

Health and Social Care Committee
HSC(4)-09-11 paper 12
Inquiry into the contribution of community pharmacy to health services in Wales – Additional information from the Royal Pharmaceutical Society

Mark Drakeford AM
Chair, Health and Social Care Committee

17 October 2011

Dear Mr Drakeford,

Thank you for the opportunity of presenting information to the Health and Social Care Committee inquiry into community pharmacy on 28th September. I am pleased to provide below further information as discussed and requested during the session.

1. The pharmacy contract in Scotland

We were asked a number of times about the community pharmacy contract in Scotland and asked for further information. The following information is taken from the NHS Scotland Community Pharmacy website (<http://www.communitypharmacy.scot.nhs.uk/index.html>) where much more detailed information can be found if required.

i) Minor Ailments Service

The Minor Ailment Service (MAS) allows eligible individuals to register with and use a community pharmacy as the first port of call for the treatment of common illnesses on the NHS. A patient registers with the community pharmacy of their choice in order to use MAS. Once registered they can present at any point with symptoms and the pharmacist, having ascertained whether the patient is still eligible to use the service, will treat, advise or refer them to another health care practitioner where appropriate.

ii) Acute Medication Service

The Acute Medication Service (AMS) introduces the Electronic Transfer of Prescriptions (ETP) and supports the provision of pharmaceutical care services for acute episodes of care and any associated counselling and advice.

iii) Chronic Medication Service

The Chronic Medication Service (CMS) allows patients with long-term conditions to register with a community pharmacy of their choice for the

provision of pharmaceutical care as part of a shared agreement between the patient, community pharmacist and General Practitioner (GP). It introduces a more systematic way of working and formalises the role of community pharmacists in the management of individual patients with long term conditions in order to assist in improving the patient's understanding of their medicines and optimising the clinical benefits from their therapy.

iv) Public Health Service

The Public Health Service (PHS) element of the contract aims to encourage the pro-active involvement of community pharmacists and their staff in supporting self care, offering suitable interventions to promote healthy lifestyles and establishing a health promoting environment across the network of community pharmacies by participating in national and local campaigns. It comprises the following services:

- the provision of advice to both patients and members of the public on healthy living options and promotion of self care;
- the provision of NHS or NHS approved health promotion campaign materials, other health education information and additional support materials to patients and members of the public;
- the participation in national health promotion campaigns which are on display and visible in the pharmacy for agreed periods of time, including the display of materials in a window of the pharmacy, or in the absence of a suitable window space, another space in the pharmacy;
- the participation in local health promotion campaigns where agreed between the local NHS Board and community pharmacist;
- the provision of a smoking cessation service, comprising of advice and supply of nicotine replacement therapy (NRT) and other smoking cessation products over a period of up to 12 weeks, in order to help people give up smoking; and
- the provision of a sexual health service comprising of the supply of emergency hormonal contraception (EHC), a Chlamydia testing service and a Chlamydia treatment service.

2. The Joint Statement by the Royal Pharmaceutical Society and the Royal College of General Practitioners

I am pleased to attach the joint statement between RPS and the RCGP. This can also be accessed electronically at <http://www.rpharms.com/public-affairs-pdfs/RPSRCGPjointstatement.pdf>. This document was prepared by the RPS and the RCGP in England, and in Wales we are currently working with RCGP Cymru on the priority areas we want to take forward.

3. Men's Health

The attached document (Commissioning a Health and Wellbeing Service from Community Pharmacy) is a document prepared in England by a number of pharmacy bodies to highlight the benefits of such a service from community pharmacy. It contains the following case study;

“Knowsley PCT targeted men aged 50-65 with their free health checks in 10 pharmacies across the region. After conducting the check, Knowsley PCT surveyed participants to evaluate the service. The study found that 96 per cent of men said they have made at least one lifestyle change as a result of the check-up, while almost 100 per cent said they were either very or quite likely to attend a follow-up health check and would recommend the checks to other men”.

Source: NHS Improvement Programme, 2009

4. The number of pharmacies with a consultation area

We have been informed by the Pharmacy and Prescribing Branch of the Welsh Government that the number of community pharmacies accredited to provide Medicines Use Reviews in 2010 was 613, or 87% of all premises. A consultation area is one of the requirements of accreditation.

I trust this information is helpful. If you need any additional information or would like to discuss any issues in further details, please do not hesitate to get in touch. We look forward to the results of the inquiry with interest.

Yours sincerely,



Mair Davies
Chair, Welsh Pharmacy Board
Royal Pharmaceutical Society

(Enc.)



JOINT STATEMENT

Breaking down the barriers – how community pharmacists and GPs can work together to improve patient care

Introduction

This joint statement sets out the background, summarises the evidence and makes recommendations for the benefits to patients of improved liaison between community pharmacists and general practitioners.

