

Tackling health inequalities: Delivering accessible pharmaceutical care for everyone

Pharmacy teams in all settings play crucial roles in supporting people to get the most from their medicines and keep well. By providing accessible health care, pharmacy teams help tackle health inequalities. This position paper focuses on how pharmacy can go even further to reach currently underserved populations and deliver accessible pharmaceutical care for everyone.



Introduction

The stark reality of health inequalities in Britain today were laid out by Professor Sir Michael Marmot, Director of the Institute for Health Equity, at the RPS annual conference in November 2022. Palpable shock waves rippled through the room as he shared chart after chart demonstrating the worsening picture of health inequalities since 2010 (see figures 1-4).

Pharmacy teams across all settings – community, hospital, primary care and specialist settings – already provide many services that can help reduce health inequalities. These services support people to get the best from their medicines, to improve their health and to live well. They cover a wide range of health improvements including in long-term conditions, substance misuse, sexual health and infections.

Community pharmacies provide accessible health services, including being located in areas of higher deprivation, which can put them at the front line of improving inequalities. This makes community pharmacies one of the few health services that has the potential to buck the inverse care law (which states that people who need health care the most are the least likely to receive it).

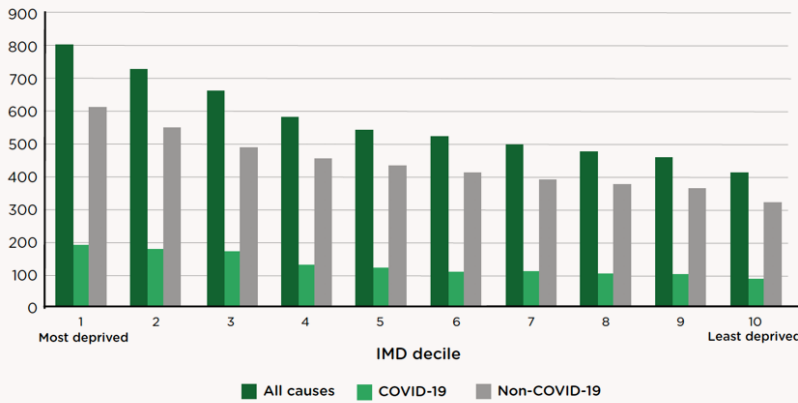
However, the bottom line is that pharmacy services, whether in primary care, community, hospital or specialist settings, do not reach everyone. Sadly, it is often the people suffering the greatest inequalities who do not access the full range of services that are available. This not only fails to address health inequalities, but worse, it can exacerbate them.

Jenny, a patient in Glasgow, told RPS of the barriers she had experienced: “The pharmacist saw me as nothing more than my script,” she said. Making assumptions about people drives them away, she explained. It is highly unlikely that this was the intention of the pharmacist, but what Jenny felt should make us all stop and think.

This position paper is born from conversations like this. We consulted with pharmacists, public health specialists, patients, other professions and pharmacy organisations. We scoped opinions through focus groups and surveys, and we attended meetings with experts in the field.

We recommend that to enhance our role in tackling health inequalities, pharmacy needs to think not just about what services it provides but also about how it provides them. This paper focuses on exactly that: how pharmacy can provide services in ways that reach currently underserved populations and deliver accessibility for everyone.

Male age-standardised mortality rates from all causes, COVID-19 and other causes (per 100,000) by deprivation deciles in England 2020

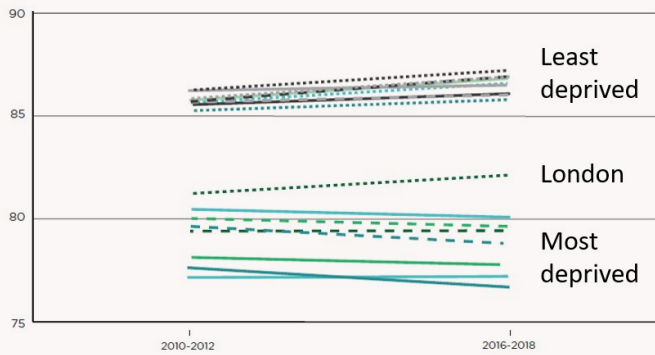


Source: RPS Conference presentation, 2022. From ONS data, 2020
Reproduced with permission from the Institute of Health Equity



Figure 1. Impact of deprivation on mortality (from RPS conference)

Differences in life expectancy for women widen by deprivation in England's regions



Source: RPS Conference presentation, 2022
Reproduced with permission from the Institute of Health Equity



