



Delivering Faster Access to Better Care

Opportunities for GPs and community pharmacists to provide more convenient and effective services for improving personal care and public health

RECOMMENDATIONS

- ▶ Medical and pharmaceutical advances and changing public health care needs and expectations are creating opportunities for new patterns of health care delivery. Closer working between community and practice based pharmacists and general medical practitioners could further improve prescribing quality and therapeutic outcomes for patients, allow primary care workloads to be managed more efficiently, and extend choices for people seeking advice and treatment for common conditions.
- ▶ As primary care centres grow larger and the complexity of medical care in the community increases, there will be an increasing need for community pharmacists to take on roles more like those originally played by family doctors in high street practices.
- ▶ Policy makers should seek through contract reforms to align more closely the economic incentives for community pharmacists and GPs to help them deliver first class primary care. But doctors, pharmacists and nurses have a responsibility to lead improved joint working. In the absence of appropriate efforts by the professionals directly involved in the provision of primary care there is a risk that health service policies will be determined by groups with inadequate insight into service user needs.
- ▶ In settings such as city centres it will become increasingly appropriate for some general medical practices to be located in larger, easily accessible, pharmacy premises. In other contexts it will also be desirable to locate more pharmacists, and/or dispensing pharmacies, in health centres.
- ▶ In 1965 'The Doctors' Charter' strengthened general practice through introducing new nationally defined, consistently available, fees for service provision and practice development. Pharmacy now needs a similar 'Community Pharmacists' Charter'. However, this should develop community pharmacy in ways which are complementary to general practice.
- ▶ In England PCTs should be able to foster locally appropriate innovations, without depriving the national community of a consistent sense of what care and support should be available to pharmacy users. Currently variable PCT funding of 'enhanced' pharmacy services is creating a fragmented system of postcode pharmaceutical care rationing across the country.
- ▶ Electronic prescribing and prescription transmission will open up new opportunities for increasing the efficiency of medicines dispensing, and for freeing community pharmacists to provide clinical care. However, community pharmacy should continue to play a central part in the NHS medicines supply chain, in part to ensure the integrity of local services and permit the further development of community pharmacists' roles in improving pharmaceutical care and public health.
- ▶ NHS users should have the power to not only see their complete care records when they so wish, but also to allow community pharmacists to access them. Pharmacists in primary and secondary care should be able to have read-write access to care records, and when necessary make entries.
- ▶ Confidentiality and other safeguards will be needed. But to deliver faster access to better care, political and health service leaders must ensure appropriate service user sanctioned community pharmacy access to NHS care records.

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INTRODUCTION

From a health care customer perspective, general medical practice and community pharmacy can often appear to be entirely separate entities. The role of doctors in the NHS has been principally focused on diagnosing and treating diseases, while that of pharmacists has, at least in recent decades, centred mainly on the safe supply of prescribed medicines. However, community pharmacy and general practice are in reality closely linked. When working well they complement each other in ways which go beyond guarding against prescribing errors. Closer GP/pharmacy collaboration can positively enhance care quality and health outcomes for both individuals and populations.

A well integrated, conveniently accessible, primary care system provides the public with not only effective therapies when illnesses and their symptoms become apparent, but also with preventive and risk modifying services. It should facilitate the detection of very early stage diseases when this is beneficial, and help individuals and families to live as normally as possible with potentially disabling long term conditions when this becomes necessary.

The opportunity this brief paper addresses relates to how best family doctors and community pharmacists, along with other health professionals such as community and practice nurses, can strengthen their partnerships in order to provide twenty first century Britain with first class primary care. This will permit greater NHS patient and wider public choice at all levels of health

and allied social care delivery. The latter, as Figure 1 illustrates, range from facilitating well informed self care to the provision of complex surgery. Activities across the entire range of this spectrum can be life saving.

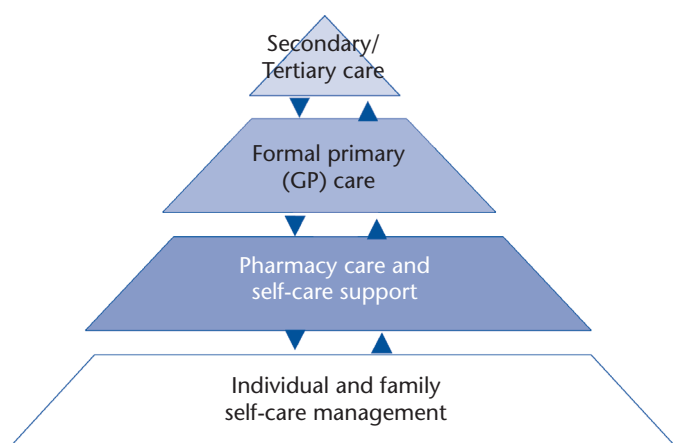
Historically, today's community pharmacists and general practitioners grew from a common root. The apothecaries evolved in England for around a thousand years. They made and supplied medicines and also (especially after, in the seventeenth century, the plague had caused many of the relatively affluent physicians to flee London) diagnosed illnesses and prescribed treatments. Even in the early Victorian era apothecaries were still referred to as 'people's doctors'. But later in the nineteenth century they split. Many joined with the physicians and surgeons to become general practitioners, within the then newly unified medical profession. The remainder joined with the 'chemists and druggists' to become the progenitors of modern pharmacy.

This background helps explain some of the tensions occasionally found even today within primary care, and between doctors and other health professionals working in hospital as opposed to community settings. But over and above this it also underpins some of the important strengths the NHS inherited in the late 1940s. (See, for example, Payne et al 2005.) Although they are criticised on occasions when harmful individual treatment delays occur, the ability of GPs to regulate the referral 'gateway' to specialised hospital care has been an important factor in the maintenance of overall NHS efficiency and effectiveness (Taylor and Bloor 1994, Starfield 1998, Colin Thomé 2000, Taylor 2001).

The family doctor's role typically involves promoting service user confidence and independence, ensuring care continuity, assessing risks and when appropriate avoiding needlessly intrusive investigations and interventions. These are vital aspects of effective and efficient health care, but very different from much of the work of surgeons and specialist physicians. Yet this reality is often inadequately understood by policy makers and managers whose attention and experience is principally hospital care focused.

Similarly, community pharmacy frequently serves as a bridge between self care and formal medical care, to the advantage of not only the NHS but – more importantly – the people who use it. In modern 'post-transitional' communities (Box 1) an increasing proportion of the population wishes health care – while believing it should be universally available to all in need – to be provided as a

Figure 1 Levels of health and self-care



Box 1. Changing patterns of health care need – helping older people to live well with long term conditions

In the second half of the nineteenth century (when the progenitors of modern pharmacy were emerging to in part meet the needs of people who had moved to the rapidly growing industrial cities, and were no longer able to access traditional remedies) Britain was in the midst of demographic transition. Infant and working age adult death rates started to fall as a result of increased prosperity and better diets. This progress was subsequently – after a period of rapid population growth – followed by birth rate reductions. Such trends in time led to today's situation in which the UK population's size has stabilised, except for cross border movements.

'Post-transitional' communities age: that is, the proportion of older people living in them rises. This is associated with 'epidemiological transition', and a greatly increased overall (but not necessarily age specific) prevalence of long term degenerative illnesses. Health care needs in modern societies differ fundamentally from those that the early pioneers of pharmacy were trying to meet when infections were the most important cause of death, when there were few effective medicines, and when the idea of a universally available high quality health service was all but inconceivable.

