The contribution of community pharmacy to improving the public's health. Report 4 - Local examples of service provision 1998-2002

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Introduction

Rationale

This report is aimed at Directors of Public Health and Pharmaceutical Advisers in primary care organisations, and other stakeholders interested in community pharmacy's contribution to public health. It is one of a series of reports examining the evidence relating to community pharmacy's contribution to improving the public's health jointly commissioned by the charity PharmacyHealthLink (formerly the Pharmacy Healthcare Scheme)[1] and the RPSGB.[2] The first of these reports[3] reviewed

[1] PharmacyHealthLink is an independent charity that aims to promote and improve the public's health through pharmacy.

the UK and international research literature from 1990-2001, while the second[4] considered the UK non-peer reviewed literature from 1990-2002. A third report synthesises the findings from the two reports, and a subsequent update of report one makes recommendations for action.[5]

During initial discussions it was acknowledged that a review of both the published and unpublished literature could only provide a retrospective view of relevant work carried out in the field. Consequently it was decided to undertake a survey of existing health promotion[6] and public health[7] initiatives in community pharmacies concurrently with the review of the published and unpublished literature.

The objectives of the survey and subsequent report were to:

- Produce an outline of current and recent local health promotion and public health initiatives involving community pharmacies in the UK.
- Identify and describe similar initiatives in Europe, Australia and North America.
- Use in-depth 'case studies' to provide a descriptive analysis of innovative or successful projects and to investigate the perspectives of key stakeholders regarding the current and future role of community pharmacists in health improvement.

Method

A questionnaire (See Appendix 1) was used to gather data on local health improvement projects involving community pharmacists in England, Wales, Scotland and Northern Ireland that had taken place in 1998 or later. Previous surveys [8] of activity have been conducted in the UK, but there had been no such data collection since 1998.

The survey aimed to capture data on as many projects as possible and to obtain systematic details about their context, operation and evaluation. The geographical scope of the work made face-to-face interviews impossible and a telephone survey was rejected as time-consuming and impractical. Instead the survey was circulated by e-mail. The survey pro forma, as agreed with the research commissioners, asked for

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[2] The Royal Pharmaceutical Society of Great Britain is the regulatory and professional development body for pharmacy in England, Scotland and Wales. It has responsibility for the registration of pharmacists and pharmacy premises as well as for overseeing the development of pharmacy practice.

[3] Blenkinsopp, A. Anderson, C. & Armstrong, M. (2003).

[4] Anderson, C., Blenkinsopp, A. & Armstrong, M. (2003).

[5] www.pharmacyhealthlink.org.uk for PDF copies of all reports.

[6] The Ottawa Charter for Health Promotion (WHO, 1986) states that *'Health promotion is the process of enabling people to increase control over, and to improve, their health'*.

[7] Public health has been defined as *'the science and art of preventing disease, prolonging life and promoting health through organised efforts of society.'* (Acheson Inquiry into the Future Development of the Public Health Function, 1988).

[8] Anderson, C Community pharmacy Health promotion activity in England: a survey of policy and practice. *Health Education Journal* 1996; **55**: 194-202

Anderson C Guidance for the development of health promotion by community pharmacists *PharmJ* 1998; **261**: 771-775

the following information: health topic, setting, intervention, training provided, outcome measures, key findings and local partners.

Key sources of information were identified as:

- Health Promotion Units
- Health Authorities[9] and primary care organisations
- Pharmaceutical Services Negotiating Committee (PSNC) community pharmacy database (launched 14/04/02)

Key local informants were identified as:

- Heads of Health Promotion Units
- Centre for Pharmacy Postgraduate Education[10] tutors
- Local Pharmaceutical Committee Secretaries
- Pharmaceutical Advisers

As the NHS was undergoing significant infrastructure changes at the time of the survey[11] and as there was no existing sampling frame, a number of strategies were used to reach potential respondents. For Health Promotion Units the list of local units and contacts on the Health Promotion England website was used.[12] Each was contacted by phone to identify the individual who would be most appropriate for the survey. Centre for Pharmacy Postgraduate Education tutors received the survey by email through their head office. PSNC distributed the survey to Local Pharmaceutical Committee Secretaries and the PSNC community pharmacy database was accessed when it became available in April 2002. Unfortunately, it was not possible to access the database of all Pharmaceutical Advisers in England, but in Scotland, Wales and Northern Ireland, key informants were identified and invited to complete the survey. The National Pharmaceutical Association also shared information from their database of community pharmacy health promotion projects.

Survey respondents were asked whether they were undertaking, or had undertaken, any projects in the following areas: smoking cessation, sexual health, drug misuse, heart disease prevention, health screening, diabetes, obesity and accident prevention. They were also asked to provide information about any other areas in which pharmacy health improvement work had been undertaken. For each specific project, the survey requested the following information: geographical area, number of community pharmacies participating and how they were selected, activities, funding, outcome measures, any evaluation and collaborating agencies. The survey was distributed in March 2001 with a reminder sent out in June 2001.

9 In April 2002 Health Authorities in England were superseded by Primary Care Trusts and Strategic Health Authorities. The Survey was issued just before this re-organisation.

10 Centres for Pharmacy Postgraduate Education (CPPE) are the primary national providers of postgraduate pharmacy education in the UK.

11 See Department of Health (2001). *Shifting the Balance of Power: Securing Delivery.* London: Stationery Office. Available online: www.doh.gov.uk/shiftingthebalance for further details.

12 Since publication the list of contacts at HPUs has transferred to the Department of Health (England) Communications Division.