Figure 2. Impact of deprivation on life expectancy (from RPS conference)

Defining health inequalities

Health inequalities are defined as avoidable and unjust differences in health and wellbeing between different groups of people. Health inequalities are determined by circumstances beyond an individual's control which result in differences in:

- Health status
- Life expectancy
- Access to care (availability, opening hours, transport, information, language, experience, misinformation, fear)
- Quality of care

Factors that can lead to people suffering from health inequalities include:

- Socio-economic (deprivation, power, education, language, employment)
- Geography (region, urban/rural, neighbourhood)
- Protected characteristics (ethnicity, sex, age, disability, sexual orientation, gender reassignment, religion, pregnancy, being married or in a civil partnership)
- Determinants of health (poverty, housing, education, community)
- Groups vulnerable to being excluded (homeless, traveller communities, sex workers, drug dependence, modern slavery)
- Lack of diverse representation and cultural awareness in decision making and policy setting

Active avoidance of engaging with health services (low self-worth, tolerating health conditions)

Many people facing health inequalities may experience more than one of these factors which can make them even more vulnerable to their effect.

Data indicate that health inequalities were reducing prior to 2010 but that this pattern has been reversed. The gaps are particularly striking in relation to deprivation and poverty. This was the finding of two key reports:

“Since 2010 life expectancy in England has stalled: this has not happened since at least 1900... The health of the population is not just a matter of how well the health service is funded and functions, important as that is. Health is closely linked to the conditions in which

people are born, grow, live, work and age, and inequities in power, money and resources – the social determinants of health.”

– Health Equity in England: The Marmot Review 10 years on (February 2020)
www.health.org.uk/publications/reports/the-marmot-review-10-years-on

“Between 2000 and 2012 [in Scotland], life expectancy was increasing, and avoidable mortality was decreasing. Progress was being made in deaths from cancer and cardiovascular disease, alcohol deaths and suicides. In line with these improvements, absolute inequalities in mortality outcomes were generally reducing. However, in the decade since we have seen a stagnation in these previous improvements and in some cases a worsening of outcomes and inequalities.”

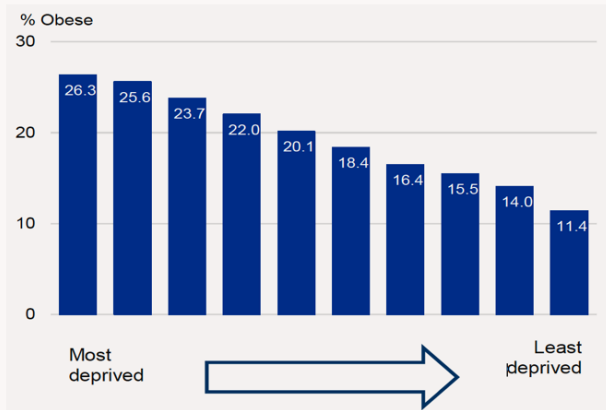
– Health Inequalities in Scotland (University of Glasgow and the Health Foundation, October 2022) www.health.org.uk/sites/default/files/2022-11/health-inequalities-scotland-reportandappendices.pdf

Some key themes that have been proposed to help tackle health inequalities, which come both from our scoping work for this paper and from published resources, include:

- Create healthy communities
- Focus on prevention of ill health and improving good health
- Tackle discrimination
- Understand the huge impact of socio-economic deprivation
- Take a human rights approach*
- Ensure services are person-centred
- Be culturally aware in the provision of health services
- Pursue environmental sustainability alongside health equity [this is being covered separately in RPS sustainability policies]
- Improve communication between services so that people do not receive disjointed care or fall through service gaps

*A human-rights approach means being person-centred, treating people as individuals with respect and dignity, ending discrimination, empowering people, enabling shared decision making, and respecting and protecting human rights.

