case of health checks conducted in pharmacies, for example, their greatest value may be amongst those groups least likely to visit their GPs and already be on patient registers such as those for coronary heart disease or diabetes.

The timely introduction of adequate pharmacy access to patients' electronic health records is another key reform, which 'world class commissioners' should strongly support if they wish to facilitate the creation of both well integrated health care and choice driven service quality and patient satisfaction. The view taken here is that personal health records ultimately belong to the individuals to whom they relate, and that the NHS will not have successfully been modernised until this reality is accepted by policy makers, service commissioners and providers at all levels.

CONCLUSION

The core objective of this report has been to identify and prioritise, in the light of current developments relating to primary and community care strategy in England and the NHS's policies for the future, what should be done to ensure that the vision for service improvement contained in *Pharmacy in England* is translated into a substantive reality. Its main findings relate to the need to as rapidly as possible develop remuneration and information systems that encourage and facilitate joint working between GPs and community pharmacists, while also allowing for competition led innovation where this will benefit public health.

The aim should be to provide well integrated and effective care for NHS service users with complex requirements, while at the same time defending the public's interests in the exercise of choice and service plurality. It is to be hoped that the NHS in general and service commissioners in particular will in future fully appreciate the importance of the latter. They should also be aware of the dangers of promoting structural and 'accommodation based' changes in the provision of local services at the expense of healthier human relationships and more open information exchanges between those providing and receiving care. Investing in new buildings and establishing large organisations which effectively restrict competition and choice as it is experienced by people using the NHS is unlikely to deliver the public's highest priority health needs.

With regard to the future of pharmacy in the health service and as a profession able appropriately to offer directly purchased health care, there are also important issues to be considered regarding the education and continuing professional development of its members. If their roles are to be expanded in ways that will allow them to make fuller clinical use of their knowledge of medicines, their education must reflect this. Government policies on developing pharmacy as a clinical resource logically demand that the undergraduate education of pharmacists is funded to reflect this shift, and that the financial support and other incentives available for the ongoing postgraduate education and professional development of existing practitioners is also adequate.

To contribute as much as possible to the further improvement of public health, both hospital and community pharmacists need their skills and potential to be more fully recognised by both the public and the medical profession. But a final point to emphasise here relates to the need for pharmacists as a professional group to both communicate their abilities to cost effectively improve health to others and to recognise the value of, and to constructively support, general medical practice. The latter remains central to the health care of most people in Britain. Even if its focus continues to shift more towards relatively intensive and complex care for the more seriously ill, this will not mean that community pharmacy could or should seek to replace the unique contributions of general medical practitioners. Making this clear, and defining satisfactorily the borderlines – as well as the complementarities and appropriate overlaps – between community pharmacy care and GP practice provisions within primary care as a whole will be central to the success of the NHS as the twenty first century progresses.

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