Whilst it was possible this data collection strategy may have led to some overlap or duplication, it was intended to provide as complete a picture as possible of activity across the UK. A matrix was constructed with an entry for each project reported, arranged by health topic then geographical area. Details of service design, participating pharmacies, key findings, outcome measures and any evaluation undertaken were included. In February 2002 the matrix was distributed to Pharmaceutical Advisers working in primary care to ask them to check the entries for their area and report any additional projects.

International examples were drawn from a range of sources. One of the authors (CA) had recently worked on a European project to draw together definitions, policy and practice in health promotion in primary care.[13] The report of this project was used to identify relevant examples of community pharmacy initiatives across a range of topics and selected informants in Europe, Australia and the United States were contacted to obtain more information. A narrative report illustrating examples of international innovative practice or development was produced.

Certain UK examples of innovative practice that were potentially transferable to other areas were also selected for more detailed investigation. In-depth 'case studies' were conducted for Manchester, Salford and Trafford Health Action Zone on the supply of emergency hormonal contraception and in Greater Glasgow for drug use services. An additional case study with Lloydspharmacy explored how a community pharmacy could take a holistic view of health and make provision within its premises to create a CHAT centre that would facilitate advice and support customers on the wider determinants of health.

The case studies set out to investigate the perspectives of key stakeholders with respect to the current and future involvement of community pharmacists in health improvement activities. As a result, data collection consisted principally of two strands:

- A profile of the relevant case study built through analysis of key documents and reports;
- Face-to-face (or telephone) qualitative interviews conducted with local stakeholders reflecting public health and pharmacy perspectives.

Summary of recommendations to run a 'successful' community pharmacy-based health improvement initiative

1. **Conduct a local 'health needs assessment' amongst regular users of the pharmacy and local residents.**

- Try to use existing 'templates' and 'frameworks.' To help you do this, for example, contact the main pharmacy associations to see if they have any relevant support material.

[13] See Health promotion in primary health care: general practice and community pharmacy www.univie.ac.at/phc/webindex.htm (accessed 18/08/03) for further details.

- Contact and work with local pharmacy development groups, community pharmacy facilitators and the local public health department where possible.

2. **Recognise all the key influences on health**, such as income and education, as well as lifestyle issues such as smoking and diet.
- Work in active partnership with a wide range of health improvement organisations particularly those that help reduce inequalities in health, both in the pharmacy and in other settings such as primary care premises, schools and workplaces.

3. **Initiate and design projects that reflect and utilise the pharmacy's unique position, and contribution to, the community.**
- Define the 'added value' of community pharmacy – e.g. highlight increased access to healthy people as well as ill, describe benefits of consultations being conducted in an informal environment, etc.
- Determine how community pharmacy involvement can help deliver local targets and other NHS performance measures (see below)

4. **Try to find dedicated funding that will be sustainable in the longer term.**
- Tap in to national agendas and select a topic area that is already a NHS or a local priority.
- Make clear in funding proposals how the project will contribute to local and national targets.
- Consider alternative sources of funding to 'kick-start' the project.

5. **Build a committed network of participating community pharmacies.**
- Enlist the support of local pharmacy bodies to the proposal such as Local Pharmaceutical Committees, Pharmacy Development Group Facilitators or Pharmaceutical Advisers.
- Discuss and agree terms of how the proposal might work
- Hold a local event to explain the project / proposal to interested community pharmacists and their staff
- Identify, support and promote local *'project champions'*

6. **Seek and maintain the support of other stakeholders.**
- Hold a number of separate events or meetings to discuss and consult with non-pharmacy stakeholders, such as local GPs and health service managers. Non-pharmacy professionals, especially other public health practitioners and specialists, can be strong supporters of community pharmacy-based health improvement services and can be key to their long-term survival.
- Agree the way forward for the service and terms of how it would operate.
- Identify and support 'non pharmacy' project champions.
- Discuss funding arrangements and arrange fees to reward sustainable practices, long-term commitment and high standards of service provision.

7. **Provide training for all staff – preferably in a multidisciplinary environment.**
- Ensure all staff taking part in the project has received training - ideally before the service begins or as soon as possible after it starts.

- Use nationally recognised standards and guidance where possible but adapt training to local needs.
- Establish whether local protocols, e.g. use of patient group directions, need to be followed and by which staff members. Provide specific training for this if required.
- Ensure that key messages to be communicated to service users are consistent across different health professionals and staff providing the service.
- Provide appropriate training on communication skills and use 'role play' scenarios when dealing with sensitive health issues.

8. Focus on the needs of the service user.

- Ensure all staff are knowledgeable about the service and can provide helpful advice in a professional and non-judgemental manner.
- Think about when the service might be accessed and by which target groups.
- Try to ensure the most knowledgeable or highly trained staff are available at busy times.
- Provide a private consultation area in the pharmacies where conversations cannot be overheard by others, and ensure that requirements for confidentiality and record keeping are well publicised.
- Make sure that arrangements for services 'out of hours' and information that 'signposts' users to other relevant services are easily visible.
- Provide convenient ways for users to feedback their experiences of the service and how it might be improved.

9. Carry out careful and thorough evaluation of the service.

- Build record-keeping and other ways of collecting meaningful information about the project into the original service design.
- Make outcome measures clear from the start. These should reflect government or local targets where possible.
- Allocate funds to the evaluation process (normally 15% of total project budget).
- Consider using independent evaluators. This may be done in collaboration with a local university or other research and development centre.

10. Provide feedback to stakeholders and the public on progress of the service.

- Offer to hold a local event to publicise the results of your evaluation to professional stakeholders, e.g. NHS managers, local GPs, other pharmacists.
- Consider providing information on updates and feedback on the service to users in the pharmacy.