Obesity prevalence in School year 6 by deprivation in England

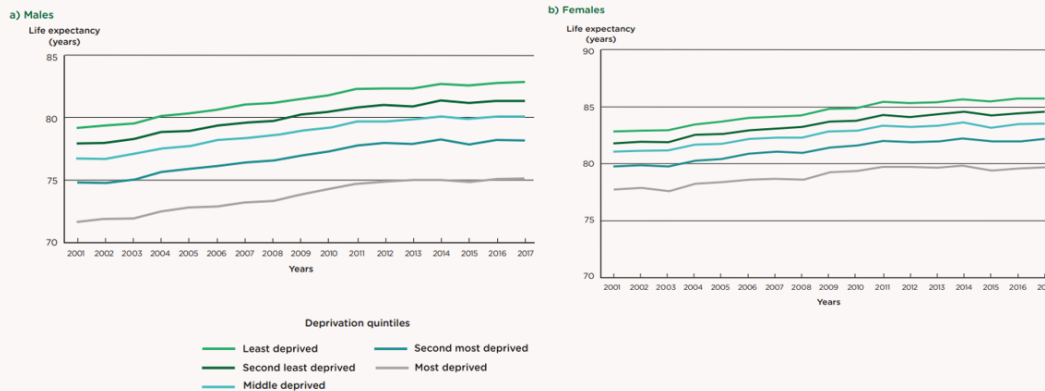


Source: RPS Conference presentation, 2022. From National Child Measurement Programme 2016/17. Obesity: 95th centile of Body Mass Index
Reproduced with permission from the Institute of Health Equity



Fig 3: Impact of deprivation on obesity in children (from RPS conference)

Life expectancy at birth by area deprivation quintiles in England



Source: Health Equity in England: The Marmot Review 10 years on, 2020. Using ONS data
Reproduced with permission from the Institute of Health Equity



Fig 4: Impact of deprivation on life expectancy (from Marmot Review)

Actions for pharmacy

Every pharmacy team in every sector of pharmacy already supports people to live healthy lives and to get the best from their medicines. The actions set out in the sections below can be taken by all pharmacy teams in all settings to enable pharmacy services to reach more people, particularly underserved populations who are at most risk of health inequalities.

1. Deepen our understanding

The first step for pharmacy teams is to understand the health inequalities that people using the pharmacy service may face (whether that's a community, hospital, primary care or specialist service). These fall into two categories: external factors relating to individuals' life circumstances and internal factors relating to the pharmacy service itself.

1A: UNDERSTAND OUR POPULATION

Demographic data for the population a pharmacy service serves can provide vital insights into meeting the population's needs. Population health profiles could include age, life expectancy, socio-economic deprivation, employment, ethnicity, disability, avoidable mortality, disease prevalence for leading causes and faith. Public health teams in NHS organisations may have useful reports available or be able to advise on where to access local information. It may also be possible to access data via freedom of information requests to public bodies.

However, statistics only tell part of the story. Understanding your population also involves engaging with people directly. This might be through approaching local community or faith groups, seeking views from patients or gaining insight from pharmacy staff members. The richness of understanding you gain from hearing from someone living in poverty every day is significantly greater than reading about socio-economic data; similarly, speaking with someone of a different faith can transform your understanding of cultural differences.

Once you have gathered the information, consider who uses your pharmacy service:

- Does it replicate the population profile of your locality or are there groups missing?
- Are your services reaching the whole of your local population?
- What services are available in your locality?
- How can you reach people who are not currently accessing health services, for example those from excluded and underserved communities such as the homeless population, travelling communities or refugees?

These questions may need to be answered across a number of pharmacy teams in community, hospital, primary care and specialist services, with some teams providing services for specific populations. However, this only works if there are effective referral mechanisms in place and services are still accessible for patients. Pharmacy teams should also consider working with others, such as community and third sector organisations, to identify the underserved and “missing” populations and then work to close these gaps.

INFORMATION RESOURCES: WHERE CAN I FIND POPULATION DATA?

England:

Office for Health Improvement and Disparities
<https://www.localhealth.org.uk/>

English indices of deprivation
<https://www.gov.uk/government/collections/english-indices-of-deprivation>

Scotland:

Scottish Public Health Observatory
<https://www.scotpho.org.uk/comparative-health/profiles/online-profiles-tool>

National Records of Scotland
<https://www.nrscotland.gov.uk/>

Scottish Index of Multiple Deprivation
https://www.gov.scot/collections/scottish-index-of-multiple-deprivation-2020/?utm_source=redirect&utm_medium=shorturl&utm_campaign=simd

Wales:

Populations - Health in Wales
<https://www.wales.nhs.uk/healthtopics/populations>

Freedom of information requests:
<https://www.gov.uk/make-a-freedom-of-information-request>

1B: UNDERSTAND OUR BIAS

Remember Jenny, our patient in Glasgow mentioned above? She told us she was more than her script, yet that’s not how the pharmacist made her feel. The vast majority of health professionals start each day wanting to help patients, aiming to do their best for

everyone, perhaps even believing that they achieve it, so it’s very unlikely Jenny’s pharmacist intended to make her feel unwelcome.

