



Healthy Lives, Healthy People: Our strategy for public health in England 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.

Major themes

The EPB supports the Department of Health's aim to strengthen public health provision via a new National Public Health Service. Our response provides comments which will assist the development of this service as well as helping pharmacists and other healthcare practitioners engage with this development.

The EPB believes that the new public health services should utilise the network of community pharmacies as its natural frontline. Community pharmacists are highly qualified health professionals who lead well trained teams already delivering public health services on a daily basis from very accessible and convenient locations. Informal public health provision has been central to pharmacies throughout their history and there is a growing evidence base for good outcomes from their delivery of formal public health services.

Increasingly, public health interventions will require the use of medication. Pharmacists are the experts in medicines and have a great deal of public health expertise within primary care, especially in service design and improvement, which does not appear to be recognised in this white paper. The contributions pharmacists in Great Britain already make at strategic and commissioning levels in wider public health must be recognised and supported in the new NHS structures in England. These include needs assessments, public health policy and planning, quality frameworks, evidence-based delivery and medicines management.

General Comments

The EPB supports the Department of Health's aim to strengthen public health provision, via a new National Public Health Service; we are pleased to see that Government recognises the growing public health role for pharmacy by including some elements of the community pharmacy role in this consultation. We would like to draw attention to a number of issues that are important to public health and the contribution the pharmacy profession can offer which are not covered by the consultation questions.

We feel that public health in the 21st century should 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.

Using community pharmacy to deliver public health:

Pharmacists are highly qualified health professionals who lead well trained teams that deliver public health on a daily basis from premises that are conveniently located and open at times the public need them.

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 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.

Pharmacy is one of the few healthcare providers that engage with people whilst they consider themselves well. The estimated total number of visits to community pharmacies per day in England is 1.6 million, of which 1.2 million are for health related reasons.¹

Usually pharmacies are sited in towns and communities with high levels of deprivation, higher than average morbidity and low levels of health literacy.² Pharmacists are well positioned to identify and approach people from target groups e.g. persons from ethnic communities, the older people and the vulnerable, asylum seekers, travellers and the homeless, and can and do offer services that more traditional NHS services may not offer, and in premises which are more local and convenient, thereby improving access and uptake. Many pharmacists offer support to Muslim populations that fast in Ramadan and have concerns about not taking their medicines during that period.³ A number of community pharmacies provide bespoke services for these vulnerable people, see example 1, and we would like that particular role to be strengthened and supported as the new NHS structures develop.

Example 1: Greenlight pharmacy in London. This pharmacy knew a number of members of the local population were from Bangladesh and did not understand English particularly well. They therefore developed a Bangladesh Health Education service. More information can be found at <http://www.greenlightpharmacy.com>

The community pharmacy network is highly accessible to patients and the public – many of whom will not necessarily access other parts of the NHS. 99% of the population are able to access a pharmacy within 20 minutes by car and 96% by walking or using public transport⁴. This network can be used, not only to provide information to the public, such as public health messages but also to harness the public and patient views. Community pharmacy is the window into the NHS on every high street and has long been promoted as the first port of call for promotion of health and wellbeing and prevention of ill health, treatment and advice on minor ailments, management of Long Term Conditions (LTCs) and support and advice on medicines. Community pharmacy is highly accessible for patients of the NHS and those

¹ COI/ Department of Health. 2008. Community Pharmacy Use: Quantitative and qualitative research. Market Research Report

² <http://www.pharmacy.manchester.ac.uk/cpws/publications/Bulletins/bulletinn5.pdf>

³ <http://muslimmatters.org/2010/08/27/radical-nhs-campaign-to-tackle-health-issues-during-ramadan/>

⁴ The Bow Group target paper. Delivering Enhanced Pharmacy Services in a modern NHS: Improving Outcomes in Public Health and Long-Term Conditions

seeking to maintain good health. As well as being trusted by patients and the public, community pharmacies provide an obvious location for delivery of NHS primary care and public health services. Over 85%⁵ of pharmacies now have consultation areas where they can undertake confidential discussions with patients. The informality, anonymity and accessibility of pharmacy encourages patients to feel comfortable in raising difficult or embarrassing problems that they may not want to see their GP about, such as sexual health advice⁶. It also means that when patients present themselves with one problem, other aspects of their health can be assessed and responded to.⁷

Example 2: 92% of young people on the Isle of Wight choose to access sexual health services through community pharmacy because they like the anonymity, convenience and access as well as the range of services available

Increasingly, community pharmacists and their pharmacy teams have been delivering clinically based services,⁸ such as INR clinics, diabetes management and substance misuse services. This provision of clinical information is now accepted by patients as part of the usual role of community pharmacy.