The Survey

The email survey identified 184 projects. Returns were received from 78 primary care organisations some identifying more than one project. Of these responses, 62 came from former HA areas in England, 7 from Scotland, 4 from Northern Ireland and 5 from Wales. A further 34 projects were identified from PSNC community pharmacy database.

The survey pro forma (See Appendix 1) asked for specific details about each project. Some areas provided additional information but, in a few cases, very limited details were returned. Details of individual projects recorded include setting, numbers of pharmacies participating, outcome measures and any evaluation undertaken.[14]

The report summarises and synthesises findings by topic. Table 1 gives a breakdown by health topics of the number of UK local projects identified. By far the most commonly reported health topics were smoking cessation, drug misuse and sexual health.

Table 1: Number of UK local projects by health topic

Topic	No. of projects reported
Smoking cessation	64
Drug misuse	44
Sexual health	31
Accident prevention	7
Health Screening – general	3
Heart disease	5
Diabetes	4
Obesity/weight reduction	3
Immunisation	2
Travel health	3
Other	18
TOTAL	**184**

[14] More details on individual projects are available from the PharmacyHealthLink website: www.pharmacyhealthlink.org.uk.

Results: Projects Identified by the Email Survey

Smoking cessation – 64 projects

Smoking cessation services was the most commonly reported project. These were usually at specialist level, and included the supply of nicotine replacement therapy. Some schemes invited all pharmacies within the local area to participate. Others focused on Health Action Zones, areas poorly covered by other smoking cessation services or low-income clients. For example, in the Calderdale and Kirklees area they aimed to recruit pharmacies in areas not covered by the local stop smoking advisers.

Many schemes identified outcome measures in line with the national data requirements for stop smoking services; in particular the number of clients attending and the number of self-reported 'quitters'. Some areas added other indicators such as the 'client return rate for support', which was assessed in a number of ways including the number of requests for advice in a two-week or four-week period. Public uptake of these services was generally good, with some schemes exceeding their targets. Stop smoking co-ordinators, National Health Service specialist advisers and local health promotion services were common partners in the development of community pharmacy-based smoking cessation services.

Training for pharmacists ranged from an evening session to a two-day course. Only four schemes did not include any form of training. In general, pharmacists were paid to participate. Local arrangements varied considerably and in some cases included longer-term elements. Examples include:

- Payment per client or per intervention.
- Fee for the first week's supply of NRT and eight weeks' counselling.
- Fee per client over a six-week period.
- Fee per monitoring form completed after four weeks.
- Initial payment, reimbursement for the NRT product supplied and a fee per voucher.

Funding came from a variety of sources including Department of Health 'ring fenced' smoking cessation budgets, primary care organisations and Health Action Zones. At the time of the initial survey (spring 2001), the availability of funding to continue pharmacy-based smoking cessation services was uncertain. Nevertheless some areas reported schemes continuing and some introduced new schemes later in 2001.

Innovative example of service provision
UK:
The 'Trash the Ash' campaign in Hull and East Riding incorporated a media campaign supported by posters and information packs displayed in community pharmacies. Smokers were encouraged to contact the local paper and pledge to stop smoking for the New Year 2000. Over 450 did so. The project was supported by the pharmacy development group, a local newspaper, the Hull and East Riding Health Action Zone and the Humber Alliance on Tobacco.

Drug use – 44 projects

Thirty-six of the reported projects were for supervised methadone and/or sublingual buprenorphine (Subutex) consumption, 6 were for needle/syringe exchange programmes, one aimed to improve the dental health for users, and one prepared pharmacists to train teachers about drug misuse.

Outcome measures for methadone supervision schemes included reductions in street methadone use, accidental child overdoses, the presence of other drugs found at urinalysis of clients, police reports of drug-related crime and acceptability to clients. Needle and syringe exchange schemes used client numbers and items supplied and returned as key outcomes. Evaluation was ongoing in most schemes.

Initial training was provided for almost all reported schemes and one area also trained pharmacists new to the scheme. The CPPE's Drug Misuse programme was widely used. One scheme in the Forest of Dean area included a presentation from a community pharmacist providing a methadone supervision service.

Collaboration with drug agencies and other local stakeholders was widespread. A shared care scheme involving the methadone client, drug misuse key worker, GP and community pharmacist was implemented in West Berkshire, and then extended to East Berkshire through their community drugs teams.[15]

Innovative examples of service provision

UK:

The remuneration system for general practitioners and pharmacists in the Berkshire project was based on treatment 'slots' of 12 months for which each professional received £90. For pharmacists, the slot included up to 13 weeks of methadone supervision within that period. By March 2001, almost 60% of local community pharmacies had been involved in the scheme and over half had provided supervised methadone consumption.[16] The remuneration structure for the Greater Glasgow Health Board service (see Case Study 1) included both retainer and item of service elements and was designed to encourage pharmacists to provide the service seven days a week so that the 'take home' methadone supply was reduced.

International:

A national study of community pharmacy-based methadone services in Australia reported pharmacies having higher client retention rates than public methadone clinics without pharmacists.[17]

For methadone various service specifications and remuneration systems operated, many pharmacists were paid a £1 fee per supervised administration**.** In West Berkshire pharmacists' remuneration is based on treatment 'slots' of 12 months for which they

[16] *Pharmaceutical Journal*, 2001. 266: 547-552.

[17] Con Berbatis, personal communication.

receive £90 per patient, the slot includes up to 13 weeks of methadone supervision within that period In Gloucester pharmacists are limited to 20 ‘slots’ at any one time and funded at £156 per ‘slot’ quarterly. Currently, there are approximately 4,000 individuals receiving daily supervised dispensing of methadone from 170 community pharmacies in the Greater Glasgow Health Board area. Some pharmacies are conducting 150 supervisions per day.