The reality is that every one of us has some degree of unconscious bias. Without knowing it, our bias may be expressed in the services we provide, potentially making patients hesitant to use services or even driving them away. Part of every pharmacist’s and every pharmacy team’s development should be to better understand their biases, and then act to challenge them.

Linked with this is stigmatisation of some groups of vulnerable individuals using pharmacy services, for example, people who use drugs or who are homeless. Understanding our own bias is an important step to addressing stigmatisation and it also needs to be addressed within the culture of the whole pharmacy team (see section 2b).

LEARNING RESOURCES: HOW CAN I UNDERSTAND MY BIAS?

Unconscious bias: how to address and acknowledge it (e-Learning resource, 15 minutes, NHS Education for Scotland) <https://learn.nes.nhs.scot/58715>

Understanding beliefs and bias in decision-making (journal article, NHS Education for Scotland) <https://learn.nes.nhs.scot/6336>

Avoiding unconscious bias at work (article, 11 minutes, Mind Tools) <https://www.mindtools.com/a09zkd6/avoiding-unconscious-bias-at-work>

Seek lived experience: invite local organisations (such as third sector organisations, charities or groups) to speak with the pharmacy team about the barriers they face when accessing services

1C: IDENTIFY PHARMACY-RELATED BARRIERS

The way in which pharmacy services are provided can sometimes make them harder or less comfortable for some people to access. However, these barriers may not be universally the same and therefore a greater sensitivity and awareness of the needs of individual groups is essential. This can be explained with the following two examples:

- Consultation rooms: for some people, privacy is paramount, they would consider a consultation in a public area of a community pharmacy embarrassing so consultation rooms are essential. But an individual's personal values, beliefs, and dignity should also be considered and respected, for example, entering a private consultation room with a pharmacist of the opposite sex is not appropriate or in line with some individuals' beliefs.
- Remote consultations: some people consider in-person consultations at their general practice

or hospital outpatient clinic to be the preferred, gold standard of care. However, for others, remote consultations may be preferable due to factors like finding it difficult to get away from home due to caring responsibilities, not having enough money for the bus fare, or the effect of an over-stimulating health care environment on some people with autism.

These examples demonstrate how pharmacy teams should be more aware of the potential barriers that users of their services may experience, and that the solution must be to provide person-centred choice.

ACTION RESOURCE: HOW CAN I IDENTIFY BARRIERS?

Walk into the entrance to your pharmacy or location where you provide pharmacy services (eg, GP practice, hospital). Put yourself in a patient's shoes and consider the following:

ACCESSIBILITY

1. Is the pharmacy service easy to find? Is it clear from outside what services are offered?
2. Can you access the services?
 - Is the physical building accessible for someone using a walking aid or wheelchair, has limited mobility or has impaired vision? This includes getting into the building, moving around it and using the services
 - Is there a hearing loop for hearing impairment?
 - Is there a choice in how to access services, such as in-person and remotely?
3. Inside, is it clear what services are offered? Are there signs helping you find the service you need?
4. Does the pharmacy team provide outreach services in the local community?

CULTURE AND COMMUNICATION

5. Do you feel welcomed? Are the pharmacy team friendly and inclusive to everyone?
6. Do staff communicate well? Do they actively listen to you? Are they easy to understand? Are they culturally aware in their communication?
7. Is your privacy respected?
8. Are decisions made with you (shared decision making)?

9. Is "what matters to you" considered? Such as your preferences and lifestyle choices?

RESOURCES

10. Are there resources and tools available to help you manage your health?
11. Is information provided in different languages and formats, and is it accessible to those with poor health literacy?
12. Are you signposted to other services?
13. Are chaperones available for private consultations if needed?

EQUALITY IMPACT ASSESSMENT

14. Is the pharmacy service accessible to people with any of the protected characteristics listed in the Equality Act 2010 and, if not, what arrangements are in place to ensure the service is accessible? Do all staff know about the Equality Act and what it means in practice? Protected characteristics:
 - Age
 - Disability
 - Gender reassignment
 - Marriage and civil partnership
 - Pregnancy and maternity
 - Race
 - Religion or belief
 - Sex
 - Sexual Orientation

CASE STUDY: TARGETED ACTION THROUGH CORE20PLUS5

Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level.