1. Over the last 20 years successive policy changes have moved the pharmacist's role from primarily one of dispenser towards a generic health care provider advising patients on their use of prescribed medicines, self care and lifestyle as well as delivering other innovative services. However, these changes often seem to have been introduced in isolation from other primary care services, especially general practice, thereby reducing opportunities for enhanced patient benefit.
2. General practitioners are similarly taking on a broader role, particularly in England, involving commissioning services as part of the Coalition Government's NHS reforms. GPs are also working with a range of primary care practitioners to deliver services to their local communities and recognising the skills and experience of the full range of healthcare professionals is key to the thinking in this statement.¹
3. Patients may be surprised when they discover that their community pharmacist² and their GP do not share the same clinical record and that the local community pharmacist is not always an integral part of the primary care team (while recognising that patients have free choice of pharmacy and may use many pharmacies whilst being registered with a single practice). Pharmacists play a key role in the long-term management of patients with chronic disease and can see the patient as often as a member of the general practice team. Many members of the public and patients see the pharmacist as a first port of call for advice, not just on their medicines but also on their underlying health problems. This is particularly true for men seeking advice on health issues.
4. Whilst many GPs do work closely with their local pharmacist, a culture change is recommended between GPs, pharmacists and the public to allow the collaborative partnership between general practice and community pharmacy to deliver its potential.

5. Both bodies recognise and are committed to how GPs and pharmacists can learn with and from each other starting at undergraduate level and continuing throughout their professional careers. Both bodies will work together to explore continued opportunities for joint learning.
6. Both bodies welcome the joint work being undertaken to roll out the RCGP's Research Ready model to pharmacists.³

Building Blocks for Change

7. Some key building blocks need to be agreed to underpin new working relationships. This should be with the aim of offering patients a high quality, safer, more consistent and cost effective service These should include:
 - Better transfer and sharing of patient information facilitated by improved inter professional IT links and clear safeguards for consent and confidentiality
 - Shared standards and ways of working to ensure consistency of services and information to the public (for example in areas such as screening and diagnosis and pharmacy-led treatments and advice)
 - Joint education and training at undergraduate and postgraduate level, which could facilitate greater trust and understanding of the professions' respective and complementary roles, skills and expertise
 - Standard setting and clinical guidance on the provision of over-the-counter medicines where these medicines have doubtful value
 - Acknowledging the opportunity for joint working to improve medicines utilisation, cost-effectiveness and minimise waste.

Working together can improve patient care and safety

8. The benefits to patients of joint working between general practices and pharmacists are not in doubt This statement draws on a separate paper drafted by the Royal Pharmaceutical Society with input from the RCGP
9. Better use of Medicines Use Reviews (MURs)⁴ by pharmacists and the practice team can reduce duplication of effort by the primary care team as well as improve patient care through reducing errors and improving adherence to treatment⁵.
10. Pharmacist prescribers, working closely with GPs and practice nurses, can similarly contribute to better patient management and can also help improve the quality and outcome of patient management in a range of long-term conditions.⁶
11. By working together more closely, general practices and pharmacists will be able to deliver better healthcare to vulnerable groups such as those in care homes or elderly patients who are taking a large range of medicines, including anti-psychotic medicine.
12. Community pharmacists working with general practices and specialist palliative care teams can ensure reliable and prompt medicine supply, and supportive

advice (especially about analgesia) for patients, lay carers and other members of the health care team.

13. Pharmacists with the appropriate expertise, working with drug misusers, can increase retention within treatment programmes by a structured supportive approach, and those with prescribing and drug misuse qualifications can contribute to community detoxification by adjusting doses.
14. GPs and their practice teams, together with pharmacists can support lifestyle change and encourage self care.
15. GPs and pharmacists should be aware of the evidence base and efficacy of the products they promote and supply and be aware of the tension between clinically evidenced supplies and non-evidence-based products.

Managing long-term conditions

16. Patients can already benefit from being able to receive timely and accessible help from pharmacies in understanding and using medicines. Access to this should be promoted and resources should be more effectively targeted to patient need. An example of how this can work is the New Medicine Service⁷ being introduced in England.
17. Improvements should be made to improve the sharing of information between the pharmacist and general practice. This will be achieved through improved IT links and through ensuring appropriate arrangements for protecting patient confidentiality and obtaining patients' consent to information-sharing.
18. Patients should have a choice of where medicine reviews⁸ take place, with consultation between the professions and communications systems in place to support this process.
19. Locally agreed protocols relating to medicine reviews should reflect agreed standards. From the patient perspective, care should be delivered to the same standard by whomever is undertaking the task.
20. The same quality standards should be used for GPs and pharmacists when undertaking medicine reviews. These quality standards do not yet exist and the RPS and RCGP will work together to develop and agree them.
21. There should be better use of 'repeat dispensing'⁹ to increase efficiency, reduce practice workload and increase patient convenience as well as value for money.
22. GPs and carers should consider benefiting patients with long-term conditions and complex medication regimes by utilising the pharmacist independent prescriber¹⁰ jointly working with the GP and patient working in collaboration.
23. In England, in conjunction with the patient's GP, pharmacists should be able to refer to services commissioned by clinical commissioning groups within agreed care pathways.
24. Pharmacists should be able to refer patients to local GPs and pharmacists with special interest services. Pharmacists referring across to the patient's GP should do so in accordance with agreed local care pathways/protocols.
25. There should be national arrangements for patients and carers to be able to access a supply of their regular medicine(s) in an emergency.¹¹