We are pleased to see the government's recognition of the Healthy Living Pharmacy (HLP) model, currently being piloted by Portsmouth PCT. A person walking into an HLP in Portsmouth is twice as likely to set a quit date and give up smoking 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 use⁹ The EPB would support adoption of this model to encourage equitable services to the whole population. We believe that the HLP model could form the basis of the delivery of a quality based public health service.

Community pharmacy based public health services could be informed by models currently in use in other countries such as NHS Glasgow and Clyde where they have established a Pharmacy Public Health Improvement service. This is specifically aimed at community pharmacists and their staff who work in the area, but is helpful to all who are active in public health improvement. It provides information on health improvement topics which relate to community pharmacy practice and the public health agenda's of the day, giving detailed advice and contacts useful for delivering these agendas.¹⁰

The EPB believes that pharmacy led public health services should be a major consideration for the new National Public Health organisation for England such as smoking cessation, sexual health and screening.

Strategic Pharmaceutical Public Health:

The consultation document focuses very much on health improvement and health protection. There is a whole section of public health expertise in service design and improvement which

⁵ <http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/pharmacies/general-pharmaceutical-services-in-england-2000-01-to-2009-10>

⁶ Anderson C, Blenkinsopp A (2006) Community pharmacy supply of emergency hormonal contraception: a structured literature review of international evidence. Hum Repr 21: 1, 272–78 and Bissell P, Anderson C (2003) Supplying emergency contraception via community pharmacies in the UK: reflections on the experience of providers and users. Soc Sci Med 57, 2367-2378.

⁷ CBI report Best of Health, Improving Lives through Smarter Care. Feb 2010

⁸ Anderson C, Blenkinsopp A, Armstrong M (2009) [Report 7: The contribution of community pharmacy to improving the public's health: Summary report of the literature review 1990-2007](#). Pharmacyhealthlink, London

⁹ <http://tiny.cc/hlp>

¹⁰ http://www.nhs.gov.uk/content/default.asp?page=home_Pharmacy%20PH%20Improvement

does not appear to be recognised in this white paper. We would 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. These include needs assessments, public health policy and planning, quality frameworks, evidence-based delivery and medicines management.

Performing a needs assessment is important to ensure that appropriate services are developed and provided to meet need. The Health and WellBeing Boards are to take over responsibility for Joint Strategic Needs Assessments (JSNA) and Pharmaceutical Needs Assessments (PNAs). These two assessments need to be developed alongside, and inform, each other. The assessments will then inform both GP consortia and local authorities, working together, on which services should be commissioned to meet the needs of their communities. Pharmacists, currently working in PCTs, have a thorough understanding of the pharmacy contract and how pharmacy services are developed and commissioned. This expertise will be extremely valuable to ensure that needs assessments provide a valid basis for service commissioning.

Wales has benefited from having a team of pharmacists in Public Health Wales (formerly the National Public Health Service for Wales) dedicated to that discipline. The majority of Scottish Health Boards have a designated Specialist in Pharmaceutical Public Health and Grampian also has a Public Health Officer for pharmacy. There is an issue around local capacity and capability as the new structures develop. It is envisaged that local authorities will have responsibility for public health workforce planning in the future and we would encourage a unified approach to workforce supply even though the system itself may be more fragmented.

See also our responses to Q1

Concerns and issues:

The EPB believes it is essential to ensure that funding for public health is hypothecated and is commensurate with services that will deliver a high standard of care and bring real benefits to patients and the public. We support the ring-fencing of funding for public health but there is a need to ensure the funding is ring-fenced at both national and local levels and used to support appropriate public health services at all ages. 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.

