



Healthy Lives, Healthy People: Consultation on the funding and commissioning routes for public health RPS response to the consultation

The Royal Pharmaceutical Society (RPS) is the new professional body for every pharmacist in Great Britain. We are the only body that represents all sectors of pharmacy in Great Britain. There are approximately 75 pharmacists per parliamentary constituency, working in hospitals, industry, academia, GP practices, primary care trusts and community pharmacies. This response comes from its English Pharmacy Board (EPB) which is an elected body of pharmacists representing all sectors of pharmacy practice in England.

General Comments

The overall paper 'Healthy lives, healthy people' identifies the potential to use pharmacy teams more effectively to improve health and wellbeing and to reduce health inequalities. The funding and commissioning routes need to be structured and developed to allow this potential to be realised.

This consultation paper does not adequately consider pharmaceutical public health beyond that delivered by community pharmacies. Pharmacists are currently embedded in the provision of many public health services; for example the role of pharmacists working in hospitals in health prevention, pharmacists working in prison services, pharmacists working in care homes ensuring the clinical and cost effectiveness of medicines etc, need to also be integrated into patient care pathways and public health provision.

Table A demonstrates the wide range of public health activity and there are pharmaceutical contributions to be made in most of these areas across many different areas of practice. Some important pharmaceutical public health roles such as medicines disposal, reporting and cascading hazard warnings and drug alerts, information to patients and the public on unsafe medicines, have been omitted. We would like to draw attention to the need for public health in the 21st century to recognise medicine related issues as a key part of the public health agenda. Often public health interventions can lead to the use of medicines, for example, screening for high cholesterol levels can lead to a requirement for a statin to be prescribed. Medicines are a major contributor to the nation's health and yet not enough focus has been given to medicines in this document. It will be crucial to ensure that new organisations have a competent understanding of the legal and ethical issues affecting medicines, controlled drugs, pharmacy services and pharmaceutical public health.

The consultation mentions ring-fenced funding for public health services in the region on £4 billion. We would want to ensure that funds which government intends to be used for health prevention services are not diverted to prop up infrastructure and capital developments. The focus needs to be on improvements that truly improve public health and social wellbeing.

The consultation also mentions the 'any willing' provider model (AWP). While we support the principle of the 'any willing and suitably qualified provider' model, we feel strongly there must be 'fair competition' for all suitably qualified providers. It is also important that all commissioners have an understanding of the different cost models in place for all providers.

An example of this is the contract duration, which needs to be long enough for independent sector operators e.g. community pharmacists, GP practices, optometrists, dentists etc to recoup the investment necessary to deliver a high-quality, high standard service. It is also important that outcome measures for providers are consistent and applied in line with national policy.

Specific Questions:

Q1. Is the health and wellbeing board the right place to bring together ring-fenced public health and other budgets?

The RPS continues to support the move to transfer the responsibility of public health to local authorities. As the exact roles and remit of the HWB are unclear at present and the budget flow diagram is acknowledged to be incomplete, it is difficult to comment properly on this question. In theory, the Health and Wellbeing board (HWB) would seem a sensible place to bring together all elements of health and social care as it will span the NHS, Social care and public health. We suggest the HWB should not hold the budget but have the ability to ensure that those organisations, who do hold the budgets i.e. the Local Authorities (LAs) and the GP Commissioning Consortia (GPCC), are held to account. It is imperative that the use of the public health budget (as with all budgets) is transparent but as yet no detail is available as to how much of this information will be in the public domain and how the spending from each budget will be scrutinised.

It is vitally important that the HWBs have members who can maximise the utilisation of all potential expertise available to ensure delivery of their elements of the public health strategy. The HWB will need to understand the capacity and capability of all providers, how they are funded etc. When the HWB discuss issues affecting or about pharmacy-led services, it will be essential for a pharmacist to be present, ideally as a full member, to inform the debate and ensure that practical and affordable outcomes are reached. Medicines are the most common intervention in the provision of healthcare and are also often an outcome of public health service provision. Pharmacists have unique expertise in the safe and effective use of medicines, their storage, use, supply, costs and legalities and logistics and must be involved where treatment with medicines is being discussed.