Globally, it is uncertain whether or not all societies will follow the same path to population stability. But across Europe, as communities grow more educated and personally secure most individuals in them come to expect increased autonomy and – as service users and health product consumers – control over their health care and to live on into old age without avoidable disability. At the same time their tolerance of health and social inequalities tends to fall.

To meet new service demands health professionals must adapt their roles. Hospital medicine is becoming increasingly specialised, while co-ordinating care in the community for the minority of older people with complex needs is becoming a progressively more difficult challenge for GPs and other practice professionals. In such circumstances a key way forward for community pharmacy is to help support individuals as they care for their own health and wellbeing, by directly offering preventive and less complex treatments as well as a safe and effective system of medicines supply. Achieving such a 'care transition' is a central challenge not only for today's pharmacists, but also their partners in medicine and nursing.

normal service, at least in as much that informed and autonomous consumer/patient choice can play a decisive role in treatment and care process direction (Coulter 2002).

This analysis explores issues relevant to GP and community pharmacy relationships in the light of such trends, together with recent national policy developments and recommendations such as those offered in the summer of 2007 by the UK Parliament's All Party Pharmacy Group (APPG 2007). The APPG pointed to not only the health gains that extending community pharmacy roles will bring. Its report also highlighted difficulties such as the variable and to date very limited Primary Care Trust (PCT) funding of 'enhanced' pharmacy services in England. This threatens to create a fragmented system of 'postcode' pharmaceutical care across the country.

The first main section below provides a brief overview of NHS primary care development and recent GP and community pharmacy policy and practice initiatives. The second discusses how modern pharmaceutical care may, especially when constructively coupled with high quality general medical care provision, help further to meet modern demands for easily accessible, effective,

forms of preventive, curative and 'maintenance' health care. Some illustrative examples drawn from Alliance Boots service innovations are offered in Boxes 2-7. However, it should be noted that community pharmacies of all sizes and types can provide illustrations of good practice. Further, PCT employed pharmacists such as prescribing advisors are also making important contributions to better care provision in many practices.

The final part of this report considers how barriers to desirable progress can best be overcome in contexts such as the development of a comprehensive medical and pharmaceutical care record system, genuinely capable of supporting a more plural – consumer choice led, managerially well co-ordinated, professionally delivered – primary care system. One important concept highlighted is the opportunity to link more closely the contractual arrangements underpinning the provision of GP and pharmacy services. This could create stronger financial incentives for more collaborative approaches to care provision, and drive forward the development of clinical community pharmacy in future years via mechanisms similar to those employed in general medical practice since the 1960s.

NHS GENERAL PRACTICE AND COMMUNITY PHARMACY – BUILDING ON SUCCESS

During the lifetime of the NHS the structure and nature of 'family practitioner' based primary care has changed radically. The health service as it was established in the immediate post-war era was not strongly led from the centre, and was divided into three very distinct parts – the hospital services, the local government run community nursing and allied services and the 'independent contractor' services. The main elements of the latter were, and remain, community pharmacies and general practices. In the UK as a whole there are today about 10,000 GP practices and 12,000 pharmacies, working in what is as compared with the past an already better planned and co-ordinated health service environment.

The creation in recent years of commissioning bodies such as Primary Care Trusts in England was only one of a series of NHS (and social service) developments that have taken place over fifty years. Notable innovations included the 1974 NHS reorganisation, which distanced health care direction from local government and established multi-professional district level management teams. This was followed in the early 1980s by the introduction of general management. These and other changes in areas such as care quality management can all be broadly seen as intended to permit the provision of a more unified service with the capacity to not only treat but also prevent acute illnesses, and to enable individuals with chronic conditions to live as satisfactorily as possible in the community.

Initially, NHS general practitioners were often isolated and poorly resourced. But during the 1960s the then Labour government introduced a 'Doctors' Charter'. This provided enhanced economic incentives for practice development. Since then other key landmarks in the evolution of British general medical practice included:

- the introduction of GP fund-holding, in the context of a wider NHS internal market, during Margaret Thatcher's period as Prime Minister. The subsequent 'new Labour' administration at first moved away from this strategic approach. But since then there has been an apparent return to an in part competition driven approach to fostering health care efficiency and effectiveness; and
- the establishment since 2004 of a new GP practice based contract, a central element of which is the Quality and Outcomes Framework (QOF). This embodies a

sophisticated set of target and service payments aimed at enhancing primary health care performance, along with other changes that the government and medical representatives responsible for negotiating the contract sought to achieve. These most notably included ending 24 hour GP responsibility for the care of 'their' patients. This has had significant consequences. Some PCTs have struggled to provide 'out of hours' care efficiently while some GPs may have tended to lose touch with the individuals and communities they serve.

GP fund-holding was politically controversial in that, for example, critics argued that it threatened to exacerbate the disparities and inequalities in NHS care quality that its introduction highlighted. But it had some important strengths, that recent NHS reforms can in part be seen as seeking to recover (Le Grande 2006). These included a demonstrable capacity to limit some aspects of medicines and secondary care expenditure, while also responding to expressed patient preferences.

Similarly, although the 'independence' of NHS contractor organisations such as general practices and privately owned community pharmacies and their employees has sometimes been said to demonstrate that they are 'not part of the NHS', present efforts to establish Foundation Hospital Trusts are seeking to move hospital service providers to a more independent contractor like position within a managed market environment. This is aimed at maximising the quality of service available to patients through creating pressures that have traditionally been accepted as an integral element of the NHS primary care system.

There are today over 40,000 GPs working in the NHS. This is twice the UK total recorded in the 1950s. Figure 2 shows trends in GP practice partnership sizes. While the number of doctors working in single handed and two partner practices has declined, the number in practices with five or more partners has increased significantly. So too has the number of non-medical primary care practice staff like practice nurses and administrators. Overall, there are now about two full time equivalent practice staff for each working GP.

Since the creation of bodies such as PCTs in England the move away from single handed working to larger practice sizes has accelerated. Some NHS planners favour the creation of centres housing relatively large numbers of GPs and a range of additional specialised medical and other professionals. The evidence on how

trends in this direction have impacted, or might in future impact, on the quality of personal care is equivocal. (See, for example, Majeed 2005). Some single and double handed practices offer exceptionally high quality care. But it is generally true that larger primary care organisations and/or networks can support larger managerial systems and a wider range of 'in-house' services than can smaller ones working in more fragmented ways.

Many other important changes have taken place within the GP system. For instance, alongside the important shift from individual to practice based contracting, average 'list' sizes have fallen to around 1,500 patients per doctor. This compares with a figure of 2,500 in the 1950s. Yet against this the number of consultations per GP service user has risen markedly. This may help account for the trend shown in Figure 3. The proportion of home visits by doctors has declined significantly since the 1970s. Then only a third of all GP consultations with people aged over 75 were surgery based. Today the equivalent proportion is four fifths.