To do this, several issues need to be addressed:

- i) *Further clarity on what is considered to be within the remit of public health in terms of promotion, prevention and protection would be welcomed.***

Many community pharmacies in England already promote healthy lifestyles by proactively engaging in discussions with patients around smoking, weight management, diet and physical activity. Many provide healthchecks and screening for a range of conditions e.g. cardiovascular checks and chlamydia screening and provide services that protect the health of the population as well as the individual e.g. vaccinations and immunisations. Substance misuse and mental health services both sit under the public health umbrella and the actual needs of the population in these areas should be identified with an appropriate level of service development relevant to age and chronicity of the problem. Pharmacy has a role in developing and delivering services

in these areas as well, and has a good track record for delivering services for substance misusers.¹¹

ii) Further guidance on the role that Directors of Public Health will be undertaking would be welcomed.

We believe that Directors of Public Health will have responsibility for the development of Pharmaceutical Needs Assessments (PNAs) as well as the commissioning of relevant public health services to satisfy the needs of their community. They may also be responsible for the Controlled Drug Accountable Officer (CD AO) role and the development of Patient Group Directions (PGDs) used as part of public health service provision. Pharmacists currently working in Primary Care Trusts (PCTs) have skills and expertise in developing PNAs and in the commissioning of public health services as well as collating evidence and outcomes. Many of them also undertake the CD AO role and have experience in and responsibility for developing and signing off PGDs. These skills should not be lost. Local Authorities should consider employing such pharmacists within their organisations or commission their services via other routes e.g. SLA with GP CC, social enterprises etc. We have major concerns that there will be a complete loss of skills, expertise and resources that can contribute to the delivery of the public health agenda in this current climate of efficiency savings. We believe that primary care pharmacists must continue to play an active role in the clinical design of local public health services and patient pathways. It will be crucial for a successful outcome for there to be pharmacist input to every public health department as there already is in Wales and Scotland.

iii) Contractual issues:

It is important for public health and public understanding that there is an equitable provision and quality specification for public health services across the country as much as possible.

The current arrangements work well in some places but not in others and can lead to confusion for patients and the public. We would suggest this could be solved by moving some of the public health pharmacy services into a national contract for pharmacy. 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. Whilst pharmacies would only be commissioned to provide such a public health service in relation to the needs of the population they serve, if a suite of such services was nationally defined this would enable standardised quality and equity of service provision for patients.

The RPS would welcome a consistent approach be taken 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 the service to a good standard which will ensure good outcomes for patients. One such model for pharmacy is the ‘Harmonisation of Accreditation’ (HAG) model, elements of which could usefully be adapted and adopted nationally¹². 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. The RPS is keen to work with Public Health England and all interested parties to define content and move this work on. By drawing from the good work of HAG and HLP, the

¹¹ Anderson C, Blenkinsopp A, Armstrong M (2009) Report 7: The contribution of community pharmacy to improving the public’s health: Summary report of the literature review 1990-2007. Pharmacyhealthlink, London

¹² <http://www.pharmacyworkforcenw.nhs.uk/?page=115>

RPS could support the profession in delivering Public Health across the country in a flexible way to a consistently high standard, which benefits both commissioners and the public alike. We also recommend evaluation be maintained at a national level with quick and easy access for employers and commissioners, particularly throughout the transition period.

iv) *Interface issues need to be defined.*

For example, 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. Key findings from an, as yet unpublished study managed by the RPS, show that the community pharmacy environment provides a good point of access for health messages. They are able to reach men as well as women and that referrals made to GPs were appropriate with patients with more symptoms being referred and those with fewer symptoms getting an OTC sale¹³. The EPB believes that there is a public benefit case for direct referral of patients from community pharmacy in the secondary screening where certain key signs of early cancer are identified by pharmacists.

v) *The role of Health and Wellbeing Boards needs to be more clearly defined.*

GP consortia and local authorities (LAs) will need to co-ordinate healthcare planning to ensure that the scope and scale of services are suitable for the numbers of patients transferring from public health screening to mainstream NHS treatment to provide a seamless care pathway for individual patients. We believe that Health and WellBeing Boards will have a significant role in this area; they will hold both GP consortia and local government to account in the commissioning of local services and ensure that services are in place to support those patients who may be identified, via screening services, of being at risk e.g. NHS Healthcheck may identify individuals at risk of heart disease who may require services such as smoking cessation, weight management or interventions with medicines etc. Community pharmacy is well placed to support individuals at low and moderate risk to change behaviour by accessing the relevant service either within or outwith community pharmacy commissioned services, depending on individual choice.