Q2. What mechanisms would best enable local authorities to utilise voluntary and independent sector capacity to support health improvement plans? What can be done to ensure the widest possible range of providers are supported to play a full part in providing health and wellbeing services and minimise barriers to such involvement?

It will be important for LAs to understand the nature of the national pharmacy contract and the locally enhanced and advanced services they may access and to influence commissioning of the services required. They should ensure that any strategies are consulted upon amongst all potential influencers or service providers, including voluntary and independent sector, and for empowerment of those who have the skills, knowledge and expertise to help deliver the strategy in their communities. Community pharmacy often works with charities to promote public health messages and to deliver services, e.g. working with Hepatitis C Trust. RPS has also worked with charities to develop resources to assist pharmacy teams to deliver new or improved services and resources e.g. working with Beating Bowel Cancer to raise awareness of early symptoms.

Community Pharmacies are also independent providers, in that some provide privately funded services and these also need to be considered as part of the development of health improvement plans.

Q3. How can we best ensure that NHS commissioning is underpinned by the necessary public health advice?

The NHS Commissioning Board should seek advice from PHE. There needs to be expertise and advice to inform public health commissioning at these levels.

It is essential that all public health departments have specialist advice on pharmaceutical public health and legislation issues particularly in relation to the use of medicines, including medicines management and abuse. We ask that the contributions pharmacists in Great Britain already make at strategic and commissioning levels in wider public health are recognised and supported in the new NHS structures in England and existing staff are transferred appropriately. The skills will be required in such areas as needs assessments, public health policy and planning, quality frameworks, evidence-based delivery and medicines management. Both PHE and NHS Commissioning Board must have pharmacy expertise and involvement within their structures to ensure plans and proposals are competent and maximise benefits to patients.

Q4. Is there a case for PHE to have greater flexibility in future on commissioning services currently provided through the GP contract, and if so how might this be achieved?

Some of the services currently commissioned via the GP contract could be made available to 'any willing provider'. We agree that there is a case for PHE to have greater flexibility in future on commissioning services currently provided through the GP contract through other providers as long as competencies and skills are equivalent. There is evidence that other service providers such as community pharmacy are as capable and effective and the opportunity to use a wider range of providers should be encouraged. . The Isle of Wight commissioned a community pharmacy-led vaccination services which has led to more immunisation services being developed locally to improve patient choice, uptake, and outcomes. The PCT has developed the breadth of vaccination to include seasonal 'flu, which considerably increased capacity. Top line results show:

- Total vaccinated: 2903 (approx. 10% of total vaccinated through all services)
- Under-65s with co-morbidities: 36.3% of cohort vaccinated (Other providers: 17.1%)
- Percentage Rating Service OK or Excellent: 99.6% (90.9% Excellent)
- Percentage receiving flu vaccination for first time: 8.2%
- Percentage for whom vaccination unlikely without pharmacy access: 6.2%
- Percentage indicating they would use community pharmacy again: 98.4%
- Percentage indicating they found the service more accessible: 92.8%

The patient survey of reported outcomes (PROMs) at the end of the 'flu season indicated transport issues, mobility issues either due to age or handicap that make either uphill or long journeys on foot impractical, work commitments, previous experience or non-registration at GP practices when recently moved to the Island.

It is important for public health that there is an equitable provision and quality specification for locally commissioned enhanced pharmacy services across the country as much as possible. The current arrangements work well in some places but not in others and this inequity can lead to confusion for patients and the public. We would suggest this could be solved by consideration of moving as many as possible of the public health pharmacy services into a national contract for pharmacy under control of PHE and the NHS Commissioning Board.