The remuneration structure includes both retainer and item of service elements and was designed to encourage pharmacists to provide the service 7 days a week so that the ‘take home’ methadone supply is reduced.

Case Study One: Pharmacy services for drug users in Greater Glasgow – supervised methadone dispensing and needle exchange schemes

Introduction and background

In Glasgow, as in many UK cities, drug use emerged as a serious public health and criminal disorder problem during the 1980s and 1990s. The city has around 7,000 – 10,000 current or recent intravenous drug injectors out of a population of 916,000.[18] Most typically use heroin but temazepam, diazepam, buprenorphine, dihydrocodeine and oral morphine are also used.[19] Multiple drug use is a significant concern. Although less than 1% of drug injectors are known to be HIV positive, around 72% are known to have the hepatitis C virus.[20]

Methadone was prescribed extensively to drug users in the 1970s and 1980s but was later largely abandoned because of the absence of monitoring and surveillance support in the community. However, by the early 1990s, general practitioners began to prescribe methadone successfully in a controlled manner with the support of local drug agencies.

Prior to the 1990s, community pharmacists were impeded from providing needle and syringe exchange services for fear of prosecution under the common law crime of 'reckless conduct'. However, growing awareness of the spread of HIV through needle-sharing led to a softening of the law on reckless conduct and after 1988 pharmacists were allowed to sell up to five sets of injecting equipment per transaction.

Policy context

The impetus for greater pharmacy involvement in supervised consumption of methadone emerged from a major review of drug use services by the Greater Glasgow Health Board. Subsequently, the Glasgow Drug Problem Service was set-up with three main priorities:

- Reducing or eliminating illicit injecting.
- An improvement in the general health of drug users.
- A reduction in the prevalence of drug use.

Pharmacy Involvement

[18] Frischer *et al.* 1997; Ahmed 2000.
[19] ISD, Scotland 2002.
[20] Taylor *et al.* 2000.

This review established a basis for pharmacy involvement in the supervised consumption of methadone. In Glasgow, the Area Pharmaceutical Committee (the Professional Advisory Committee) and the Area Pharmaceutical Contractors Committee strongly supported the involvement of community pharmacies in Supervised Consumption of Methadone (SCM). In particular, they recognised that SCM should be provided through many pharmacies rather than from a single identifiable centre. Since 1994, the supervision of methadone consumption by pharmacists has effectively become standard practice for patients receiving prescriptions for methadone.[21]

From April 2002, around 180 out of 215 pharmacies in the Greater Glasgow Health Board area were dispensing methadone of which 170 (79%) were contracted by the Health Board to supervise the consumption of methadone for 4,686 patients.[22] Service activity forms indicate that 87% of methadone doses dispensed by contracted pharmacists are consumed on the premises. Furthermore, 91% of methadone prescriptions issued by GPs in the Drug Misuse Clinic Scheme and 99% of prescriptions issued by the Glasgow Drug Problem Service request supervised consumption.[23]

Impact of the scheme

In addition to health improvements amongst drug users, the pharmacy SCM programme is thought to have helped reduce drug-related crime in the Glasgow area by minimising leakage of methadone onto the illicit drugs market.[24] Some drug users have been able to return to work or further education.

Service description – practical aspects of operating the scheme

The role of community pharmacists on the programme is to:

- ensure that adequate blood and tissue levels of methadone are maintained, reducing the need for opiates;
- prevent the diversion of methadone onto the black market;
- make a daily assessment of patient compliance with the programme and the general health and well-being of the patient;
- build a rapport with the patient that is beneficial from a health promotion and public health viewpoint.

The Glasgow guidelines recommend that all pharmacies should have a written protocol in place, for all staff to be aware of that protocol, and to specify the procedures to be followed when a new patient enters the SCM programme and for patients who attend regularly. The operational protocol requires details of the following:

- patient medication records;
- identification of patients;
- prescription legality;

[21] Roberts *et al.*, 1998; Roberts, 2000.
[22] Kay Roberts, personal communication.
[23] Kay Roberts, personal communication.
[24] Weinrich & Stuart, 2000.

- preparation of daily doses;
- discrete and efficient supervision by the pharmacist;
- disposal of waste;
- doses to be collected when the pharmacy is closed;
- use of safety stickers for taking products home;
- confidentiality;
- behaviour in and around the pharmacy.

It is essential that the pharmacist should be friendly, supportive and understanding, and should administer the drug in a discrete area, preferably at a quiet time. The needs of other patients and customers should also be considered.

To ensure effective supervised consumption of methadone and minimum disturbance to the pharmacy, the Glasgow guidelines recommended that the pharmacist develop a contract with the patient. This was intended to cover key issues such as the time the dose may be collected; arrangements for when the pharmacy is closed; the need for the patient to have a legally signed prescription; procedures governing missed doses and the consequences of unacceptable behaviour in the pharmacy.

The guidelines also suggest that the dose of methadone should be ready and waiting for the patient. The service should be discrete and efficient, there should be full adherence to the requirements of the medicines act and the pharmacist should be convinced that the dose has actually been swallowed – usually by providing a drink and then talking with the patient.[25] To facilitate the monitoring process, it is also important for the pharmacist to build a relationship of trust with the patient.