26. Building on the guidance for general practice¹² community pharmacists and staff should recognise the front-line role they have in identifying carers and ensuring that carers are signposted to appropriate support and that GP surgeries are apprised so they may involve carers in patient care and provide ongoing support.¹³

Care home residents and the house-bound

27. There should be improved joint working between GPs and pharmacists for patients who reside in care homes; for example, pharmacists could attend care homes alongside GPs to undertake joint medicine reviews, and review medicines being prescribed to patients who reside in care homes.
28. Pharmacists should participate in medicine reviews for housebound patients.

End-of-life care

29. Patients and their carers should have better access to medicines required for palliative care. This includes working with out-of-hours providers to ensure access throughout the whole 24 hours.
30. Pharmacists should form part of the out-of-hours team for palliative care, though inclusion in a pharmacy on-call rota.
31. The sharing of information between GP, palliative care service and community pharmacist throughout end-of-life care should be improved.

Care for drug misusers

32. Drug misusers should continue to have convenient access to supervised administration of substitution treatments and be encouraged to make greater use of these interactions for other health interventions.
33. Pharmacists with the appropriate expertise should have opportunities to contribute more to care planning and review of treatment objectives, building on the knowledge of the drug misuser acquired through daily contact.
34. Consideration should be given to using pharmacist prescribers' working within a locally agreed shared care protocol to titrate doses, including during dose induction and detoxification.
35. Pharmacists should use the opportunities afforded by supervised administration to promote other health interventions, including blood-borne virus testing and immunisation,¹⁴ influenza immunisation and appropriate counselling.

Preventing ill health

36. GPs and pharmacists should collaborate in providing cardiovascular risk assessment, including, when not duplicating what has already been done, on-site cholesterol monitoring.
37. Pharmacists should ensure convenient public access to evidence-based preventive interventions including, for example, 'Stop Smoking' services, emergency hormonal contraception, chlamydia testing and treatment¹⁵ and

vaccinations. All such interventions should be delivered to the same quality standards wherever they are provided.

38. Pharmacists with appropriate expertise could become providers of travel immunisations and malaria prevention treatments and make recommendations as to what travel immunisations are required / recommended. Furthermore, pharmacists could provide advice on ailments contracted abroad, including traveller diarrhoea and sexually transmitted disease. This service must be supported by suitable communications between pharmacists and GPs to ensure that patient records are updated accordingly.
39. Better publicity for the public on how to access services (e.g. emergency hormonal contraception) should be provided.

Supporting self care

40. Patients should be able to access advice and or treatment for common minor illnesses conveniently, including outside the opening times of their general practices or community pharmacist.
41. Where possible GPs, nurses, practice staff and pharmacists and their teams should work together as part of a coordinated team across practices.
42. Provided funding can be identified a pharmacy NHS Minor Ailments Service¹⁶ should be available to support GPs in urgent care and out-of-hours provision.
43. More effective promotion to the public and others should be implemented, to encourage use of pharmacies for minor ailments and advice on self care.

Levers and incentives

44. Further work needs to be carried out to establish what levers and incentives may be appropriate in order to expedite the changes described above. These should be applicable at various levels as appropriate, including individual pharmacy and practice level, local professional group level, and national level

National level

45. It is essential for patient safety that relevant patient information should flow both ways between general practices and pharmacies and IT systems in England and Wales should enable this while ensuring clear safeguards for consent and confidentiality and that patient information is not available to counter staff without appropriate training.¹⁷
46. Ethical issues in sharing patient information should be identified and resolved with input from patients and service users. A joint code of ethics addressing issues such as consent and confidentiality must be agreed by both professional bodies to facilitate this.
47. Joint national guidance should be produced with input from patients and the public on evidence-based recommendations for non-prescription (OTC) medicines by all health professionals.
48. Outcomes and methods of measurement should be identified for assessing the pharmacy contribution to patient care.

49. New models of commissioning pharmacy input which requires joint working with general practice (e.g. the Chronic Medication Service in Scotland) should be explored.
50. Stakeholders should be consulted on how best to achieve continuity of pharmacy care, including the concepts of patient registration at pharmacies and shared records.