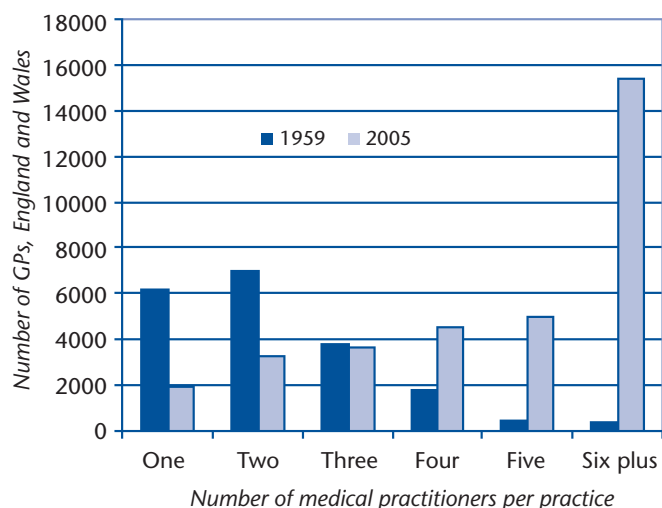
One implication of such observations is that as GP/primary care centres grow larger, and the complexity of medical care in the community increases, there will be an increasing need for pharmacies and pharmacists to take on local roles more like those originally played by family doctors in high street practices. Another related conclusion is that in urban areas where the population is both relatively mobile and concentrated it will become increasingly appropriate for some general practice surgeries or other forms of medical or nursing care to be located in easily accessible pharmacy premises – see Box 2 (overleaf).

COMMUNITY PHARMACY SERVICES

Although during the last decade the overall number of community pharmacies has stayed more or less constant in England and Wales (and elsewhere in the UK), there has been a trend away from independent ownership towards the formation of chains of five or more pharmacies. Between 1995 and 2005 the number of independent pharmacies fell by over 20 per cent. Further, those pharmacies that dispense a relatively high number of NHS prescriptions per month are less likely to be independently owned than are smaller pharmacies – see Figure 4 (overleaf). Multiple pharmacies also tend to enjoy relatively high incomes from non-NHS sales of over-the-counter medicines (Taylor and Carter 2002).

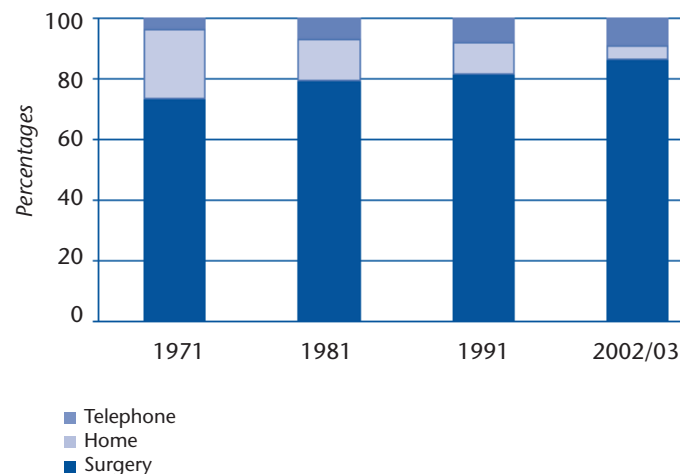
In other major European Union member states – including France, Germany, Spain and Italy – the ownership of community

Figure 2 Number of GPs in England and Wales by practice size, 1959 and 2005



Source: Office of Health Economics 2007

Figure 3 GP consultations – where they take place



Source: National Statistics 2006

Box 2. Shared premises, enhanced services – the Poole example

In January 2007 a GP led NHS Healthcare Centre opened in the Boots store in Poole, Dorset. This local collaboration was developed in partnership with the Bournemouth and Poole Primary Care Trust. The pharmacy acts as host for the health centre which – although patients using it enter via the main store entrance – is in a clearly separated section of the premises. Nine consultations rooms are available. In addition to advice and treatment from doctors or nurse practitioners, many additional services are provided. They include phlebotomy, podiatry, echocardiography, physiotherapy, an acute back pain service, dietetic service and support for stopping smoking. The centre currently sees 500-600 patients a week, who are normally referred there by their GPs.

Feedback from customers has been positive, not least because this town centre based facility is convenient for transport links. Car parks, bus stops and a train station are all easily accessible. Following the success of the Poole store, Alliance Boots is investigating further opportunities to open GP led health care centres in over a hundred additional locations. Other UK pharmaceutical service providers are in time likely to in various ways follow this lead. Experience in the US has already demonstrated that pharmacy based nursing and medical clinics have an important potential to offer an extended range of primary and community health services to large sections of the community (Farley et al 2007).

pharmacies is presently more like that of general medical practice in the UK. The formation of extended pharmacy chains is prohibited in most of Europe. So too is pharmacy ownership by non-pharmacists. The stated purpose of such restrictions has been to preserve traditional professional autonomy, and freedom from 'commercial' bias. However, the logic of this position is now being called into question by the European Commission and other agencies. (In the UK provisions are now in place for 'alternative providers' to establish new types of – so called APMS – primary care organisation. Some commentators believe that this could eventually lead to the creation of privately owned chains of primary care providers that could contract to the NHS to supply health care for patients preferring such an alternative.)

New thinking about how in the twenty first century both public and private service health care quality can most effectively be

assured is driving change. Nevertheless, regulators concerned with promoting balanced competition are likely to wish to preserve plural systems of service supply. A general lesson for primary care providers of all types is that different groups of service users (including young and old, male and female, and the established and prosperous as opposed to the vulnerable and poor) may well prefer different models of service provision.

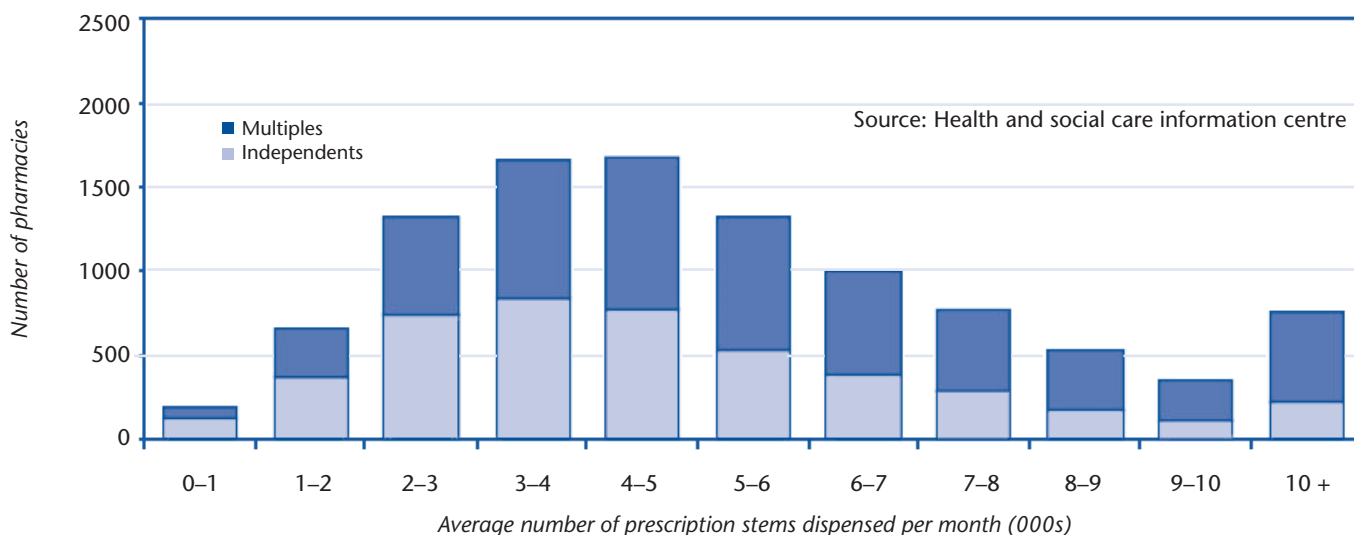
This has, for example, been demonstrated by recent Swedish research (Anell 2007). Such observations suggest that although large pharmaceutical care organisations may be particularly well placed to invest in offering new, evidence based, pharmacy services, there is also likely to be a useful future place for smaller chains and independent local pharmacies.