Since 2002 the Health Board has paid pharmacists a retainer of £102.50 per month plus a £2.02 dispensing fee. The pharmacy received 60p per supervision if it was open five days a week and 81p per supervision if it is open six or seven days a week. Participating pharmacists were, in return, required to take part in clinical audits and training, and to submit activity reports.[26]

Pharmacy needle and syringe exchange schemes in Glasgow

In April 2002, 15 Glasgow-based pharmacies were participating in the free needle and syringe exchange service and issued 468,738 needles/syringes. Under the terms of the Scottish Drug Tariff[27] participating pharmacists are required to:

- supply needles, syringes and equipment for safe disposal free of charge to drug users;
- receive used equipment for safe disposal from drug users, normally in exchange for new needles and syringes;
- provide advice to injecting drug users after suitable training;
- keep a record of transactions;
- complete a self-study course on the administration of this service.[28]

Participating pharmacists are paid an annual fee for offering this service and a fee per exchange.

[25] Roberts, 2000.
[26] Roberts, 2000.
[27] Scottish Executive, 2001.
[28] Scottish Centre for Pharmacy Postgraduate Education, 1999.

Training and support for community pharmacy in drug misuse

The Audit Commission[29] argued for an even greater role for pharmacists in drug use services. It has been suggested that the full range of training requirements for pharmacists to fulfil this demanding role needs to be addressed. To this end, a number of developments in education have taken place in Scotland:

- Through the University of Strathclyde/Greater Glasgow Health Board Academic Pharmacy Practice Unit, 107 pharmacists have completed an accredited health promotion training programme.
- The Scottish Centre for Pharmacy Postgraduate Education has provided continuing education for pharmacists on drug use and the treatment of opiate dependence.
- All pharmacists participating in the needle/syringe exchange scheme must complete the Scottish Centre for Pharmacy Postgraduate Education package 'Needle and Syringe Exchange Schemes in Community Pharmacy Practice'.
- Completion of the Scottish Centre for Pharmacy Postgraduate Education package 'Pharmaceutical Aspects of Methadone Prescribing' is now a requirement for Glasgow pharmacists entering the contracted methadone programme.
- Joint education meetings are held for general practitioners and pharmacists involved in the methadone prescribing and dispensing programme to discuss matters of common interest.

The Greater Glasgow Health Board now also employs a Pharmaceutical Policy Adviser to provide professional guidance and develop strategies to meet the pharmaceutical care needs of the population. Furthermore, in 1996, the Greater Glasgow Health Board appointed an Area Pharmacy Specialist – drug abuse worker, which was a senior pharmacist with responsibility for planning, development and implementation of pharmaceutical services for drug misuse and harm minimisation.

Funding has been obtained for a peripatetic pharmacist to work with participating pharmacists on making links between community pharmacy and social work departments, to provide locum cover for pharmacists attending case conferences and to support pharmacists in their work with drug users.

The Scottish Executive has offered funding for the construction of specific areas in Glasgow and Lothian pharmacies to allow methadone consumption to take place in private and away from other customers. This initiative has come about in response to the concerns of patients who did not want to be seen consuming methadone on local pharmacy premises.

Funding has also been secured for Eppendorf Varispenser®[30] pumps to dispense methadone, for additional controlled drug cabinets for high activity pharmacies and

[29] Audit Commission, 2002.

[30] The Eppendorf Varispenser® is a bottle-top dispenser designed for taking aliquots of liquid from large supply bottles that ensures exact reproducible dispensing and protects the user.

for CCTV cameras in needle and syringe exchange pharmacies and pharmacies with high levels of supervised consumption of methadone activity.

Finally, a Pharmacy Methadone Advisory Group has been set-up. This is a multidisciplinary group consisting of social workers, the Drug Action Team co-ordinator, the Director of Public Health, Glasgow Drug Problem Service, psychiatrists, a GP facilitator and pharmacists. Its aim is to drive forward the involvement of pharmacy in drug misuse.

Interviews with stakeholders

Introduction

Seven qualitative interviews with key stakeholders in the Glasgow drug misuse services were conducted – three with pharmacists participating in the SCM service, one with a pharmacy manager and three with individuals involved at a strategic level with the development of drug use services. The interviews aimed to explore the perspectives of stakeholders and those participating in these services, and also to discuss the scope for future initiatives in pharmacy. With one exception, interviews with participants were tape-recorded and transcribed.[31] Information about the identity of the interviewees is withheld to protect confidentiality.

General views of stakeholders and participants regarding pharmacy involvement in drug use services

All of those interviewed were generally positive about the involvement of pharmacists in the provision of services to drug users. Widespread recognition of the public health and street crime issues associated with illegal drug injecting, coupled with the innovative approach adopted by the Greater Glasgow Health Board and other partner agencies, were motivating factors for pharmacists. Participating pharmacists noted that they had an opportunity to exercise both their clinical and communication skills, receive remuneration for the service and have an impact on a major public health problem.

One stakeholder noted that pharmacist participation in SCM tended to be much higher than for needle/syringe exchange schemes because pharmacists felt more in control of the service and because users who decided to embark on substitution therapy were less likely to be troublesome to staff and other customers.

Several participants commented on the advantages of having pharmacists provide a monitoring and supervision role for methadone therapy. These included the fact that pharmacies are positioned in the local community, with straightforward access to areas in which drug users live and the fact that the non-specialist nature of pharmacies helped reduce the stigma of drug use. Others commented on the importance of building a relationship with patients.

[31] One participant asked not to be recorded so verbatim notes were taken of the interview.