vi) *The prevention of ill health and delivering health improvement must be embedded into the NHS services.*

Whilst the EPB understands the rationale of moving responsibility for public health to local authorities, it is concerned that much of the current integration with mainstream NHS care will be much more complex and may be weakened. 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. Another important driver is 'no health without mental health' and it needs to be ensured that good public mental health is supported, maintained and / or

¹³ Unpublished data on an RPS study to create an evidence base to support the assertion that cancer can be detected through pharmacy, and specifically that pharmacy can aid the early detection of cancer. Due to be published in the Pharmaceutical Journal in April 2011

improved where necessary to prevent people going on to suffer from mental illness if support services are offered too late.

vii) Professional Public Health leadership.

Although many aspects of the services in community pharmacies are carried out by support staff the oversight and leadership of these services is undertaken by the pharmacist. It is essential that local authorities consider pharmacists as part of their local public health leadership network. Practically this means that pharmacists should be included in professional development programmes for public health practitioners

viii) The consultation document makes mention 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. 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.

Promotion:

The current pharmacy contract ensures that the public receives up to six health promotion programmes each year as agreed with the Primary Care Trust (PCT). The EPB would wish to build on this with the new public health service to deliver efficient and effective programmes. We would like clarity on how the new NHS and Public Health structures will maintain and enhance this service in the future. Pharmacies have played a role in reducing health inequalities, particularly in the areas of smoking cessation, alcohol, sexual health and minor ailment schemes. The role of pharmacists in public health should be recognised and developed further in order to maximise benefit and reduce the overall burden of smoking related illness and sexually transmitted infections on the NHS.

Prevention:

Community and hospital pharmacy prevent ill health and also maintain the health of those patients with LTCs. Pharmacists provide advice on the management of LTCs and self care and advice and support on the safe and effective use of medicines taken by patients. Pharmacists also play a significant role in improving the mental health and well being of patients, many patient suffering from a LTC also suffer from depression¹⁴. Pharmacists support older people, for example, by reducing the use of medicines associated with falls and increased mortality and morbidity¹⁵. Supporting the delivery of better management of health, pharmacists working in the community carry out Medicines Use Review (MUR), which while focusing on medicines use, also deal with other aspects of a patient's life including healthy lifestyle advice and consultations around weight, diet, alcohol and smoking. In addition, many pharmacists are offering diagnostic services for screening and monitoring purposes. Recently, community pharmacists have become more involved in the early identification of cancer symptoms and are also involved in adherence to chemotherapy as

¹⁴ [http://icn.csip.org.uk/library/Long-term conditions and depression PBC.pdf](http://icn.csip.org.uk/library/Long-term%20conditions%20and%20depression%20PBC.pdf)

¹⁵ <http://www.nhs.gov.uk/content/default.asp?page=s1360>

this treatment moves from secondary to primary care settings. A number of pharmacies now offer complete packages of care around sexual health, including Emergency Hormonal Contraception, Chlamydia testing, tracing and treatment and oral contraception. For every £1 invested in contraceptive services, it has been estimated that £11 is saved through prevention of unintended pregnancy¹⁶. Evidence also shows that the NHS could save a further £30 million a year by improving contraceptive services, in particular ensuring access to the full range of methods¹⁷.

Example 3: Over 820 patients with a respiratory condition have been supported in the effective use of their medicines. Initial outcomes show that 74% were not optimally controlled and 37% had not seen another healthcare professional in the previous 12 months; 70% of patients showed an improvement in the management of their condition as a result of the pharmacist intervention (see <http://tiny.cc/hlp>)

Protection:

At the strategic level pharmacists currently lead in areas of horizon scanning, financial planning and surveillance of medicines use. The importance of these functions to current PCTs and SHAs is recognised and must be factored into any new NHS infrastructure. In particular aspects such as antibiotic stewardship and surveillance of prescribing in support of appropriate antibiotic use in order to reduce antibiotic resistance should remain a vital aspect of pharmaceutical public health. Hospital pharmacists play a significant role in the reduction of hospital acquired infections such as MRSA and *Clostridium Difficile*. Additionally, the surveillance of substance misuse and drug related deaths should continue. Pharmacists working across all sectors are involved in emergency planning and preparedness and were a vital part of planning and delivery in the recent swine flu pandemic as well as the July 7th 2007 bombings in London. We believe that both commissioning consortia and local authorities should have independent professional pharmacist input at the appropriate level.