As a proportion of total NHS expenditure pharmaceutical services – including total medicine costs and all pharmacists' fees – account for a little under 12 per cent. Contrary to the exaggerated comments about pharmaceutical costs sometimes reported, this is about the same as the proportion recorded in the late 1960s. Yet since the 1950s the number of items dispensed has risen almost fourfold. The increase in prescribing volume has been particularly significant in the older population. On average each person aged over 60 now receives over 40 NHS prescription items a year, albeit that in age standardised terms the typical person aged over sixty is no more likely to be receiving some form of medical treatment that was so in the 1960s.

The workload associated with this rising volume of medicines dispensing has, some have argued, in the past prevented pharmacists from developing wider clinical and/or public health improvement roles. Yet notwithstanding this, a series of important pharmacy reforms has been introduced. In the English context key developments have been described in documents such as *A vision for pharmacy in the new NHS* (Department of Health 2003) and *Choosing health through pharmacy* (Department of Health 2005.) They include:

- revised arrangements for repeat dispensing, which permit pharmacists to take longer term responsibility for supplying and monitoring therapy for chronic conditions;
- the development of Patient Group Directions (PGDs – see Box 3), that allow both nurses and pharmacists to agree treatment protocols for defined patient groups with doctors, and take responsibility for prescribing and treatment delivery;

Figure 4 Prescription items dispenses in England and Wales 2004-05



Box 3. Patient Group Directions

Boots is presently, because it has acquired the appropriate registration, the only pharmacy chain to operate private Patient Group Directions (PGDs) in England and Wales. Health care professionals working with the company also, of course, contribute to patient care via NHS PGDs. In both instances these involve the development of medically agreed treatment protocols – covering the supply of prescription medicines along with other appropriate interventions – that pharmacists (and nurses) deliver to service users.

A wide range of PGD based and other services is already provided by Alliance Boots pharmacies – see Boxes 5, 6 and 7. Many customers appreciate the convenience and quality of the pharmaceutical care they receive, even in areas that might sometimes be considered medically trivial. Although, for example, losing one's hair may on occasions be dismissed as a minor problem, it can be a source of serious distress to some men. Throughout life issues of appearance are often deeply linked to the maintenance of good health, and coping well with both illness and normal ageing.

- the introduction for supplementary and, potentially more importantly in the community setting, independent pharmacist prescribing;
- provisions for the further development of dispensing and other non-pharmacist staff members' roles, in order to free pharmacists' time for clinical and other health improvement activities; and
- the phased introduction of electronic prescribing. This will ultimately mean that prescriptions can be sent instantly from general practices and other sites to community pharmacies, or larger scale dispensing centres. This should free pharmacists to extend their clinical and public health roles.

The new pharmacy contract introduced from 2004 onwards sought further to address this area, through (in the case of England and Wales – the Scottish and Northern Irish systems differ, as noted in Box 4) the introduction of both nationally funded 'advanced' services and locally purchased 'enhanced' services. The former include providing Medicine Use Reviews (MURs) and a prescription intervention (essentially, medicines use problem identification) services. Enhanced pharmacy services may include:

- minor ailments management schemes, designed to reduce GP practice workloads and improve service user access to appropriate care;
- diabetes or other screening programmes;
- substance misuse service provision;
- emergency hormonal contraception supply;
- specialised smoking cessation support; and
- out-of-hours emergency and allied service provision.

Issues relating to the need to further develop community pharmacy services and to co-ordinate their funding and provision more closely with general practitioner and other primary care services are discussed later. But the most important point to highlight here is that, over and above the requirements of the NHS and the specific provisions of the 2004 GP and pharmacy contracts, social and technical forces already in existence mean that further

Box 4 Community pharmacy in Northern Ireland and Scotland

Patterns of health care organisation and delivery differ significantly between the various UK countries. In Northern Ireland, for example, there has for many years been a structurally more integrated approach to delivering health and social care than that found elsewhere. In the pharmaceutical context there have been notable innovations in areas such as smoking cessation support (Brock et al 2007, Maguire 2007). In Scotland the national approach to pharmaceutical care delivery and ensuring that it in community settings serves appropriately to complement and augment GP services has been set out in documents such as '*The Right Medicine – a strategy for pharmaceutical care in Scotland*' (Scottish Executive, 2002) and '*Delivering for Health*' (Scottish Executive, 2005).

The latter outlined a ten year plan for the NHS. It emphasised the importance of community pharmacy in promoting wider public health and individual care improvements. In part for historical reasons, working partnerships between pharmacists and family doctors in Scotland are in the main well developed compared to those found elsewhere in the UK. Unlike the arrangements agreed in England and Wales, there is not a funded Medicine Use Review system in Scotland. Rather, the Scottish community pharmacy contract identifies four core activities which all community pharmacists must undertake, to provide services for:

- meeting acute medication requirements;
- minor ailment care;
- chronic medication supply and support; and
- promoting public health improvement.

Pharmaceutical care model schemes have been established in areas such as hypertension management, diabetes care and COPD and asthma. Alliance Boots pharmacies in Scotland are providing clinical pharmaceutical care in all these areas. The Scottish community pharmacy contract differentially rewards clinical service provision as opposed to dispensing, and may in time facilitate a transfer of the mechanistic aspects of the latter away from individual pharmacies to larger medicine dispensing and distribution centres (Scott 2007).

Such advances, which are dependent on the further development of both electronic prescribing and systems for the electronic transmission of prescriptions, might lead to cost savings. However, this should not, Scottish pharmacy leaders have emphasised, mean that community pharmacy will no longer play a central part in the NHS medicines supply process. Were this to be the case it could undermine the economic basis of community pharmacy, depriving the population of local accessible services and preventing the effective development of pharmacies as centres for clinical care and public health improvement.

developments affecting both GP practices and community pharmacies can be expected in the coming decade.

Given this, perhaps the most fundamental question facing primary care providers and professionals such as community pharmacists, practice and community nurses and family doctors relates to the extent to which they are able to work together to guide service evolution in a manner likely to protect public interests. What is certain is that in the absence of appropriate joint efforts by doctors, pharmacists and nurses directly involved in the provision of primary care, health service policies will be determined by other, sometime less well informed, groups.

NEW NEEDS, NEW TECHNOLOGIES AND NEW MODELS OF PROFESSIONALISM

As discussed earlier in Box 1, demographic and epidemiological transition radically transformed British and wider European patterns of illness and morbidity over the course of the twentieth century. In 1900 UK infant mortality was about 150 per 1,000 live births, and average life expectancy for men and women combined was just under 50 years. Today only six babies out of very thousand born alive in the UK die in their first year, and average life expectancy is approaching 80 years. Even as compared to the situation in the 1950s the task facing the modern NHS is radically different from that of the past. It is more than ever before focused on preventing avoidable illness associated with lifestyle choices, and treating longer term conditions in later life.

As the British population has become older, better educated and more affluent there have also been significant changes in social values, and service users' expectations of health care providers. It would be wrong to generalise too much about this process of 'care transition' at the international level (Taylor and Bury 2007). Nevertheless, the broad characteristics of common moves towards managed consumerism across many Western health care systems encompass:

- raised public expectations regarding service convenience, and a reduced tolerance of what are seen as needless restrictions on access to treatments;
- similarly raised requirements regarding the provision of safe and effective health services for all, and a decreased tolerance of discrimination in areas such as physical disability and mental health care;
- greater emphasis on the importance of personal autonomy and choice in individual treatment contexts, balanced by a wider acceptance of the need for regulatory action in public health fields such as, say, tobacco harm reduction and accident prevention; and
- reduced deference towards professionals such as doctors and pharmacists, coupled with raised requirements for open information provision and shared decision making at all levels of care provision.