Local level

51. Examples and models of shared practice should be shared and disseminated.

Communication at local and national levels

52. Better ways of communicating between GPs and pharmacists should be explored. For example, the following may be considered:
 - Meetings between Local Pharmaceutical Committee (LPC) and Local Medical Committee (LMC)
 - RCGP Faculties and RPS local practice fora discussion of health needs and how joint working can improve the provision of healthcare and encourage better self care
 - Shared learning events for the primary health care team, including pharmacists
 - Shared critical event analysis
 - Periodic joint practice level meetings where this is feasible.
53. Professional bodies for general practice and pharmacy should meet regularly and provide leadership on joint working for members.

Sharing information

54. There should be a consultation process on the following areas:
 - a) The extent to which pharmacists or qualified and appropriately trained staff involved in the provision of care to the patient should have access, with consent, to the patient's medical record
 - b) pharmacist access to the Summary Care Record.¹⁸
55. A mechanism should be identified for the pharmacist to be able to record, and with the patient's consent share with the patient's practice, clinically significant over-the-counter sales, NHS Minor Ailment scheme consultations and public health interventions such as immunisation.

Shared standards and ways of working

56. Pharmacies and GP practices should work to common quality standards for screening and diagnostic testing.
57. Shared formularies for prescribing and supply for common conditions should be jointly developed.

58. Patient feedback should be used systematically to assure the adequacy of privacy and facilities in pharmacy consultation areas.¹⁹ Pharmacists need to ensure they can provide confidential places to consult.
59. It should be recognised that continuity of care is particularly important when locums are involved.

Education and training

60. Ongoing CPD/ training using joint e-learning modules, case reviews and significant event meetings should be encouraged.
61. Through education and training ensure that a basic level of life support training is available in general practice and community pharmacy settings so that vulnerable patients with long term conditions are protected.

Moving forward

62. Action is now needed from individual clinicians, local professional groups, NHS organisations, national bodies and patients to shape how local care develops. The Royal College of General Practitioners and the Royal Pharmaceutical Society will start this process by:
 - a) bringing together an invited multi-stakeholder group to explore the recommendations in this paper and identify the actions that are needed
 - b) setting up a joint working group including patients and service users to take an agreed work programme forward.
 - c) The initial scope of the working group will focus on the development of quality standards for medicine reviews

Notes

¹ This Statement applies to Great Britain only.

² Community pharmacists are responsible for controlling, dispensing and distributing medicine. They work to legal and ethical guidelines to ensure the correct and safe supply of medical products to the general public. They are involved in maintaining and improving people's health by providing advice and information as well as supplying prescription medicines.

Community pharmacists also sell over-the-counter medical products and instruct patients on the use of medicines and medical appliances. Some pharmacists will also offer specialist health checks, such as blood pressure monitoring and diabetes screening, run smoking cessation clinics and weight reduction programmes and are able to prescribe as well as dispense medicines.

Community pharmacists work in high street pharmacies, supermarkets, local healthcare centres and GP surgeries. http://www.prospects.ac.uk/community_pharmacist_job_description.htm

³ Research Ready is an online self-accreditation tool covering the basic requirements for undertaking primary care research in the UK. Developed in conjunction with the NIHR Clinical Research Network and the Primary Care Research Networks, it is aligned with the latest Research Governance Frameworks. (For more information, see http://www.rcgp.org.uk/clinical_and_research/circ/research_knowledge_transfer/research_ready.aspx)

⁴ A Medicines Use Review involves a review of a patient's medicines, including items that are regularly prescribed, used only when necessary and those obtained for the purpose of self care. Its aim is to improve understanding of how, why and when medicines should be taken.

⁵ MURs are only available in England and Wales through the community pharmacy contractual framework

⁶ Evaluation of supplementary prescribing in nursing and pharmacy. Bissell et al 2008; Evaluation of nurse and pharmacist independent prescribing. Latter et al 2011

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http://www.psn.org.uk/data/files/PharmacyContract/Contract_changes_2011/summary_of_cpcf_changes_may_2011.pdf

⁸ Medicine reviews are: 'a structured critical examination of a patient's medicines with the objective of reaching an agreement with the patient about treatment, optimising the impact of medicines, minimising the number of medication-related problems.' Room for Review. A guide to medication review; the agenda for patients, practitioners and managers, published by Medicines Partnership ISBN 09544028 0 4.

⁹ Part of the Community Pharmacy Contractual Framework in England and Wales, and of the Chronic Medication Service in Scotland

¹⁰ Pharmacists who have completed the appropriate training and can prescribe any licensed medicine for any medical condition within their competence.

¹¹ Scotland already has a national scheme for patients to obtain an emergency supply of NHS medicines.

¹² Supporting Carers in General Practice

http://www.rcgp.org.uk/professional_development/continuing_professional_dev/carers.aspx

¹³ For more information see the RCGP Supporting Carers in General Practice e-learning programme

http://www.rcgp.org.uk/professional_development/continuing_professional_devt/carers.aspx

¹⁴ Immunisations are already provided by pharmacies in some areas (eg Isle of Wight 'Pharmacy Fix' service) with underpinning training and arrangements for dealing with anaphylaxis.

