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Achieving integrated care in 2020 — the importance of shared values

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The recent White Paper for pharmacy in England may prove to be the most important English pharmacy policy document since the Nuffield Foundation's seminal study on pharmacy in the 1980s. But to achieve its potential the White Paper must be translated into the delivery of better services and demonstrably improved health outcomes. Our new School of Pharmacy report, "Commissioning for choice, quality and outcomes", on enabling community pharmacy to contribute more to better integrated primary care (published this week in partnership with Alliance Boots and available at www.pharmacy.ac.uk) seeks to highlight the measures needed to make a reality of the Government's vision for 21st century pharmacy.

In the run up to the publication of Lord Darzi's NHS Next Stage Review and the Department of Health's new primary care strategy, the School of Pharmacy's report shows the urgent need for a remuneration system that will encourage closer joint working between GPs (and their colleagues) and community pharmacy-based health professionals. Physical facilities can be important. But it warns against becoming too preoccupied with funding costly new buildings (whether they are called polyclinics, health centres or hospital outreach clinics) or establishing single local care organisations.

At a time when computer technologies are making virtual integration easy, concentrating specialist and primary care resources in large new buildings will not necessarily lead to better co-ordinated or more convenient care. Rather, our analysis highlights the importance of aligned incentives and "healthy" professional values. That is, values which foster mutual respect between health care providers and the people they serve and help build independence and freedom of informed choice.

"Commissioning for choice, quality and outcomes" emphasises the need to make the best possible use of existing assets like Britain's conveniently accessible community pharmacy network. It would be a tragedy for the public if the latter were to be destroyed just when technological developments promise that it will become better able to meet public health requirements than ever before. Providing good quality hospital care is, of course, important. Yet, as recent work on achieving "world class" commissioning shows, delivering better health outcomes will most frequently hinge on improvements in primary care. Closer collaboration — and where it benefits the public — constructive competition between GPs and pharmacists will open the way to:

- Faster identification of health risks and early stage diseases, in part through health checks provided in pharmacies — the first pharmacy based screening services for diabetes and related metabolic syndrome disorders in London were announced earlier this month (*PJ*, 7 June, p680)
- Better access to treatment for both common and minor conditions — this will be facilitated via the further development of pharmacists' clinical expertise in the management of repeat dispensing and the care of people with long term conditions, alongside the targeted provision of "enhanced" medicines use reviews

Innovations such as an "MUR plus" service could facilitate better medicines-taking and prove an appropriate platform for supporting people who wish to develop their self-care competencies. It might also allow pharmacists to collect new data on the health gains associated with their contributions to better integrated primary care

Incentives for providing this last might be incorporated into a revised quality and outcomes framework designed to bridge the current divide between GP and community pharmacy payment systems. Alternatively, a new form of independent pharmacy-based health care budget line might be established to augment existing arrangements.

Improved information

Lord Darzi and DoH leaders, such as Mark Britnell and David Colin-Thomé, almost certainly understand that reforms intended to improve NHS care should not reduce patient and public choice, or "lock out" innovators such as community pharmacists seeking to provide new services in areas once regarded as exclusively medical. Aligned remuneration systems will be vitally necessary for achieving further progress, especially if they can — while encouraging beneficial collaboration — extend rather than curtail provider plurality.

Yet funding reforms alone will not be enough to achieve the fundamental developments in primary care that an increasing proportion of the public want. Indeed, just calling for new payment systems could make it look like pharmacy has not yet learnt the lesson that it must prove its worth in a changing world. Delivering more personal services and better health outcomes will also need better information sharing, coupled with values that put achieving better care and outcomes ahead of sectional goals.

With regard to the first of these priorities, we argue that community pharmacy access to NHS electronic records will be an essential requirement for true care integration. In the past the transformational possibilities associated with wider (appropriately secure) access to records has not been adequately understood. At times officials seem not have realised the importance of enabling people using health services to move more freely from one source or type of care to another.

Regarding values, many people define health in terms of having control over their lives and the ability to exercise choice autonomously. "Top down" pressures which may threaten both professional and service user autonomy in the name of improving "quality" should be resisted. So too should tribal attitudes that make individuals and groups insensitive to the abilities and needs of others. For example, doctors should, where appropriate, be prepared to refer patients to pharmacists for interventions such as health checks or MURs. By the same token, pharmacists should be prepared to defend the special role played by GPs.

Specialist physicians and hospital managers do not always appreciate the value of generalists. They may even be actively hostile to them when they fear that GPs, together with patients seeking to exercise informed choice, could increase the competitive and financial pressures on their institutions.

Some community pharmacists may believe that if GPs are to be concentrated into large centres this will leave pharmacy in a better position to extend its future role. But there is as yet no substantive evidence that this would benefit the public. Indeed, it could prove detrimental. It might also lead to a critical undermining of the existing funding base of community pharmacy before new ways of working have become adequately established.

"Commissioning for choice, quality and outcomes" concludes with a caution that community pharmacy should be careful to respect the proven contributions of general medical practitioners and, if necessary, join with doctors in defending them from unfair attacks. Competition is healthy when it benefits patients and the public. But the future success of the NHS will at heart depend on GPs and community pharmacists working better together, and recognising that they must increasingly depend on each other to deliver genuinely integrated care.