NHS Restructure Implications:

While we support the principle of the 'any willing provider' model we argue strongly for 'fair competition' for all providers and 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 and dentists 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.

The role of Health and Wellbeing Boards (HWB) should be to bring local authorities and GP consortia together to identify gaps in service provision relative to the JSNA and to prioritise which services are to be delivered. The EPB envisages JSNAs, along with accurate local population health data, as the key to making this new structure work at a local level. There must be a strong and effective relationship between pharmacy and local councillors, directors of public health and GP consortia and also between GP practices and other healthcare professionals to help facilitate dialogue across local healthcare providers and to minimise variation between commissioners in the same consortium area. The HWB is the only body that will be able to assess whether delivery of services across all commissioning organisations, meets the needs of the community which they serve.

¹⁶ The Economics of Family Planning Services, Family Planning Association, McGuire, A and Hughes, D. (1995)

¹⁷ The Economics of Sexual Health, Family Planning Association Armstrong, N and Donaldson, C. (2005).

The HWB will be required to understand the capacity and capability of all providers, how they are funded etc and they may require some support in understanding both this and the new NHS structure. 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, legalities and logistics and must be involved where treatment with medicines is being discussed.

We have concerns that service delivery will be disrupted during the transition period and pharmacists with valuable public health skills could be lost. There is already evidence that PCTs are decommissioning public health services before the budget has transferred to local authorities and before the local authorities are in a position to commission them

Responses to Consultation Questions:

1. Are there additional ways in which we can ensure that GPs and GP practices will continue to play a key role in areas for which Public Health England will take responsibility?

The JSNA, and the PNA linked to this, will provide all commissioners with relevant information on their communities and the current picture of service provision. The JSNA will be the key to local commissioning and GP consortia should be required to commission services against this. The process of creating the JSNA and commissioning of services must not be disjointed. We support the initiative that enables HWBs to hold GP consortia to account, particularly in regard to the JSNA, and believe that the HWBs will need real powers to address any shortcomings.

Pharmacists input into the public health agenda at many levels. Pharmacists currently working in Primary Care Trusts have the skills, expertise and knowledge to support commissioners in both GP consortia and local authorities. The services that these pharmacists provide are essential for patient care and the containing of NHS resources. They must continue in the new structure and in some places may need enhancement to meet the growing prioritisation of public health issues in the NHS. Some of the key areas are:

- the management of the prescribing budget
- development of prescribing incentive schemes
- antibiotic stewardship
- medicine use surveillance
- substance misuse monitoring
- the procurement of community pharmacy services
- the development of Pharmaceutical Needs Assessment (PNA)
- pharmacy input into the wider commissioning of health services, including public health, across the PCT
- promoting and commissioning community pharmacy as a provider of public health services.

We believe that primary care pharmacists must continue to play an active role in the clinical design of local services and patient pathways. The vital role of medicines management to ensure quality and transparency in all commissioning decisions about medicines must be encouraged to continue and develop through local decision making processes. The impact of medicines in improving outcomes e.g. statins in reducing heart disease, and how this is delivered across a whole health economy from the strategic level to practice based pharmacists and community pharmacists

requires strategic pharmacy involvement. As mentioned previously, Scotland and Wales have both recognised the valuable contribution of pharmaceutical public health and have provided for this by employing pharmacists in the strategic organisations within their devolved NHS structures. Pharmacists are a valuable resource that must work across interfaces between GP consortia, local authorities and the managed NHS to ensure that the commissioning of services involving medicines is completely joined up. To maximise the potential for greater pharmacy public health involvement there must be suitably experienced pharmacist input into operating plans, PNAs, implementation of safety alerts, service developments and policy guidance has demonstrated their value to commissioning organisations.