¹⁵ Supply of emergency hormonal contraception and provision of Chlamydia testing are part of the Public Health component of the pharmacy contract in Scotland and provided by all pharmacies in Scotland.

¹⁶ A national Minor Ailments Service has been in place in Scotland since 2006. Currently 60% of PCTs in England commission such a service.

¹⁷ The Chronic Medication Service in Scotland includes electronic communication between the patient's nominated pharmacy and his or her GP practice.

¹⁸ Emergency Care Summary in Scotland

¹⁹ The Pharmacy Regulator the General Pharmaceutical Council is currently updating guidance on confidentiality.

HIGH IMPACT CHANGES AND PUBLIC HEALTH:

COMMISSIONING A HEALTH AND WELLBEING SERVICE FROM COMMUNITY PHARMACY



KEY MESSAGES:

- Community pharmacy is a valuable and under-utilised resource that should be part of the solution to reduce health inequalities and improve the wellbeing of our communities.
- Community pharmacy provides a range of health and wellbeing services that improve public health. These include NHS Health Checks, stop smoking, weight management and alcohol interventions.
- Community pharmacy's health and wellbeing services are well established and are an efficient mechanism to effectively roll out new public health initiatives.
- Community pharmacists and their teams see many people who are not registered with GPs; they can provide accessible and personalised services that can reach the individuals that GPs are missing.
- This is more than a policy briefing; it is a call to action for you to:
 - **Engage with your Local Pharmaceutical Committee** to discuss how community pharmacy can help improve public health services in your area; and
 - **Maintain and develop your relationships** with community pharmacy to ensure a smooth transition of health and wellbeing services into the new public health landscape.

HIGH IMPACT CHANGES:

The Department of Health has previously identified a number of High Impact Changes that highlight practical measures that can be implemented at local level. These have been extensively used across the NHS and local government and include:

- Working in partnership;
- Influencing change through advocacy;
- Appointing a champion;
- Developing integrated activities to reduce variation and align priorities;
- Personalising services by providing more help to encourage people to improve their lifestyle;
- Improving the effectiveness and capacity of services; and
- Amplifying national social marketing priorities.

HIGH IMPACT CHANGES THAT COMMUNITY PHARMACY CAN DELIVER:

Community pharmacy is ideally placed to implement these High Impact Changes and help drive the Government's new public health agenda. We can do this by providing:

- Greater patient choice;
- Personalised services and enhancing patient involvement and understanding of their care: 'no decision about me, without me';
- Accessible care closer to home, in pharmacies at the heart of local communities;
- Early intervention and effective outcomes; and
- A positive patient experience in an open and friendly environment.

THE COMMUNITY PHARMACY HEALTH AND WELLBEING SERVICE

There are over 10,500 community pharmacies across England, including in areas of significant social deprivation, under-doctored areas and in rural communities. Department of Health data shows that 99 per cent of the population, even those living in the most deprived areas, can get to a pharmacy within 20 minutes by car. An estimated 1.6 million people visit a pharmacy each day, of which 1.2 million do so for health related reasons (Department of Health, 2009).

The convenient locations of community pharmacies, where people live, work and shop, and their extended opening hours make them the most accessible point of contact for health services. Accordingly, community pharmacy is better able to reach all members of the community and, in particular, make it easier for certain groups to choose to access services locally.