The approach defines a target population of the most deprived 20% of the national population – the ‘Core20PLUS’ – and identifies ‘5’ focus clinical areas requiring accelerated improvement. It can be applied to adults and children and includes a focus on mental illness, early cancer detection and hypertension. Pharmacy teams make significant contributions to these areas through national campaigns focusing on smoking cessation, cancer awareness and prevention and management of cardiovascular disease.

2. Understand and improve our pharmacy culture

There’s a well-worn phrase that “culture eats strategy for breakfast” which basically means that the culture within an organisation will overpower even the best strategic plan. When it comes to creating inclusive, open, welcoming pharmacy services, there can be no doubt that this is true. The way a pharmacy team behaves – the normal everyday traits and behaviours of all team members – are what makes the pharmacy culture.

2A: UNDERSTAND OUR CULTURE

The first step to ensuring a positive pharmacy culture is to assess its current state. Every pharmacy team, no matter the sector or location, should consider how their culture makes patients feel when they use their services:

- Are people welcomed?
- Are they shamed?
- Are people comfortable to ask for help?
- Are staff attitudes patronising and oppressive?
- Is the pharmacy team actively reaching out to different parts of the local population?

Assessing the pharmacy team’s culture could involve an open team discussion, seeking patient feedback (eg, asking questions, providing anonymous response forms or electronic tools), and pharmacy team members observing each other’s interactions with patients. Pharmacy teams might also want to consider how the culture within their team impacts on the culture that patients see.

Discussing negative findings of culture assessments can be challenging, so pharmacy teams may find facilitated support useful to discuss how to address challenges.

2B: IMPROVE OUR CULTURE

Culture takes time to improve so it is essential to break change down into manageable steps and set realistic goals. Effective leadership, particularly setting a clear vision and demonstrating positive



behaviours, is important but culture change is about more than managers: it's about the involvement of every team member. That means culture change can be more difficult to achieve for pharmacy teams with continually changing members: continuity and a shared purpose supports change.

A good starting point for pharmacy teams intent on improving their culture is to improve communication skills. All members of the team should demonstrate actively listening to patients, using clear language pitched at an appropriate level for individuals' understanding. They should see the patient beyond their words, accent or history; consider the person's facial expression and body language; engage patients in decisions about their care; and avoid confrontations. Also essential for pharmacy team members is to consider their own communication: what does our facial expression and body language communicate to a patient? A lack of empathy can be damaging. Patients who do not feel listened to can feel frustrated: acknowledging this and more actively listening can improve engagement and accessibility for patients, and reduce potential escalation to aggressive situations.

Addressing stigma is another vital element of improving culture. Certain groups of people and those with specific health conditions, such as people who are homeless or from traveller communities, and people who use drugs, are sometimes made to feel stigmatised when trying to access health services. The result of this is that they do not access services

at all which can result in poor health outcomes.

There are many training resources available which help develop people's skills to be able to interact with and support patients in a more culturally competent way. A good place to start is to undertake training in trauma-informed care. Trauma-informed care means recognising the impact that trauma has on an individual and adapting the provision of care to enable trust, reduce barriers and minimise distress. Trauma means an event or series of events that is physically or emotionally harmful; examples include adverse childhood experiences, abuse, chronic life-threatening illness and road traffic accidents. Many people are affected by trauma at some point in their lives and this can impact how they engage with health services. Therefore, adopting a trauma-informed approach is recommended widely across the multi-disciplinary team and would be useful for all pharmacy teams in community, hospital and primary care.

LEARNING RESOURCES: HOW CAN I IMPROVE OUR CULTURE?

Inclusion and diversity resources including an inclusive culture pledge (RPS):

<https://www.rpharms.com/recognition/inclusion-diversity>

Microaggressions: what they are and how to challenge them (variety of resources, RPS)

<https://www.rpharms.com/recognition/inclusion-diversity/microaggressions>

Introduction to trauma informed practice to support people with problematic substance use (webinar recording, RPS) <https://www.rpharms.com/resources/webinars/an-introduction-to-trauma-informed-practice-to-support-people-with-problematic-substance-use>

Motivational interviewing – introduction and foundations of person-centred counselling

(NHS Education for Scotland, 2 hours): <https://learn.nes.nhs.scot/15236>

Communication and active listening (Guidance document, NHS Education for Scotland):

<https://learn.nes.nhs.scot/32613>

Active listening (Mind Tools, web article)

<https://www.mindtools.com/az4wxv7/active-listening>)