A number of pharmacists, currently working in PCTs, have taken on the role of Controlled Drug Accountable Officer (CD AO) for their organisation. This role ensures the safe management of controlled drugs and ensures patient safety where these particular medicines are concerned. This must continue in the new structures.

Many pharmacies also provide invaluable services to discrete communities such as prison services, care homes, children's services and forensic units.

2. What are the best opportunities to develop and enhance the availability, accessibility and utility of public health information and intelligence?

We believe that community pharmacies are an ideal place for the sharing of public health information and for helping develop and maintain a thriving sustainable community. They also provide an opportunity to gather data that is not obtainable through other routes, such as information on what medicines patients are buying, information of the levels of methadone supervised doses and total methadone use, the amount of medicines returned unused etc.

An estimated 1.6 million people visit a community pharmacy each day, of which 1.2 million do so for health reasons.¹⁸

At any one time a local pharmacist is likely to be looking after and providing the medicines for:

- 50 people with diabetes
- 150 people with asthma
- 50 people recently discharged from hospital
- 8 people with a colostomy
- 750 pensioners
- 20 people suffering with cancer, of whom 4 are likely to be terminally ill
- 500 people with raised blood pressure
- 600 carers¹⁹

Community pharmacists currently provide a number of services which produce information that is captured in systems that are separate to other parts of the NHS. For example, a number of community pharmacies are commissioned to provide flu immunisation services to members of the public and patients who are in the 'at risk' groups. Data shows that they are capturing a number of people who would not normally receive the vaccination as they do not access their GP regularly. However, this information is not currently recorded on the patient's health record and the GP would not necessarily be aware that they had been immunised. For population health and herd immunity, this information also needs to be passed onto national public health data capture service (see example 4)

¹⁸ Improving Quality in Primary care, Department of Health 2009

¹⁹ Understanding and Making the Best Use of Community Pharmacy

Pharmacists are also providing private services, such as blood pressure monitoring, weight management and chlamydia screening²⁰ as well as services related to self-care such as general health advice and provision of over the counter medicines. It would be beneficial, both for patients and professionals, for this information to be captured and shared in an interoperable, integrated patient healthcare record. This will also enable all professionals to contribute to the knowledge around public health and patient behaviour at a national level.

Pharmacists who are suitably trained and competent could also run medicine education clinics around long term use of medicines such as antipsychotics, lithium, antidepressants (more than 50% of patients stop their antidepressant in the first 2 weeks meaning it remains untreated and associated poor function and morbidity increases). These could also be linked to physical health clinics including vascular checks.

Example 4: NHS Isle of Wight commissioned a community pharmacy-led vaccination service 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.

3. How can Public Health England address current gaps such as using the insights of behavioural science, tackling wider determinants, achieving cost effectiveness, and tackling inequalities?

The role of PHE is not clear to us. We believe that community pharmacies are the window into the NHS on every high street and should be promoted as the first port of call for health promotion and prevention of ill health, and that this role should be recognised and endorsed by PHE. We would encourage the appointment of a pharmacy advisor role within PHE.

We would encourage government to consider moving the enhanced public health pharmacy services into a national contract for pharmacy. Whilst pharmacies would only be commissioned to provide such a public health service in relation to the needs

²⁰ Anderson C Thornley T [A\(2011\) pharmacy-based private Chlamydia screening programme: results from the first 2 years of screening and treatment](#) International Journal of Clinical Pharmacy: Volume 33, Issue 1 88.

of the population they serve, if a suite of such services was nationally defined this would enable standardised quality and equity of service provision for patients, which must be desirable for government and the public as well as the pharmacy profession.

PHE should obtain sufficient input from behavioural sciences to help understand why people, patients and professional behave in the way they do and use this information to expedite change.

The Middlefield project in Aberdeen is a good example of an innovative approach to taking pharmacy services to deprived areas²¹.

The National Audit Office found that people in the poorest communities are less likely to attend GP practices and that those areas still tend to be under-served with doctors. The Public Accounts Committee has recommended that “the Department of Health has failed to adequately address GP shortages in areas of highest need” and recommends that the Department should implement an action plan to deliver this objective. We recommend that this action plan includes proposals for the targeted expansion of pharmacy services to deliver public health objectives. Commissioners must consider mixed care pathways whereby multiple professions provide integrated, cost effective care.