Other change drivers relevant to pharmaceutical/primary care provision include:

- the development of computer based technologies that can effectively mechanise processes such as dispensing, and allow greatly enhanced access to information about all aspects of health care by both the public and professionals;
- the evolution of innovative diagnostic and risk monitoring technologies, that will over time reduce dependence on traditional medical expertise and costly facilities currently located in specialised centres;
- increased complexity in the provision of primary health and social care at practice level, and increased specialisation in secondary and tertiary care; and
- raised labour costs throughout the UK health sector, especially in the context of doctor provided services.

Taken together, progress in the medical and pharmaceutical sciences and changed public health needs and expectations are creating opportunities for new patterns of health care delivery. In the UK, perhaps more than any other European nation, medical manpower shortages coupled with cost pressures have helped to generate increasing interest in alternative forms of care delivery by both pharmacists and nurses. This mirrors developments already

observable in the United States. There market pressures have led a growing number of pharmacies to house nurse led clinics. Some operate with consumer focused slogans such as 'you're sick, we're quick' (Bowe 2007).

Such unions of nurse practitioner and pharmaceutical care are, as public perceptions and expectations shift, challenging other models of US care provision. In some instances similar developments may prove desirable in this country. However, there is a good case for arguing that within the NHS robust effort should be made to avoid types of competition that would create destructive conflicts of interest between GP and community pharmacy service providers. The public's interests will almost certainly be best served by fostering collaboration and co-operation, within a framework that acknowledges the importance of both patient choice and health care continuity.

For example, it will be desirable if choices about being able to obtain prescriptions for common medical conditions from either doctors or pharmacists open the way to faster treatment access. But this end should not be pursued at the expense of increasing the risk of inappropriate or needless therapy being recommended.

The recent All Party Pharmacy Group (APPG) report *The Future of Pharmacy* highlighted advances that have already been made in areas such as the provision of Medicines Use Reviews (MURs) by pharmacists. In England and Wales there has after a relatively slow start since 2006 been a rapid rise in the number undertaken. The total is currently in the order of 70,000 per month (PSNC 2007).

There is a need to further ensure that such reviews contribute usefully to the overall quality of patient care. Yet there is no question that the successful establishment of this new pharmacy service (over 14,000 community pharmacists had by the summer of 2007 been accredited to conduct MURs) represents a strong base upon which to build. Notwithstanding preliminary assessments (see, for instance, Blenkinsop et al 2007) a definitive evaluation is not as yet available. But pharmacists have reported important benefits to patients in areas such as identifying side effects from medicines like statins (which can cause muscle pain and damage) and other widely used treatments. MURs may also reveal potentially life threatening conditions, such as kidney infections.

Further progress will require more two way communication between pharmacists and GPs, and a greater commitment to understanding and meeting pro-actively the support needs of family doctors and their practice colleagues on the part of community pharmacists and other health service stakeholders (Hassell et al 1997, Stoate 2006.) Box 5 provides some illustrations of how Alliance Boots is enhancing the range of services it offers. Other smaller chain and independent pharmacies are also seeking to provide better care, and meet emergent public health problems such as increasing rates of obesity

Trends in this last area are described in Figure 5. It provides an important example of how life style changes linked to increased incomes and a reduced need for physical labour may bring health risks as well as benefits, albeit that as yet higher average Body Mass Indices across the UK have not at a population level been accompanied by raised mortality rates.

From a pharmaceutical care and public health policy perspective it is important to stress that information based and other public health programmes aimed at curbing obesity rates (and which may on occasions increase the stigma and distress experienced by overweight individuals) ought to be balanced by clinical services that can support individuals in need of help. Reducing tobacco related harm via public health interventions can also create increased public and/or private personal service demands, to which pharmacists can respond effectively.

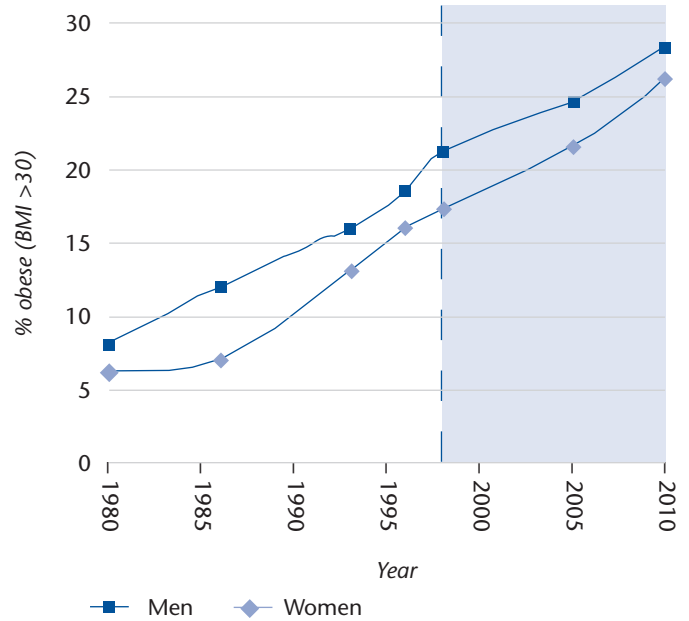
Box 5 Extending pharmaceutical care

There are over 2,200 Alliance Boots pharmacies serving the UK, representing one pharmacy in every five. The Boots and Alliance pharmacy chains had differing histories. But the unified organisation is now working to provide continuously improving services in a wide range of contexts, from city centres and large shopping developments through to local settings close to GP surgeries. Current examples of services being offered by Alliance Boots pharmacies include:

- **Midnight pharmacies.** Boots launched the 'Midnight Pharmacy' initiative in April 2006. This is aimed at ensuring late night pharmacy services are readily available throughout the UK.
- **Anticoagulation clinics.** Anticoagulation therapy requires careful monitoring and adjustment. Three Alliance pharmacies provide pharmacist led anticoagulation clinics, run on a weekly basis. These were established via a formal PCT tendering process, and with local GP endorsement.
- **Emergency hormonal contraception.** Alliance Boots is the largest UK pharmacy provider of EHC.
- **Substance misuse and needle exchange services.** Alliance Boots pharmacies are extensively involved in the provision of these services. Supporting people with drug misuse problems protects both the wellbeing of the affected individuals themselves and the wider public's health.
- **Chlamydia screening.** The NHS London pharmacy Chlamydia pilot was successfully launched via Boots in 2005. It provides a free service targeted at 16-24 year olds. To date just over 20,000 NHS screens have been performed. As a result some 1200 individuals and their partners have been treated by pharmacists. Separately, a Boots national Chlamydia screening programme was launched in 2006, and is now available in over 1,000 stores. Customers pay a fee of £25 for a screen and £19 for treatment. Thirty six percent of those so far using the test kits have been male, a higher figure than the equivalent for the NHS service. Males are traditionally less frequent users of health care, but availability of the service online may explain their relatively high uptake of this offer. The overall rate of positive tests from the national service is 9 percent. The rate amongst the younger age group (aged 16-18 years) is higher, at 16.5 percent.
- **Minor Ailments.** Some 500 Alliance Boots pharmacies are involved in the NHS minor ailments scheme. This helps to moderate GP practice workloads in ways which ensure that care costs are not inappropriately transferred from the NHS to economically less advantaged individuals.
- **The hair retention programme.** Hair loss can, as noted in Box 3, be a distressing experience. Over a hundred Boots pharmacies now provide care for customers who have male pattern baldness. Along with an initial and a follow up consultation with a pharmacist, customers receive a hair retention medication. The service costs from £7.50 a week, and has proved successful. The available outcome data indicate that nine out of 10 men on the programme retain their hair.
- **The erectile dysfunction programme.** Boots is currently piloting the erectile dysfunction programme in three stores in Manchester, using a PGD based scheme. This, when it is clinically appropriate, allows men to be prescribed sildenafil by pharmacists after an initial consultation to assess their needs and suitability for treatment.