If public health services are to be left to local design and implementation, there needs to be consistency so commissioners can be satisfied that providers are delivering to the required

levels and outcomes. The ratified framework for Healthy Living Pharmacies (HLP) could be used as a template for this. HLP is underpinned by Quality Criteria and provides a commissioning framework which can be used to meet local health needs. The model of Healthy Living Pharmacies in Portsmouth is starting to provide evidence that pharmacies can deliver high quality public health services for their communities. A person walking into an HLP in Portsmouth is twice as likely to set a quit date and give up compared to a person walking into a pharmacy which is not an HLP. Over 3500 patients received brief advice on safe alcohol consumption; 36% were at increasing risk and 10% at high risk from current levels of use. The interim outcomes show that HLPs benefit from having a Healthy Living Champion, trained to Royal Society of Public Health Level 2 Health Improvement Award to help individuals proactively. These members of the pharmacy team promote health and wellbeing within their practice. Health and wellbeing services are delivered by the appropriate members of the team, optimising skill mix and capacity and avoiding reliance on one person to deliver everything¹

The 'Harmonisation of Accreditation' (HAG) model currently used to accredit some pharmaceutical services in some areas of the country, particularly in the North West of England, may be an approach that could be used nationally². In the new world, with the concept of AWP who is suitably qualified, the HAG model could provide community pharmacists with an opportunity to assure commissioners they can deliver the service to a good standard which will maximise positive outcomes for patients

To achieve the government's vision for public health there needs to be an increased number of healthcare professionals delivering services to cover the wider public health arena. Increased options, access and choice result in more opportunities to nudge citizens and pharmacy can play their part in this. Their location and skills allow them to deliver services and offer advice in support in locations and at times that fit with the lifestyles of the public and patients.

Q5. Are there any additional positive or negative impacts of our proposals that are not described in the equality impact assessment and that we should take account of when developing the policy?

Minor ailments schemes provided by community pharmacies can be extremely valuable and should be taken into account. Treating minor ailments in a community pharmacy setting rather than in general practice can save money and allow the GP to concentrate on more serious conditions. The average GP surgery consultation lasts 11.7 minutes and costs £32. The same 11.7 minute consultation in pharmacy would cost £18 and deliver an equally, or even more effective outcome³.

It is not clear if the proposed activity of the public health budget includes provision for some of the more vulnerable people in society such as the homeless, refugees or other people who are not currently registered on GP practice lists.

Q6. Do you agree that the public health budget should be responsible for funding the remaining functions and services in the areas listed in the second column of table A?

Yes. Almost all of these functions and services have pharmaceutical components, either of current service provision or potential future developments and covering all areas of pharmacy practice.

Pharmacies are privately funded and, we feel, are under utilised by the NHS. We would encourage the government to build on the existing community pharmacy infrastructure to

¹ <http://tiny.cc/hlp>

² <http://www.pharmacyworkforcenw.nhs.uk/?page=115>

³ Bow Group, September 2010, Delivering Enhanced Pharmacy Services in a Modern NHS

create a local and public facing network for public health. This resource would operate at the interface between more formal primary medical care and unsupported self care which is achievable at limited cost. This could contain overall NHS premises, running and staff costs. This would then improve outcomes and prevent episodes of ill health by allowing more activity to be cascaded down from tertiary / secondary care to GP led primary care as capacity is made available.

Public health and GP commissioning budgets also need to be aligned to connect health and public health services, which may be commissioned on a collaborative basis.

Q7. Do you consider the proposed primary routes for commissioning of public health funded activity to be the best way to:

- **Ensure the best possible outcomes for the population as a whole, including the most vulnerable; and**
- **Reduce avoidable inequalities in health between population groups and communities?**

If not, what would work better?

We would draw attention to the mixed economy on pharmacy provision for services in the areas outlined in Table A. Some of these services are provided by all pharmacies, others by those with an NHS contract and others by community service pharmacists in the managed sector.