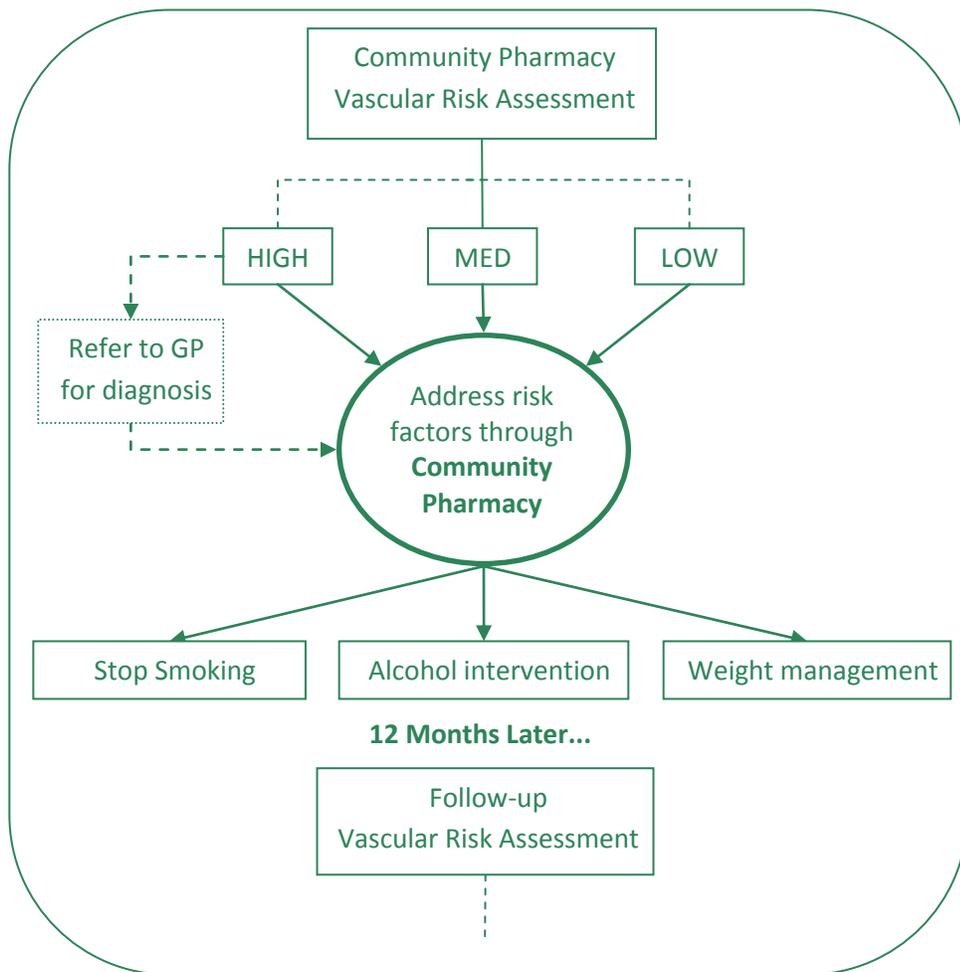
Community pharmacies are ready, willing and able to deliver a package of health and wellbeing health services for commissioners; Healthy Living Pharmacies are one vehicle for this that is currently working particularly effectively.

HIGH IMPACT CHANGE:

Develop integrated activities to reduce variation and align priorities.

The Health and Wellbeing service pathway is illustrated in Figure One. We highlight each of the potential elements of such a package in the rest of this briefing.

FIGURE ONE: HEALTH AND WELLBEING SERVICE PATHWAY



CASE STUDY:

Healthy Living Pharmacies (HLPs) are making a real difference to the health of people in Portsmouth, with 10 pharmacies awarded HLP status by NHS Portsmouth. HLPs have to demonstrate consistent, high-quality delivery of a range of services such as stopping smoking, weight management, emergency hormonal contraception, chlamydia screening, advice on alcohol and reviews of the use of their medicines.

They proactively promote a healthy living ethos and work closely with local GPs and other health and social care professionals. Early indications show that HLPs have greater productivity and offer higher-quality services. 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.

Source: NHS Portsmouth, 2010.

NHS HEALTH CHECK PROGRAMME

The NHS Health Check Programme is a national initiative which aims to identify and reduce cardiovascular risk in people aged 40-74 (NHS Improvement Programme, 2008).

The burden of vascular disease falls disproportionately on people living in deprived circumstances and on particular ethnic groups and it accounts for the largest part of the health inequalities in our society (NHS Improvement Programme, 2008).

Vital Signs national outturn results for 2009/10 show that around 1 million people were offered an NHS Health Check, and almost 800,000 NHS Health Checks were delivered (Boyle, 2010). GPs have been responsible for conducting the vast majority of checks to date; however, a study of 338 patients by Pfizer revealed that two-thirds of those at risk said they would not access screening at their GP (Hunt, 2010). In the Pfizer community pharmacy-based pilot, 26 per cent of people accessing the service had not visited their GP in more than a year, and 66 per cent said they were unlikely to have a similar screening appointment at their GP practice (PrimaryCareToday, 2010).

Results from a GP-led pilot study suggest that GPs are missing a large number of at-risk individuals (Polak, 2010). Consultations were undertaken at a major supermarket in south east London, screening over 1,000 people. On average, each consultation was only four minutes 23 seconds. The study revealed that 425 participants needed a follow-up, 261 were previously undiagnosed, while 106 had abnormal results in a previously undiagnosed condition.

The lead GP in the study said, '...my practice worked really well and our QOF

targets were great...so where are these people?' This indicates that if people are unwilling or unable to present to the practice during normal working hours then healthcare providers must go out and find them opportunistically.

Community pharmacy can provide these quality services, reaching people who would otherwise not access GP services. Community pharmacy, as an additional provider of NHS Health Checks, can identify individuals who are at risk of developing vascular disease and can support them to reduce their risk through lifestyle modifications. Community pharmacy provides an opportunity for greater patient choice and access to one-to-one professional assessment, advice and support.