Trauma-informed care, with the aim of creating: “A trauma informed and responsive nation and workforce, that is capable of recognising where people are affected by trauma and adversity, that is able to respond in ways that prevent further harm and support recovery, and can address inequalities and improve life chances.” (variety of resources available from NHS Scotland’s National Trauma Training Programme) <https://learn.nes.nhs.scot/37896>

Civility and respect in NHS systems (variety of resources produced by NHS England)

<https://www.england.nhs.uk/supporting-our-nhs-people/health-and-wellbeing-programmes/civility-and-respect/>

Introduction to diversity, inclusion and multiculturalism (e-learning module, NHS Education for Scotland) <https://learn.nes.nhs.scot/47217>

Inclusive pharmacy practice in England (variety of resources, NHS England, RPS and APTUK) <https://www.england.nhs.uk/primary-care/pharmacy/inclusive-pharmacy-practice/>

HEIW Pharmacy Cultural Awareness Campaign <https://heiw.nhs.wales/education-and-training/pharmacy/heiw-pharmacy-cultural-awareness-campaign/>

Welsh Government Future Generations Act – An act in that helps us all work together to improve our environment, our economy, our society and our culture <https://www.gov.wales/well-being-of-future-generations-wales>

The Welsh NHS confederation Making the difference: Tackling health inequalities in Wales <https://www.nhsconfed.org/system/files/2021-05/Making%20the%20difference%20-%20April%202021.pdf>

Study being undertaken with non-Welsh speaking pharmacy healthcare professionals to equip them with key phrases and words to help people with Welsh as a first language access services:

<https://www.gov.wales/sites/default/files/publications/2022-07/more-than-just-words-action-plan-2022-2027.pdf>

CASE STUDY: PROMOTING AN INCLUSIVE CULTURE

Pulse Pharmacy in Kirkintilloch promotes a truly inclusive culture within the community pharmacy.

The pharmacy staff get to know patients by name, greet them when they come in and ensure anyone who accesses the pharmacy’s services is treated in the same way. The Covid-19 pandemic has enabled them to meet patients within the community they would not normally have met due to many more people working from home. The pharmacy team are all aware of the mental health struggles of the local population and make a point of taking an interest in their patients to get a better insight into their lives. They also make a point of speaking to patients they know to be vulnerable, being conscious they may be the only people they interact with that day.

HEARING LIVED EXPERIENCE: CHANCE 2 CHANGE

Chance 2 Change is a community peer support group in Glasgow which provided an Expert Reference Group on lived experience to the Scottish Government's short life working group on primary care health inequalities. Chance 2 Change recommended the following ideas for change in terms of health professional communication:

- See me – I am a person with feelings
- Listen – my opinion matters
- Be honest – even if you don't know, because I would appreciate that
- Help me understand – please don't tell me what to do, offer me advice and where appropriate alternative solutions
- Remember I am an expert in your professional hands – a 50:50 partnership, each valuing the other's experience

Reference: <https://www.gov.scot/publications/chance-change-scotland-report-chance-2-change-expert-reference-group-lived-experience-primary-care-health-inequalities-short-life-working-group/>

2C: EMPOWERING PATIENTS AND PEOPLE

Tackling health inequalities includes empowering people to take control of their health, not the paternalistic approach of "doing to" patients. Instead, it is about providing the support and tools that people need to make their own decisions and to "own" the changes to their health.

For example, few people give up smoking simply because they have been told to. Instead, they need to make their own decision that quitting is the right thing to do because they understand the health benefits and have the support in place to help their quit attempt.

Empowering people to take an active role in their care is based on person-centred care and shared decision making, which means ensuring people have sufficient information in an understandable form to enable them to take part in decisions. It also means supporting them to self-manage their health – this means the information and the skills, as well as

tools. For example, good self-management is about teaching someone to measure their asthma control, provide a peak flow monitor, and understand what is normal and what should trigger a healthcare appointment.

Some of this support to empower people can be provided within community pharmacy and by hospital or general practice pharmacy teams. Whether that's verbal advice, providing written information or QR codes for resources, lifestyle calculators, devices to support self-monitoring or health check terminals; all can be provided, and better still is providing choice to enable people to access information in a way that works for them. Community pharmacy teams also have specific opportunities for regular brief interventions and conversations with people when they collect medicines.

Pharmacy as a whole offers fantastic services but "offering" services alone is not enough: pharmacy teams should consider how they can reach the people who don't currently use their services. This could mean going to community centres, libraries, faith groups, charities and social care to provide information and tools about pharmacy services, medicines and health. Making people aware of the pharmacy services available to them, showing them that they would be welcomed, is a first step to reaching these missing populations.