There is also evidence that community pharmacists' interventions can contribute effectively to improving the quality (including the safety) of medical treatment given to groups such as older people

Figure 4 Trends in prevalence of obesity amongst men and women in England extrapolated to 2010



Source: Health Survey for England 2002

(Spinewine et al 2007). They can also help to limit primary care pharmaceutical treatment costs, moderate GP practice workloads, and – most notably in areas such as smoking cessation – facilitate beneficial changes in health behaviour. (See, for instance, Rodgers et al 1999, Hassell et al 2001, Krska et al 2001, Petty et al 2001, Zermansky et al 2001, Brock et al 2007, NAO 2007.) Yet there is also evidence that pharmacists' present contributions to health improvement could in many instances be further enhanced.

For example, an over-emphasis on promoting 'compliance' in medicine taking and allied behaviours, as opposed to understanding and trying to meet individual service users' highest priority personal requirements, can undermine the levels of health gain achieved. There have been suggestions of this in areas ranging from the pharmaceutical care of patients with conditions such as heart failure and depression to the support of people who have drug misuse problems (Salter et al 2007, Holland et al 2007, Cape 2007, Kushlick 2007). In Britain, and across Europe as a whole, realising to the full the potential for enhanced pharmaceutical care will require not only better designed financial incentives for professionals such as doctors and organisations such as PCTs and Health Boards. Pharmacy itself needs reform and additional strengthening.

PROFESSIONALISM IN TWENTY FIRST CENTURY PRIMARY CARE

There are trade-offs to be made between the possible benefits of new approaches to health care quality management and the public's interests in preserving those elements of traditional professionalism that can on occasions serve to counter-balance negative political and commercial pressures. During the past decade events such as the publication of the Kennedy Inquiry (2001) into children's heart surgery at the Bristol Royal Infirmary and the Shipman murders have led to reforms aimed at more clearly separating the regulation of medical and pharmaceutical practitioners from their representation. These have on the whole been welcomed.

It may be said that such reforms will align British regulatory arrangements more closely with those in place elsewhere in the

EU. The extent to which this is actually so is contestable, although would be outside the scope of this analysis to explore the details of recent and planned future changes to organisations such as the General Medical Council and the Royal Pharmaceutical Society of Great Britain. However, it appears broadly agreed that it would no longer be appropriate to regard any professional group as being entirely 'self governing'. Yet it would also be wrong to suggest that independent professional organisations and groups have no future part to play in autonomously seeking to ensure high standards of practice and good service design and delivery.

As the development of the NHS progresses the scale of secondary care providers such as NHS Foundation Trusts may well increase, along with the intensity of competition between them. Should this be so, constructive co-operation between primary care pharmacists, doctors and nurses is likely to become an even more important element in the delivery of appropriately integrated, personally sensitive, health and social care. A key opportunity for professionals at all levels is to recognise the importance of collaborative competition in community settings, and to find effective ways of ensuring that it can be achieved in ways that are genuinely consistent with service users' preferences and best interests.

OVERCOMING BARRIERS TO FASTER, BETTER, CARE

High level solutions to functional challenges often focus on achieving visible structural changes. In primary care it is sometimes argued that a key way forward for facilitating better co-ordination of GP, pharmacy and other contributions lies in co-location. In the case of London, for instance, an analysis led by Professor Sir (now Lord) Ara Darzi recently suggested that 'polyclinics' (in essence, modern community hospitals) housing in the order of 20 GPs together with similar numbers of specialist physicians, plus professionals like pharmacists, could provide improved primary care for people with long term conditions requiring relatively complex patterns of treatment (NHS London 2007).

NHS 'polyclinics' may in inner city areas in particular also serve to reduce pressures on larger hospital accident and emergency facilities, and might also contribute to the further rationalisation of prescribing. At the secondary care level the 'Darzi Plan' – which could in future serve as a national development model – envisages a phasing out of district general hospitals, and the expansion of more specialised centres serving relatively large catchment areas. This would, it is envisaged, improve the quality of care offered to people with conditions such as strokes.

The value of achieving such goals should not be under-estimated. However, simply co-locating specialist and generalist doctors would not in itself guarantee enhanced primary medical care, or necessarily allow the delivery of social and health support to be combined more effectively in patients' homes or other community settings. At worst, inadequately planned reforms might drive up care costs to the public purse and/or individuals, and alienate NHS users. Some people – even amongst those with complex primary and community care needs – may well personally prefer a more disseminated system of accessible local services, perhaps delivered via medical practices with only a few – possibly just one or two – partners together with community pharmacies and other local resources.

Modern technologies are increasingly able to offer instant communication between actors in distributed networks. Technical advances also offer smaller, easy to use, diagnostic and other forms of medical equipment that can replace large, high cost, resources that in the past have demanded centralised facilities. Even in city areas such as inner London significant sections of the public will

probably want familiar forms of primary care to be improved, alongside new forms of community hospital provision. These last are perhaps most likely to benefit less advantaged communities that have historically lacked both first class primary care and good district general hospital provisions, and may also contain diverse immigrant populations.

Achieving overall quality gains that build on existing primary care strengths is unlikely to depend on making 'once off' investments in new buildings and institutions, valuable though these can be. It rather demands the provision of economic incentives that can guide positive competition, and support continuous innovation at the margins of practice.

It is for this reason that pursuing the appropriate implementation of recommendations such as those made in the APPG's *The Future of Pharmacy* and the Galbraith Inquiry into the contractual framework underpinning the procurement of NHS pharmaceutical services in England and Wales should be seen as a key priority. It is anticipated that the latter – which is expected to recommend strengthening the ability of PCTs to support the development of locally appropriate pharmacy services – will be published in the Autumn of 2007, in advance of a new White Paper on the further development of pharmacy services (DH 2007).

REDUCING UNWANTED LOCAL SERVICE VARIATIONS – TOWARDS A 'COMMUNITY PHARMACISTS' CHARTER'?

The further development of pharmacy education and a shared computer based care record system will help open the way to further joint working by community pharmacists and GPs, and additional health care improvements. But from a wider policy perspective perhaps the most important questions to be resolved relate to how local agencies such as PCTs can on the one hand be enabled to foster locally appropriate innovations, without on the other depriving the national community of a consistent sense of what care and support should be available to pharmacy service users.

Critics fear that the currently highly variable PCT funding of 'enhanced' pharmacy services is creating a fragmented system of postcode pharmaceutical care rationing. They argue that a wider range of extended pharmaceutical care services should – even if PCTs are in time made responsible for fully integrated pharmacy and medicines budget 'silo' – be made available on a nationally defined and consistently available basis, like those already termed 'advanced' in the current community pharmacy contract.