> *"You can tell from day-to-day what they're doing, and you get an idea if they've been taking street drugs as well by the pallor of their skin and their eyes. Once you know them it's possible to ask them if they're OK, or if they need anything else. It's not just about making sure they take their methadone and getting them out of the shop."* [Pharmacist 1]

It was noted that pharmacists involved in SCM could act both as patient advocate and provider of a health service through their position in the local community. They could play an important linking and mediating role with local prescribers through their day-to-day knowledge of drug users. One stakeholder gave the following example:

> *"A GP might decide to strike off a patient, for whatever reason. It's possible for me to intervene. The pharmacist can act as a sympathetic ear, because we have the inside knowledge of what's going on in the patient's life."* [Stakeholder 2]

The development of linkages and partnership working between different professionals – GPs, specialist drug teams, social work and pharmacy – was held up as one of the key benefits of the service, and one that had had helped to reduce the traditional policy isolation of community pharmacists. Furthermore, the involvement of individuals from the Scottish Centre for Pharmacy Postgraduate Education and professionals from specialist drug teams in training pharmacists had helped the service succeed.

Occasional problems with users coming into the pharmacy at times when it had not been agreed that they should attend for their methadone dose were mentioned. However, such incidents were relatively infrequent. Of greater concern was the impact of the numbers of drug users attending for their daily dose of methadone on other customers. One stakeholder commented that where activity in relation to the supply of methadone was particularly high, there were simply too many drug users entering the pharmacy. One stakeholder also commented that there were not enough pharmacies providing needle and syringe exchange schemes. Furthermore, the lack of a discrete or quiet area to carry out supervised consumption in some pharmacies could be embarrassing for both drug users and customers alike, particularly after the users had become stabilised on substitution therapy. This was recognised as an issue, and in response local health boards are funding the creation of private consultation areas, but it still remains an acute problem for some pharmacies.

In accounting for the success of the service in Glasgow, one stakeholder commented that the size of the problem and the significance of drug use as a public health, criminal disorder and economic problem had stimulated funding for the service. The commitment of other partner health professionals to multidisciplinary working and to engaging with the social care agenda had also facilitated success.

Case study One: Summary of findings and lessons for future initiatives

1. Multi-agency networking, particularly the involvement of the Glasgow Area Pharmaceutical Committee in the Glasgow Drug Problem Service was an appropriate forum for addressing local priorities.
2. The commitment of other health professionals to multidisciplinary working and the social care agenda were key factors.
3. The development of linkages and partnership working among different professionals – GPs, specialist drug teams, social workers and pharmacists – were the real key benefits of the service, and helped reduce the traditional isolation of community pharmacy services.
4. Community pharmacy has shown that it can use its position as a community based health provider to improve access to drug use services. The fact that pharmacies are located at the heart of local communities facilitated the successful spread of the service. The unique combination of local accessibility and referral contacts that community pharmacists offer was a crucial factor in determining the success of this initiative. And a benefit that could be used to advantage for other health improvement initiatives.
5. The support available from pharmacists working in strategic positions, for example, as Pharmaceutical Policy Advisers, Area Pharmacy Specialists and Drug Abuse workers could be vital to the pharmacists offering the service.
6. Evaluation research, audit, the development of clear guidelines and service contracts with the commissioning agencies helped to achieve successful outcomes.
7. The use of a written patient contract and the provision of a private consultation area in the pharmacy were also important to establish so that both the pharmacist and the user found the level of support acceptable.
8. The importance of the environment in which the consultation between pharmacist and user was made was extremely important – both in physical as well as behavioural/psychological terms. This had to meet the needs of both user and pharmacist as well as the pharmacist's professional needs. The physical environment needs to provide enough privacy and confidentiality for both parties to feel comfortable. That may not simply be a matter of being overheard but being identified as using the pharmacy services, whether visually or by conversations with third parties. This is particularly the case when clients are receiving particularly sensitive services that carry moral and social stigma. There is also a need to develop a credible relationship between the pharmacist and the client. NB this may apply to the pharmacy staff as well as the pharmacist. Ideally the relationship will be based on trust, centred around the needs of the client and built-up over a period of time to ensure a long-term relationship. When this is not possible, either because the relationship is short-term and/or there are professional difficulties in establishing trust with the client, then this service should be made available in written form and could be a by providing a pharmacy leaflet or supportive computer print-out.

Sexual health and pregnancy – 31 projects

Over two-thirds (21) of the projects identified involved the supply of emergency hormonal contraception (EHC) by pharmacists under Patient Group Directions. Most schemes aimed to reduce teenage pregnancy as part of local sexual health strategies. Outcome measures were primarily client numbers.

EHC provision schemes were generally developed through local collaborations with family planning and sexual health services such as the Brook Advisory Service. In the Coventry area, a sexual health project was developed in partnership with local youth services, school nursing and health promotion services to provide free pregnancy tests for under-19-year-olds and to link young women to the appropriate services on receiving the results.

Other projects included:

- Information and encouragement for women to take up cervical screening services in Redbridge and Waltham Forest and Barking and Havering.
- In Enfield and Haringey pharmacists ran a Chlamydia Awareness Campaign including leaflet distribution and an anonymous self-test quiz.
- The use of community pharmacies as an information and advice point about contraception for young women.
- Free pregnancy testing, free condom provision in Coventry and opportunistic encouragement to use local family planning services in Rotherham.
- 'Folic Acid and Pregnancy Awareness Week' campaign
- More general campaigns to raise awareness of sexual health issues and to promote the use of local services.

Participating pharmacists were usually required to undergo training. In Manchester Salford and Trafford EHC services (see Case Study 2), included training in both clinical knowledge and communication skills from family planning experts. Payment was generally per consultation.

Problems that emerged with existing schemes included difficulties with providing quiet consultation areas and with remuneration policies (some employers expect pharmacists to provide the service as part of their 'normal' duties, while others pay them a proportion of the fee). There were also problems with lack of time and resources in pharmacies with a high number of EHC clients – for example, one central Manchester store had to deal with around 20-30 requests for EHC every Monday lunchtime.