CASE STUDY:

Birmingham South PCT commissioned a 'Heart MOT' pilot, a cardiovascular risk-based assessment, in 30 community pharmacies in Birmingham. The results of the pilot show that males who would not normally see a GP can be targeted; and in addition that individuals from deprived areas and with a minority ethnic background can be targeted.

Of those assessed, 60 per cent were male, 65 per cent were from the average, less deprived, and most deprived quintiles, and 7.4 per cent and 24.8 per cent were from Black and Asian communities respectively. Importantly, it highlights that a significant number of individuals can be identified for whom intervention for vascular disease risk or other risk factors is required; around 70 per cent of those assessed were referred to their GP.

Source: NHS Improvement Programme, 2009

Individuals are allowed to take ownership of their treatment and condition and this enhances the likelihood of improved health outcomes. Community pharmacy is able to maintain ongoing relationships with these individuals through an effective personalised service which encourages adherence with lifestyle modification programmes.

HIGH IMPACT CHANGE:

Personalise services by providing more help to encourage people to improve their lifestyle.

CASE STUDY:

Knowsley PCT targeted men aged 50-65 with their free health checks in 10 pharmacies across the region. After conducting the check, Knowsley PCT surveyed participants to evaluate the service. The study found that 96 per cent of men said they have made at least one lifestyle change as a result of the check-up, while almost 100 per cent said they were either very or quite likely to attend a follow-up health check and would recommend the checks to other men.

Source: NHS Improvement Programme, 2009

ALCOHOL INTERVENTIONS

The Alcohol Learning Centre (2010a) describes Identification and Brief Advice (IBA) as opportunistic case finding followed by the delivery of simple alcohol advice (in the research literature, this is referred to as 'Alcohol Screening and Brief Interventions').

These are effective interventions directed at people consuming alcohol at increasing or higher-risk levels who are

CASE STUDY:

In the North West of England pharmacy is playing a key role in the provision of alcohol intervention and brief advice (IBA). Around 125 pharmacies across Wirral, Blackpool, Knowsley, Oldham, Liverpool and Warrington are involved in service provision. The service can be targeted to those who may be at high risk such as those who present for treatment of hangovers, gastric problems and falls. Pharmacy sees a different demographic of people from those who may visit a GP practice, especially in areas of health inequality.

The initial reports for NHS Blackpool showed that of the 138 interventions made, 39 per cent of people screened were found to be drinking either at increasing or high risk. Based on these results the potential cost savings could be significantly greater than those estimated by the Department of Health, which makes an assumption that only one in four people would be identified at increasing or high risk.

Source: Stafford, 2010.

not typically complaining about or seeking help for an alcohol problem.

A Cochrane Collaboration review (Kaner et al., 2007) provides substantial evidence for the effectiveness of IBA. There is a large body of evidence supporting IBA in primary care, including at least 56 controlled trials (Moyer et al., 2002). Indeed, these authors suggest that for every eight people who receive simple alcohol advice, one will reduce their drinking to within lower-risk levels.

This compares favourably with smoking where only one in twenty will act on the advice given, increasing to one in ten with nicotine replacement therapy (Silagy & Stead, 2003). People who received IBA in A&E made 0.5 fewer visits to the A&E during the following 12 months (Crawford et al., 2004), leading to significant cost savings.

In this regard, NHS East of England (2009) reflected that IBA services delivered through the Direct Enhanced Services to 50 per cent of new GP practice registrants by 2011/12 would cost £873,000, but would deliver benefits of £3 million through reducing A&E

attendances by 8,500 and hospital admissions by 3,300 annually.

Using a model adapted from the Alcohol Learning Centre's 'Ready-Reckoner' tool (2010b), and based on pharmacy identifying one in four people at high risk (as assumed by the Department), the net cost saving to the NHS works out as follows:

- 100 pharmacies – net cost saving to NHS: £215,107 per annum
- 400 pharmacies: £860,427
- 800 pharmacies: £1,720,853
- 1,000 pharmacies: £2,151,067

Community pharmacy has a significant opportunity to be better utilised to deliver alcohol awareness programmes, give brief advice, and provide intervention services relating to safe alcohol consumption.

HIGH IMPACT CHANGE:

Improve the effectiveness and capacity of services.

CASE STUDY:

Hampshire and Isle of Wight LPC ran a community pharmacy IBA service in 2009. A total of 794 opportunistic and proactive interactions and 801 interventions were made. Of these, 47 per cent reported low risk, 26 per cent increasing risk, 13 per cent higher risk and 3 per cent possible dependence. Information was offered to 58 per cent of participants, 37 per cent were given brief advice and 5 per cent were referred for further support.

Source: HubCAPP, 2009.

STOP SMOKING SERVICES

Community pharmacy is now an established and trusted provider of stop smoking services and these are widely commissioned by PCTs.