4. What can wider partners nationally and locally contribute to improving the use of evidence in public health?

The RPS would like to offer assistance in this area. As mentioned previously, community pharmacies have access to information that is not obtainable elsewhere. We would like to work with PHE to ensure such data is captured and shared nationally to help build the evidence in public health and improve the quality of healthcare and outcomes for patients, appropriately underpinned with audit, evaluation and research.

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. Early evaluation results include a 140% increase in smoking quits from pharmacies compared with the previous year; and 75% of the 200 smokers with asthma or chronic obstructive pulmonary disease who had a medicines use review accepted help to stop smoking. 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 everything.

The accessibility of community pharmacy is particularly important for the delivery of services such as needle exchange and emergency oral contraception.

²¹ King, M., McFarlane, K., Juroszek, L. & Bond, C. (2005). 'The Middlefield project: Novel provision of pharmacy services to a deprived area.' *Pharmaceutical Journal*, 275, pp. 164-166 and Porteous, T. & Bond, C. (2003). 'Novel provision of pharmacy services to a deprived area: a pharmaceutical needs assessment'. *International Journal of Pharmacy Practice*, 11, pp. 47-54

The RPS believes that patients and the public receive safe, high quality treatments and interventions when these are based on robust evidence such as NICE or SIGN guidance. However, given that “best evidence” may not always be available, the RPS would expect a measure of lateral thinking to be applied when making changes to healthcare; generalising findings from one context to another, e.g. from one disease state to another, to support rapid mobilisation of knowledge for the benefit of patients. The RPS is supporting this agenda through the development of a ‘Map of Evidence’ for pharmacy to improve performance through the sharing and showcasing of good pharmacy practice and innovation.²²

Continued and varied opportunities for healthcare professionals to partner with patients and academics to analyse, evaluate and research existing and new treatments and interventions is a primary concern for the RPS. We are encouraged by the Government’s commitment to the promotion of existing National Institute for Health Research (NIHR) infrastructure to support the conduct and translation of research into practice. However, the RPS believes that existing and clinical funding available to individual healthcare professions requires review, as pharmacy professionals currently have fewer opportunities within the NIHR funding streams than their colleagues in medicine, dentistry, nursing, midwifery and allied health.

More useful public health information could be obtained from community pharmacy. Pharmacies could capture useful data that no other healthcare professional can such as levels of supervised methadone or OTC sales of head lice preparations.

5. We would welcome views on Dr Gabriel Scally’s report. If we were to pursue a voluntary registration, which organisation would be best suited to provide a system of voluntary regulation for public health specialists?

At present, the Faculty of Public Health keeps a voluntary register of those working as specialists in public health and this register can be analysed by profession, therefore we would not recommend duplication of this facility. This register can be found at UK Voluntary Register for Public Health Specialist, Chadwick Court, 15 Hatfields, London, SE1 8DJ or at register@cieh.org. Registration is by interview and the presentation of work evidencing stated competencies. We recommend that the register be developed for pharmacists who satisfy specified competencies in relation to their specialist public health role.

We believe that all health and social care professionals should be public health practitioners as part of their everyday service provision and should not be required to undergo additional regulation to deliver these services. However, for those professionals who wish to become public health specialists we could move towards a process of recognition whereby an individual can build their knowledge, skills, competency and capability to the agreed standard, with the support of the RPS.

Solutions for Public Health recently held a meeting to look at the role of GP consortia and public health in improving health and wellbeing and delivering effective health care.²³ The final report recommends that the front line delivery system for public health includes staff within local government, the voluntary sector, the wider community health family (GPs, pharmacists, dentists, health visitors and other allied health professionals) and ‘any willing provider’ – there is an urgent need to improve public health understanding and skills across this workforce. We believe that all healthcare professionals have a role in the delivery of public health promotion and

²² www.rpharms.com/evidence

²³ www.sph.nhs.uk/colloquiumreport

prevention but that pharmacies offer the best potential for efficient economic actions in health improvement, health promotion and some aspects of health protection.

The RPS are undertaking work to develop professional standards and supporting guidance for pharmacists delivering public health services. These are due to be published later this year. We would welcome the opportunity for discussions with government, the emerging PHE and the FPH to discuss how pharmacy can best help government achieve its objectives.

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.