A key step in the development of general medical practice was the introduction in the mid 1960s of the 'Doctors' Charter'. It introduced new economic incentives for developing better staffed and equipped practices. Clearly defined item of service and other structured payments have since then directed practice developments, within a framework that has been able effectively to limit total NHS primary care costs. Even including medicine outlays (around 80 per cent of all NHS pharmaceuticals by value are used in the community) primary care costs have during the life of the NHS declined as a proportion of gross NHS spending.

Recently, the 'new (2004) GP contract' put additional resources into primary care, in part via the Quality and Outcomes Framework (QOF). This incentivised further improvements in health care standards. The level and effective 'ring fencing' of GP service funding has been criticised by some commentators. No health system or profession should be seen as being beyond informed criticism. Yet the validity of such concerns is highly questionable.

World-wide, many other health care funders have recognised the individual care and population health benefits of the UK model

Box 6. Clinical pharmacy in the community

It is desirable that alternative models of community pharmacy should exist. Boots pharmacies have often been located in 'high foot fall areas', such as shopping centres and busy high streets, that are particularly likely to be used by younger and working age people. Alliance pharmacies have more often been found in quieter local settings. They work with a strong focus on forming partnerships with GPs and other local stakeholders in order to – as explored further in Box 7 – tailor their services to particular community needs. But in all cases the aim of pharmacists and pharmacies should be to provide care in ways that protect consumers' interests in being able conveniently to access good advice and safe treatment.

Recently there have been in Britain and elsewhere significant moves towards providing clinical pharmacy services (together with public health oriented forms of personal care and support) in community settings. This trend is in line with changing public preferences and the views of various political leaders over the past decade, ranging from Frank Dobson when he was Secretary of State for Health through more recently to the Prime Minister, Gordon Brown. In addition to service developments in the key field of smoking cessation support, recent Alliance Boots innovations include,

- **The Boots Health Club.** Members receive information on health topics of personal interest to them, together with shopping advantages. Customers select three topics of interest to them from a list that includes women's health, stopping smoking, allergies, pain relief, children's health, healthy heart, vitamins and supplements, weight loss and healthy eating. They receive a magazine twice a year on their chosen issues, and monthly email updates. Since the Health Club started in April 2006 over 2 million women and men have become members. Some 60 percent are under 60 years of age. The four most popular topics are women's health (1.3 million members have selected this option), vitamins and supplement use (0.95 million), healthy heart (0.9 million) and weight loss (0.9million).
- **Medicines Use Reviews.** Last year Alliance Boots pharmacies delivered well over 100,000 MURs. These pharmacist supported assessments of patients' experiences and requirements can contribute significantly to health and wellbeing (see main text). For instance, early feedback from a sample of 2,000 patients with asthma and chronic obstructive pulmonary disease who had received an MUR indicated high levels of satisfaction with the service. Over one patient in ten had not had their medicines reviewed in the 12 months previous to the MUR and a third of all those seen were referred back to their GP by the pharmacists involved for a suggested change in therapy.
- **Consulting rooms.** There are today about 1900 Alliance Boots pharmacies with consultation facilities, the majority of which are provided to a standard above that required by the national pharmacy contract. As public expectations of pharmacists and the care provide continue to rise, all pharmacies will need to review the quality of their consulting areas on an ongoing basis.
- **Influenza vaccinations.** Boots pharmacies can provide influenza vaccinations via a private PGD based service. In 2006 16,000 patients were vaccinated by nurses employed for this purpose in 130 pharmacies. In future, community pharmacists may become directly involved in giving immunisations, and contribute to NHS as well as privately purchased disease protection programmes.

- **Supporting weight loss.** Over 250 Boots pharmacies now provide access to a weight loss programme for customers with a BMI of over 30. Those taking up this opportunity receive an initial consultation with a pharmacist, weight loss medication and ongoing motivational support. The service costs from £10 a week. In 'macro' public health terms meeting challenges like increasing obesity rates will require a complex set of measures aimed at achieving behavioural changes at the population level. But providing individual level support can serve an important complementary role. As with smoking cessation, the more behaviours hazardous to health are discouraged and 'denormalised', the more important it becomes to provide those affected with supportive personal care.
- **Healthy heart checks.** The Healthy Heart service is currently being piloted in a number of Alliance Boots pharmacies. Customers supply relevant health information during a consultation with a health care assistant. There is an assessment of lifestyle factors such as smoking, alcohol consumption and exercise habits, and customers' current conditions and family histories are recorded. BMI, waist circumference, blood pressure and cholesterol (total cholesterol and LDL) measurements are also made, and ten year CHD and CVD risks calculated. The pharmacist then identifies lifestyle changes which could benefit the individual concerned, and offers appropriate advice and help.
- **Osteoporosis screening.** Boots recently conducted an eight week trial of osteoporosis screening in two pharmacies in Bournemouth and Birmingham, in collaboration with the NHS. A full body axial DEXA scanning machine was installed and used by a qualified radiographer to measure the bone densities of participating customers. The results were sent directly to patients' GPs, with treatment recommendations when appropriate. This service, which was made available to women aged over 50 and men over 60 years of age with additional risk factors, has the potential to supplement limited NHS capacity. One in 2 women and 1 in 5 men in the UK over the age of 50 years will at some point fracture a bone due to osteoporosis, although if identified early medicines can be safely used to maintain or rebuild bone strength. Customers using this service reported high levels of satisfaction, and on occasions relief that they had finally been able to overcome barriers to accessing reliable screening.

of primary medical care. Recent reforms in France – a country recognised by the WHO as already having an excellent health service – have, for instance, been aimed at developing a generalist based primary medical care system more like the British example. There is a powerful case supporting the view that for a modern health service to be genuinely patient and public interest led, it is vital for the primary care professionals in the closest daily contact with people seeking help and advice to be in a position to control directly some forms of resource allocation, and through referral and other choices significantly influence others.

Hence community pharmacists seeking funding and authority to improve their own services for the community should be careful to respect the value of GP services, and to help protect funding provisions necessary for the future of good quality primary medical and nursing care provision. Depending on future progress, community pharmacists should also be prepared to co-operate closely with, and where possible join, Practice Based Commissioning teams.

But this should not inhibit those wishing to further strengthen the provision of pharmaceutical care from also seeking further improvements in the ways NHS community pharmacists are

Box 7. Local Partnerships for the Nation's Future Health

Combining in an optimal manner the capacity to deliver personally tailored care and support with the advantages of central planning and evidence based service design is a challenge for all organisations. Alliance pharmacies have a particularly strong record in forming local partnerships and working closely with individual family doctors, small and larger GP practices and other primary care organisations. They also support the NHS and agencies providing NHS funded care throughout the UK via the provision of, for example, medicines management services for ten separate Independent Sector Treatment Centres (ISTCs), out sourcing pharmacy services for community hospitals and prisons, and undertaking out-patient dispensing and home medicines delivery for a major NHS Foundation Trust.

Alliance pharmacy teams have developed a structured approach to developing good working relationships with GPs, PCTs and Health Boards, based on a healthcare service information pack which can be adjusted to meet specific practice or commissioner requirements. Looking to the future, it is likely that the NHS will become increasingly diverse as it becomes more sensitive to caring for particular local needs. Pharmacy service providers of all sizes will need to respect this reality, and be prepared to when necessary adjust their activities to meet unique customer requirements. At the same time they must also seek to ensure that their activities are consistent with national and international best practice.

paid to practice. It may be suggested that what is now needed is a 'Community Pharmacists' Charter', in some ways comparable to that achieved in relation to general medical practice in 1965. However, any such reform should today be aimed at further developing community pharmacy in ways which are complementary to general practice, rather than moving it forward in isolation. Such thinking appears to have underpinned the 2007 APPG report *The Future of Pharmacy*. This argued – primarily in the context of the English environment, but with relevance to the entire UK – in favour of a series of innovations designed to increase the range of pharmacy services paid for on a nationally defined, consistently available, basis.