CASE STUDY:

The Isle of Wight has recognised that stop smoking services play an integral part of cardiovascular disease prevention programmes. Their programme engaged 11 community pharmacies within the target area to provide up to three hours a week of one-to-one stop smoking support. At the time of evaluation, of the 53 smokers that engaged with the pharmacy-led smoking cessation service at least 18 had not been smoking for over a month.

Source: NHS Improvement Programme, 2009

The healthcare benefits achieved by stopping smoking are irrefutable, as are

the benefits of offering stop smoking services in community pharmacy. In 2009/10 757,537 people set a quit date through NHS Stop Smoking Services in England. At the four week follow-up 373,954 people had successfully quit - 49 per cent of those who set a quit date. Stop Smoking services within a community pharmacy setting helped 140,000 set a quit date in 2009/10, and at week four 62,000 people had successfully quit compared to 55,000 in 2008/09; an increase of 15 per cent (NHS Information Centre, 2010).

WEIGHT MANAGEMENT

It has been estimated that those who are overweight or obese cost the economy £7 billion in treatment, benefits, loss of earnings and reduced productivity. If no action is taken, the total costs to society are expected to rise to £50 billion by 2050 (Foresight, 2007). Pharmacies can provide additional services to help tackle obesity in the community through innovative weight management programmes.

SAVINGS BY MOVING PATIENTS FROM THE GP SURGERY TO COMMUNITY PHARMACY

Not only will community pharmacy Health and Wellbeing Services help to provide greater access and capacity, it will also be of greater added value to commission these services from community pharmacy than from GPs. An average GP surgery consultation last 11.7 minutes and costs £32, while the same 11.7 minute consultation in community pharmacy would cost £17.75 (PSSRU, 2008).

The initial VRA in community pharmacy ought to take between 20 and 30 minutes meaning the disparity and hence

CASE STUDY:

The weight management service in Central Lancashire is a structured behavioural change programme over 12 months based on setting achievable interim goals, supported by holistic lifestyle advice including diet and exercise.

An evaluation by the University of Central Lancashire revealed that after 12 months, the average reduction in BMI was 2.4. The service was also found to be more cost effective than prescribing Orlistat over 12 months, at £160 per patient compared to £419.51 per patient. There was also found to be an average reduction in blood pressure of 9/6 mmHg.

The evaluation found significant support from the service users who appreciated the informal pharmacy environment and the flexibility for drop-in appointments.

Source: Vohra, 2010.

savings would be even greater, and GP capacity could be freed-up to deal with more complex cases.

SUMMARY

- All of the elements that make up health and wellbeing services are already commissioned as individual services by community pharmacies.
- Combining these elements into a health and wellbeing package would be more effective than commissioning and pricing individual services.
- Community pharmacy staff already have the competencies to deliver all

elements of the service efficiently and effectively with minimal additional training.

- The existing infrastructure and staff capabilities will enable quick roll-out of services and delivery of the programme within short timescales.
- Pharmacy is ready and willing to provide a package of health and wellbeing services.

Notwithstanding the above, the purpose of this paper is not just to highlight the benefits of commissioning a health and wellbeing package of services from community pharmacy. It is a call to action to ensure pharmacy is at the forefront of commissioners' thinking as the new public health landscape develops.

CALLS TO ACTION

Primary Care Trusts	<ol style="list-style-type: none"> 1. Ensure the communication lines are open: as commissioning processes change it will be crucial that commissioners are fully aware of the impact being made by community pharmacy on the ground. Regular engagement with LPCs will facilitate this understanding, so we ask that full and frequent communications with your LPC are maintained. 2. Publish the list of people involved in forming shadow boards who will have interim responsibility for commissioning in the same way as SHAs have published the bridging arrangements. 3. Publish contact details for the Directors of Public Health and key members of their team.
Local Authorities	<ol style="list-style-type: none"> 1. Identify and establish communications with the responsible persons in PCTs and shadow GP consortia for commissioning public health services. 2. Identify the process and responsibility for ensuring the public health requirements within Joint Strategic Needs Assessment and Pharmaceutical Needs Assessments are integrated and updated. 3. Publish contact details for the Joint Directors of Public Health and key members of their team. 4. Engage community pharmacy and other primary care professional bodies in the process of identifying effective representation in the formation of Health and Wellbeing Boards.
Local Pharmaceutical Committees	<ol style="list-style-type: none"> 1. Invite Directors of Public Health to meet and discuss how local community pharmacies can make a significant contribution to reducing health inequalities by providing health and wellbeing services. 2. Contact Local Authorities: commissioning of most public health services will be the responsibility of the Health and Wellbeing Board. Contact the individuals within local authorities to ensure pharmacy remains well and truly on the radar of these commissioners-to-be.

NOTES:

The CCA, NPA and AIMp are members of Pharmacy Voice, bringing together all pharmacy owners. For further information on Pharmacy Voice please contact the NPA press office on 01727 795901 or email communications@npa.co.uk

For a copy of this document or further information please email office@thecca.org.uk.

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