The commissioning of public health services is a complicated area and is not yet clear as far as it affects pharmacy; therefore it is difficult to give an informed answer to this question at present. However, we do have concerns that services, such as sexual health services currently provided as a complete service package by many community pharmacies, may become fragmented. An example of this is a Chlamydia service which currently provides testing, treatment and tracing of partners. The testing element of this service, along with partner notification etc, could be viewed as public health and would fall under the remit of LAs, whereas the treatment element is likely to fall under the remit of the NHS. This would lead to a fragmentation of a currently integrated service potentially leading to poorer outcomes for patients.

The interface issues need to be more clearly defined, e.g. the patient pathways defined by some public health initiatives, such as screening services, will cross from public health to mainstream NHS treatment and ongoing care. A clear understanding of budget responsibilities, roles, remits and expectations will need to be developed before such a system will be able to operate effectively. This links to understanding where services are going to be commissioned from and ensuring there are no gaps as a result of different agencies commissioning different elements of a health and wellbeing service. For example NHS Healthchecks will identify patients with high cholesterol levels who will require treatment from their GP, as well as potentially a number of additional services such as smoking cessation, weight management etc

Clarity is also required as to where medicines fit within the public health agenda. Medicines are the most common intervention in the provision of healthcare and are often an outcome of a public health intervention.

Q8. Which services should be mandatory for local authorities to provide or commission?

It would seem crucial that local authorities make legally competent arrangements to dispose safely of unused medicines, have emergency plans and deal with drug alerts. They will need to help meet community needs in regard to ethnic and social deprivation public health issues

in their boundaries and could include locally negotiated enhanced and advanced public health pharmacy services.

It will be important for there to be good links between hospital medicines and those prescribed in primary care. Joint formularies to minimise these problems at the interface and robust procedures around the transfer of care will assist.

Some public health services should be provided in every area, such as smoking cessation and substance misuse. In order to reduce the amount of local bureaucracy and to ensure consistent standards and delivery, we believe that such services should be commissioned nationally.

Q9. Which of the essential conditions should be placed on the grant to ensure the successful transition of responsibility for public health to local authorities?

The essential conditions that should be put in place should include that the service meets a local need, that the service is accessible and increases patient choice that it can provide successful delivery of health improvement outcomes and can lead to a reduction in health inequalities. Robust arrangements need to be put in place to ensure that the ring-fenced funds for public health are used appropriately and not for other work that is currently funded through existing budgets.

We believe the costs of pharmaceutical public health personnel, currently working in PCTs, may have been omitted from the budget and would suggest that if this has not been included than this should be rectified. The HWBs will have responsibility for leading on Pharmaceutical Needs Assessments (PNAs) alongside Joint Strategic Needs Assessments (JSNA). This will require relevant skills, expertise, knowledge as well as adequate resources.

Q10-11

We have no particular comments on these questions

Q12-16

Health premiums. Whilst we have no specific comments on these questions we do have concerns about the introduction of Health Premiums. We are concerned that although their intention is to attract service providers into areas of health inequalities by incentivising areas to make improvements or progress towards outcomes, they need be at a level that will truly engage local authorities. There are also concerns that the health premiums may paradoxically increase health inequalities if only success is rewarded. Areas currently with low levels of deprivation may find it easier to achieve health improvement in their locality and be rewarded, whereas areas of higher deprivation may make slower progress and be penalised unfairly, as it appears the premium will only be awarded if progress is made. The timeframe over which progress is measured is also crucial as some improvements will take a considerable amount of time before measurable change occurs.

The proposal that health premiums will incentivise action to reduce health inequalities from funding within the ring fenced budget may be difficult to achieve. This is because it is unclear where the monies will come from when other priorities such as efficiency savings and reductions in LA budgets of up to 25% take hold.

For further information or any queries you may have on our consultation response please contact Heidi Wright at heidi.wright@rpharms.com or 0207 572 2602.