Case Study Two: Pharmacy supply of emergency hormonal contraception (EHC) in Manchester, Salford and Trafford Health Action Zone.

Introduction and background

Community pharmacy supply of EHC via Patient Group Directions is an extremely important public health service.[32] Initiated in December 1999 within the Manchester, Salford and Trafford Health Action Zone to try to combat the very high rates of unwanted pregnancy among young people, the service involved community pharmacists supplying EHC, while also providing a range of complementary sexual health services.

Policy context

The UK has higher teenage pregnancy rates than much of Western Europe.[33] The Government White Paper *Our Healthier Nation* (1998) and the report from the Social Exclusion Unit[34] identified this area as a priority, given the adverse health and social consequences associated with teenage and unwanted pregnancy. In particular, the strong association in the UK between socio-economic deprivation and teenage pregnancy suggests that interventions need to be targeted at deprived areas.[35] The provision of EHC in pharmacies has long been advocated as one method for addressing high teenage and unwanted pregnancy rates in relatively deprived areas.[36]

Rationale for the development of the service

Evidence suggests that women's use of EHC may be influenced by difficulties in obtaining it.[37] In particular, teenagers' concerns about confidentiality and disclosure may prevent them from asking for EHC from GPs.[38] Some women also lack the confidence to access the 'health system' and make an appointment.[39] Young women also may not know about family planning clinics, and even those who do may think that services are not available early in the week or over the weekend – the time when EHC is most often requested.[40] In short, research suggests that traditional suppliers of EHC may not be meeting the needs of their patient group (teenagers in particular), and that widening access to EHC may have an important impact on teenage and unwanted pregnancies.

The campaign for a community pharmacy-based emergency hormonal contraception service was based on the fact that:

- Community pharmacists are the most accessible of all primary healthcare service providers and no appointment is required.
- An existing network of service providers covers extended opening hours including Sundays.

[32] O'Brien & Gray, 2000; Seston, 2000
[33] McLeod, 2001
[34] Social Exclusion Unit Teenage Pregnancy 1999
[35] McLeod, 2001
[36] Glasier, 1993
[37] Ellertson *et al.*, 2000
[38] Hadley, 1995
[39] Ellertson *et al.*, 2000
[40] Ellertson *et al.*, 2000

- Young people can access community pharmacies without fear of their parents being informed.
- Pharmacies in high street locations can be easily accessed by public transport.

Development of the Manchester, Salford and Trafford Health Action Zone emergency hormonal contraception service

The successful award of Health Action Zone status to Manchester, Salford and Trafford proved an essential catalyst for the development of the pharmacy-based emergency hormonal contraception service, providing the necessary funding, organisational and political commitment for innovative service developments. Set-up in 1997, the remit of the Health Action Zone was to find innovative ways to tackle inequalities in health and health service provision. The incorporation of community pharmacy into the work of the Health Action Zone was initiated by representatives from the Local Pharmaceutical Committees This led to the formation of the Pharmacy Partnerships group – a steering group consisting of Local Pharmaceutical Committee members, Pharmaceutical Advisers and, later, pharmacists from secondary care.

Project managers

The appointment of two project managers funded to work with the Pharmacy Partnerships group was crucial to the development of the Health Action Zone emergency hormonal contraception service. One was funded by the RPSGB's *Pharmacy In A New Age* initiative and the other by Manchester Health Authority. Documentary analysis and interviews with stakeholders suggest that the leadership and vision of the project managers, working alongside pharmacy partnerships, formed the basis of a cohesive pharmacy development group, able to promote community pharmacy in relation to the Health Action Zone's agenda.[41]

Patient group directions

Legal advisers confirmed the possibility for pharmacists to become involved in supplying emergency hormonal contraception (EHC) under a group prescribing protocol. Key considerations for the acceptability of the use of the group protocol for EHC were:

- Selective training and accreditation of professionals providing the service.
- Consideration of community pharmacy premises as self-contained 'clinics'.
- A protocol pro forma enabling the pharmacist and client to check understanding and to sign an agreement during the initial consultation.
- The support of a group of clinicians who accepted responsibility for the protocol.
- Patient information leaflets.
- Audit.

[41] O' Brien & Gray, 2000; Anderson *et al.*, 2001

The Pharmacy Partnerships steering group believed the way forward was to supply EHC[42] under a group protocol. It was argued that this would provide a number of benefits:

- It would demonstrate a new way of providing medicines related services for pharmacists.
- It would reinforce the notion that the EHC provided was not an item of commerce.
- The protocol would require and structure personal interaction between the pharmacists and their clients.
- Pharmacists could be paid for their professional skill in history taking and providing appropriate advice regardless of supply.
- The service could be audited via detailed record keeping using the protocol pro forma specific to each consultation.

A senior family planning doctor and health professionals who had worked on the development of nurse prescribing protocols constructed the group protocol for use by community pharmacy. The involvement of a senior family planning doctor provided the key impetus for the development of the service. Early on, the Patient Group Directions had no firm legal foundation for use within community pharmacies. However, protocols were developed for use with combined oestrogen and progestogen EHC and later with progestogen-only EHC.[43] By August 2000, the Department of Health had issued guidance in this area[44] and the legal foundation for Patient Group Directions to be used by pharmacists was established.