Importantly, it does not just need to be the pharmacist who makes these outreach visits, which is particularly important for community pharmacists who need to remain in the pharmacy premises. Instead, they could be provided by another member of the pharmacy team. These staff providing outreach could become health inequality champions, focused on understanding and meeting their local population's needs.

Breaking down barriers to using pharmacy services can sometimes be easier if people are able to engage with a pharmacy staff member who lives in or comes from their community: they may be seen as more relatable. Building relationships with local communities in this way supports the recognition of diversity in the pharmacy workforce and may encourage people to feel enabled to join the pharmacy workforce.

Finally, pharmacy teams should consider if the services they offer are obvious to patients. For people who are unfamiliar with health services, it is unlikely they will know what services can be accessed where: this further widens inequalities. Providing information about the services your pharmacy team offers is essential – right down to core functions like supplying medicines, providing advice on common clinical conditions, what a medication review involves and how pharmacists may prescribe medicines.

LEARNING RESOURCES: HOW DO I EMPOWER PEOPLE

Delivering person-centred care in pharmacy (webinar recording, RPS) <https://www.rpharms.com/resources/webinars/achieving-pharmacy-2030-delivering-person-centred-care>

Realistic Medicine – empowering people to discuss their treatment and make a shared decision (NHS Scotland, various resources including introductory video): <https://www.realisticmedicine.scot/>

Personalised Care Institute – a range of resources for health and care professionals <https://www.personalisedcareinstitute.org.uk/>

CASE STUDY: OUTREACH WORK

Pharmacist Hala Abusin provides education and engagement to minority groups by asking to attend spaces where they are: "I contacted community groups and charities to offer educational webinars tackling vaccine hesitancy and navigating the NHS in England. I have delivered webinars for Imperial College, Hammersmith & Fulham Council and WLW (a charity welcoming refugees to the UK).

"I work closely with the Sudanese Senior Citizens group by attending regular meetings on Friday evenings. The group consists of a tightly-knit community that supports its members with a number of concerns and challenges. By going to where the group meets, I was able to advise and support on how to get the most out of their GP appointments and highlight the important role of community pharmacy."

3. Improve structural barriers

This document started by saying pharmacy needs to think not just about what services it provides but also how it provides them. The final aspect of “how” services are provided is to consider the wider structural barriers and enablers, and then to work out how these can be improved to ensure services are provided in ways that improve accessibility. Structural barriers include things like the service specifications, pathways that underpin services, and the tools used within services. Therefore this section is aimed more at pharmacy service managers, commissioners and policy makers than individual pharmacy team members.

3A: EDUCATION

A basic structural barrier that exists to how services are provided is the education of the pharmacy workforce. Education about health inequalities should be included at both undergraduate and

postgraduate stages, with opportunities to develop understanding throughout a professional’s career, and should be made available to the whole pharmacy team. Making protected learning time available to all pharmacists in all sectors would help achieve this.

Education should include causes of inequalities, how inequalities can be tackled, unconscious bias, trauma-informed practice, inclusive practice, communication skills, kindness and empathy training, shared decision making and health literacy.

3B: LANGUAGE AND LITERACY

Many well-intentioned patient information resources are handed out every day, yet some are so inaccessible that they are not even opened. Good information, whether it is written or verbal, should be tailored to take account of factors like a person’s comprehension level, reading age and disabilities (such as visual impairment and learning difficulties). In pharmacy, this should be considered for the accessibility of patient information leaflets, medicine labels and health resources.

The average adult reading age in the UK is 9 years old, with around 16% of the adult population in England defined as having very poor literacy skills



only able to understand short texts on familiar topics (with similar statistics in the other nations). Health information resources can frequently be too complex, with 43% of adults not able to understand written health information. Therefore, a greater understanding of health literacy is vital for pharmacy teams.

Other barriers to good written information include the size of text, the colour of text and paper, how “busy” the layout is, and the images used. A clean, simple approach, with large black text on a white background is the most accessible. A choice of formats should also be offered, such as spoken word resources, Braille, picture-based infographics and online patient information.

The language used in written and verbal information may also be a barrier where resources are provided in English. Providing a choice of languages and enabling access to interpreters is essential, with digital tools offering fast access to translation when no interpreter is available. Language can also have less well-known barriers, such as neurodiverse populations finding metaphors hard to interpret.