In addition to expanding the current range of nationwide 'advanced' pharmacy service payments, the All Party Pharmacy Group's recommendations included:

- introducing a pharmaceutical care Quality and Outcomes Framework to encourage the development of clinical community pharmacy services;
- providing GPs and/or Practice Based Commissioning (PBC) groups with incentives for working more closely with community pharmacy, and for where it would be consistent with patients' preferences transferring to pharmacists health care tasks. Presently it may often be financially unattractive for practices to do this, even when at a national level the further development of community pharmacies as (for instance) 'public health outposts' is in fact economically desirable; and
- rationalising regulations such as those relating to pharmacy location controls, to minimise costly bureaucracy and encourage fair competition.

A PATIENTS' RIGHTS FOCUSED APPROACH TO NHS CARE RECORDS?

The Future of Pharmacy also made recommendations regarding professional leadership and education. If community pharmacists

and general practitioners are successfully to adapt their respective roles, they will need leaders capable of standing above sectional and short term concerns. Hazards to be avoided include on the one hand becoming embroiled in petty financial or procedural disputes, through to on the other undermining patterns of general medical practitioner care and authority that genuinely protect public interests. Mature leadership will also be needed to help primary care professionals of all types towards:

- further respecting consumer sovereignty in the 'health market':
- recognising the benefits of well managed, therapeutically constructive, competition between health care providers; and
- accepting and working positively within systems of corporate management and extra-professional regulation, in circumstances where this is demonstrably necessary for improving public health and individual care.

Further progress in academic pharmacy is also needed to support innovations such as independent pharmacist prescribing. Changes in undergraduate and post graduate pharmacy education and its funding are needed to bring pharmacists into closer contact with both patients and other professionals such as doctors at formative points in their careers. New educational approaches could also help primary care professionals to develop clearer approaches to issues such as balancing the need for public health programmes intended to alter populations' life styles with the provision of interventions aimed at enabling individuals and families to control factors such as their weight, mental states, smoking habits and/or alcohol use (see Box 6.)

However, the most important policy options for practically improving the delivery of better co-ordinated general medical and pharmaceutical care in the short to medium term probably relate to care records, and the potential for the NHS *Connecting for Health* programme to be taken forward in those ways most likely to permit increased service user choice in accessing timely, good quality, primary and secondary care. This is an area where there is a substantial risk of counter-productive conflict. Yet if general practitioners and community pharmacists can agree a robust way forward this would not only help those using their services to enjoy better integrated support. It could enable members of the two professions to more effectively defend their shared legitimate interests in adequate health service resourcing and appropriate working conditions.

It is understandable that, in addition to concerns about patient confidentiality, some GPs may be worried about sharing what they might regard as their business records with other professionals. At worst some may fear losing their patients and suffering reduced incomes. However, the conclusion offered here is that such fears lack substance in the British care setting. Rather, the risks of failing to work more effectively together to provide convenient and effective care would outweigh any that might stem from permitting community pharmacy access to patient care records.

To protect the public, pharmacists' future access to NHS care records should of course be consistent with patient wishes for confidentiality. The view taken here is that NHS users should have the power to not only see their full care records when they so wish, but also to allow practitioners such as community pharmacists to access them in order to provide requested services and care to a high professional standard. In such circumstances it would clearly be in the public's interests for pharmacists in primary (and when relevant secondary) care settings to have read-write access to patients' care records and to be able to make entries in them about, for instance, treatment changes and new service user requirements.

From an efficiency perspective the goal of such reforms should be to provide service users with seamless support as over the years they move up and down 'service ladders' between seeking support for informed self management, needing professionally co-ordinated primary health and social care, and having to undergo specialist interventions. To deliver faster access to better care, political and NHS leaders will need to ensure appropriate community pharmacy access to NHS care records.

Failure to attain this goal would mean that not all of the advances promised by recent investments in NHS ICT will materialise. It could even in time deprive people in this country of community pharmacy services altogether, at least with regard to independently located smaller pharmacies. Conversely, the successful achievement of appropriate community pharmacy access to NHS care records would further enhance the capacity of pharmacists, GPs and other NHS service providers to form patient focused local partnerships (Box 7), and improve both individual choice and public health. This would allow them successfully to meet the key challenge of providing well integrated medical and pharmaceutical care for people with long term conditions and other complex needs (Noyce 2007), without undermining other types of community pharmacy service.

CONCLUSION

The health and longevity of the UK population is better assured than at any other point in history. Today more of the country's total wealth is spent on health and social care than ever before, and the pharmaceutical and other treatments available have become progressively more effective. Yet it does not always appear that the public is confident that they are as well served as such facts suggest.

There are many reasons for this apparent paradox. They in part relate to the raised aspirations of individuals living in communities where suffering death or disability before retirement age has become seen as a relatively rare personal tragedy. Today even people in later life hope and expect to be in good health, or at least to have the support they need to go on living comfortably at home for as long as possible. Yet one of the prices of greater social equity and higher overall standards of education and employment is that the costs of providing health and social care have risen faster than have many other factors.

Measures aimed at accommodating such pressures can lead to a sense of declining service standards. Changes in traditional patterns of care can also lead to an impression of service withdrawal, even if technical standards are rising. Successful health service commissioners and providers therefore need to seek progressive increases in efficiency in ways that accommodate sensitively such human factors. Facilitating improvements in primary and community care via more collaborative, if also in some contexts more competitive, working between community pharmacists and general practitioners offers a solution to this fundamental challenge.

In the past the physical and financial separation of community pharmacy and GP services from each other and other parts of the NHS has impeded progress. So too have limitations in professional education, skills and attitudes, combined with insufficient public understanding of how first class primary care can best be delivered. Today, however, new technologies and more sophisticated approaches to the economic incentivisation of professional collaboration can offer additional improvements in primary care quality and customer choice. The potential fruits of more complementary ways of working between GPs and community pharmacists should build on the successes of the past. They range from supporting whenever possible well informed self

management, through to when necessary accessing specialist care in a timely manner.

The precise details of how a new 'Community Pharmacists' Charter', could – through more sophisticated patterns of nationally defined, consistently available, payments to pharmacies and other mechanisms – further improve pharmaceutical and wider primary care delivery need further analysis. Advances in areas such as relieving pharmacists' dispensing workloads and extending their clinical care contributions cannot be achieved 'overnight'. Neither can reforms such as those needed to break down unhelpful 'tribal' hostilities within and between pharmacy, nursing and medicine, or to improve professional respect for patients' social and psychological, as well as their more narrowly defined biomedical, needs.

But important steps forward have recently been taken in the UK, not only in contexts such as the advent pharmacist conducted Medicines Use Reviews in England and the Scottish community pharmacy contract's core activities, but also in areas such as the Quality and Outcomes Framework element of the current GP contract. One way forward might be extend this last in ways that will in future reward practices for working more effectively and efficiently with community pharmacies. If the experience already gained in fields such as these can be used with good will to further enhance the provision of better integrated, optimally accessible primary care, there is good reason to conclude that this will significantly improve the public's health. It should also enhance service user satisfaction with the NHS, and increase patient confidence in all the health professions and public and private organisations that together provide the nation's health and social care.

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