Finally, as we move into an increasingly digital age, pharmacy services must guard against digital exclusion by ensuring that everything provided digitally – from Apps and QR codes for information to prescription ordering systems and remote consulting – also has a non-digital option for the people who cannot access digital tools.

LEARNING RESOURCES: UNDERSTANDING HEALTH LITERACY

Health literacy e-learning resource (Health Education England and NHS Scotland) <https://www.hee.nhs.uk/our-work/knowledge-library-services/improving-health-literacy>

NHS advice on translation is available at: <https://www.nhs.uk/about-us/health-information-in-other-languages/>

NHS organisations can provide information about the translation services they use, for example Language Line <https://www.language-line.com/uk/industries/medical-translation/> is used by 111/NHS24 <https://www.nhs24.scot/get-in-touch/language-line/>

CASE STUDY: WRITTEN INFORMATION

NHS Greater Glasgow and Clyde and the Scottish Specialist Pharmacists in Substance Misuse (SSPISM’s) group worked together to create accessible leaflets for patients explaining how to dispose of used injecting equipment safely. They used graphics instead of text to illustrate the steps to take and included an easily recognisable red cross or a green tick to highlight the do’s and don’ts.

The SSPISM’s group also worked on the accessibility of treatment information by adapting for use in Scotland a leaflet created by patients with lived experience in conjunction with the European Network of People who Use Drugs (EURONPUD). The leaflet was created using language the patient group wanted to use. Both of these examples show how consideration was given to both literacy and language and the importance of these in making resources accessible to patients.

3C: SERVICE SPECIFICATIONS

The way in which services are specified and funded can impact their accessibility.

When a service is first established, whether that is commissioned by the NHS or set up independently by a pharmacy team, undertaking an Equality Impact Assessment (EQIA) will help understanding of whether the service offers accessibility to all and enables adjustments to be made from the beginning to address any inequalities. Templates exist to support the completion of EQIAs and many organisations have expertise who can provide support.

When considering health inequalities, it is worth broadening the core protected characteristics of an EQIA to include socioeconomic status and other factors identified through a greater understanding of the local population. For example, this may include rurality and transport links, or focusing on specific needs such as refugees or people who use drugs. Another underserved group to consider is the homeless population who face barriers such as an expectation to provide a postcode which can be overcome by using the pharmacy team’s location postcode.

Ensuring the patient's voice is heard within the service design stage is vital to developing inclusive and accessible services. Services should be co-designed with patients and the public, including actively seeking involvement from underserved communities. For engagement to be successful, service providers must act on what they hear from patients and the public, and design services to deliver patients' needs.

Sometimes it may be necessary to tailor services to the needs of a specific population but in doing so it is important to recognise that this approach may miss people with the same needs who live in a different location where that need is far less prevalent. Furthermore, by targeting services at particular groups, eg, those in the lowest socio-economic group, then people who are just outside the specification may suffer particularly badly. Being aware of these challenges and mitigating for them is key in the service design stage.

A final important part of service specification is ensuring the service can complete a patient journey, through appropriate referral pathways which enable a pharmacist or member of the pharmacy team to refer the patient to another service in health, social care or the third sector. Social prescribing is becoming an increasingly important part of health care and underpins people's ability to be empowered to take control of their health. There may also be opportunities to refer people to other support services, such as those who can provide advice on financial support and benefits (for example link workers in GP practices).

TOOL: COMPLETING EQUALITY IMPACT ASSESSMENTS

RPS has produced guidance on the process for completing an Equality Impact Assessment and a reporting template to use. It can be downloaded at: <https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Health%20Inequalities/RPS%20Equality%20Impact%20Assessment%20Process%20and%20Template%20Health%20Inequalities.docx>

Guidance on protected characteristics
(Equality and Human Rights Commission)
<https://www.equalityhumanrights.com/en/equality-act/protected-characteristics>

Conclusions

The aims of this position statement are to open pharmacy teams' approaches to improving health inequalities and to support their understanding of how they could deliver services differently to improve care.

Pharmacy teams in every sector of pharmacy provide excellent care, and very many patients find pharmacy services accessible. But until this is a universal experience, and no-one feels excluded or unable to access care, we must remember the words of our patient, Jenny, who says: "You don't know someone's pain and suffering, why they are where they are. Stop judging, stop making assumptions and start treating every person with respect. That's what will help people to feel able to use pharmacy services."

Pharmacy must think differently, proactively seek out people who are less engaged, make pharmacy services are welcoming to all, and ultimately ensure the whole population can benefit from accessible pharmaceutical care.



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