Patient Group Directions are group prescribing protocols that give suitably trained and accredited pharmacists the legal authority to supply prescription only medicine to requesting clients. In this case, the Patient Group Directions establishes that EHC should be supplied free of charge and can be supplied to girls under the age of 16 if the pharmacist considers it appropriate. The development of the Patient Group Directions was a lengthy process supported by a specification outlining the project's aims, objectives and audit standards to be applied. The project support materials included: pro forma assessment sheets and medical record sheets, data monitoring forms, payment claims forms, locum payment claim forms, guidelines on documentation, emergency clinical contact sheets, referral forms, accreditation certificates and lists of other local health services. A telephone support system made clinical advice and information from local family planning doctors available to pharmacists. A local branch meeting of pharmacists in Manchester, Salford and Trafford also provided an opportunity to discuss the expected problems and solutions with the service.

[42] In this case, Schering PC4.

[43] Levonelle-2 became available as an over-the-counter product in January 2001 as a result of a successful application by manufacturers Schering Healthcare for a pharmacy product license. It retails at a cost of £24. As a result, both the over-the-counter product and the Patient Group Directions schemes operate side-by-side in some areas.

[44] Health Service Circular 026 (2000). London: Department of Health. Available online: www.info.doh.gov.uk/doh/coin4.nsf/circulars.

A group of local doctors and managers signed the group protocol to authorise accredited pharmacists within the Health Action Zone to supply EHC. The pharmacist and the client work through each stage of the protocol and both parties are required to sign each section of the protocol pro forma to confirm understanding.

Recruitment and training of pharmacists

Once the appropriate project support material had been prepared, it was necessary to recruit a cohort of community pharmacists to supply. Interviews with stakeholders demonstrate that there was a commitment to recruit pharmacists who would provide a non-judgmental and empathic service to users. In late 1999, two community pharmacies per primary care organisation were selected for the service. Pharmacists underwent training and skills enhancement programmes incorporating clinical and communication skills appropriate to supplying emergency hormonal contraception. Training was mainly provided by local family planning doctors and the Centre for Pharmacy Postgraduate Education. 'Role-play' was included in all the programmes and was designed to cover situations about which pharmacists were most concerned – as determined from early discussions. Evidence from evaluations indicates that the 'role-play' scenarios were extremely useful and equipped pharmacists with the social and communication skills necessary for dealing with sensitive issues.[45]

In 2002 the service was available at over 120 pharmacies within the Manchester, Salford and Trafford area.

Brief service description

After completing the training programme, pharmacists were permitted to supply emergency hormonal contraception to requesting users free of charge following a thorough consultation. The pharmacist had to adhere to the Patient Group Directions protocol, which guided their decision about whether to supply EHC. If the pharmacist was unsure about whether to supply, local family planning doctors offered back up. The service was confidential and anonymous, and no records that could identify the requesting user were kept, although the pharmacist did record the client's postcode for data-monitoring purposes. The pharmacist recorded basic details of the consultation separately on a pro forma audit sheet.

Consultations with clients were expected to take place in a private area. From its outset, the scheme was designed as a sexual health service, rather than simply the provision of emergency hormonal contraception. Pharmacists recorded the reason for requiring emergency hormonal contraception (e.g. unprotected sexual intercourse, missed contraceptive pill, broken condom), provided verbal and written information on contraception and sexually transmitted infections, and offered sources of further advice and information. They also provided counselling about the possible risks and the side effects of EHC and some provided free condoms with the EHC supply.

In Manchester, the protocol indicated that clients should be asked to take the first of the two pills in store. Pharmacists received a payment of £10 per consultation.

[45] Anderson *et al.* 2001 *a,b.*

Evaluation of the service

Researchers from the School of Pharmacy at University of Nottingham researchers carried out an independent evaluation of the service.[46] In Manchester, Salford and Trafford, some 13,256 women accessed the service between 24 December 1999 and 31 March 2001 and 93% of these were supplied with EHC. Of those women, only 28% were aged under-19 years.

Independent evaluations showed that users expressed high levels of satisfaction with the service - 99% of users in Manchester, Salford and Trafford were 'very satisfied' or 'satisfied'. Over 95% of users stated they had received sufficient information about EHC from the pharmacist and over 90% suggested that they felt comfortable talking to the pharmacists about EHC. Just over three-quarters felt there was sufficient privacy in the pharmacy. However, approximately one-fifth of users had concerns about the confidentiality of their request.[47]

The evaluation showed that pharmacists were also extremely positive about the service.[48] Pharmacists commented that they believed they were providing an important service for users that allowed them to use their clinical and communication skills which was also professionally rewarding.

Key Findings and lessons for future development

1. Successful award of Health Action Zone status to Manchester, Salford and Trafford; funding against political commitment. Development of local objectives for reducing health inequalities in five areas (children, young people, active senior citizens, mental health, community capacity building). Funding and focus on health improvement.
2. Development of local organisational structure (Local Pharmaceutical Committees and Pharmacy Partnerships group) and appointment of Project Managers providing basis for leadership, promotion of community pharmacy agenda and networking with Health Action Zone.
3. 'Brainstorming' of Health Action Zone local objectives by Local Pharmaceutical Committees and production of 13 potential service options for community pharmacy.
4. Questionnaire consultation process with community pharmacy contractors on potential service options: ensured pharmacist support, despite 33% questionnaire response rate.
5. Project managers liaise with Health Action Zone Director - reducing teenage pregnancy and medicines review selected as pharmacy priorities.
6. Project mangers liaise with family planning doctors and Brook Advisory services – ensured multi-agency support for reducing teenage pregnancy.
7. Development of Patient Group Direction protocol and related administrative infrastructure by project managers, with support from legal advisers, family planning doctors and other health professionals.

[46] Anderson *et al.*, 2001*a,b.*
[47] Anderson *et al.*, 2001*a,b.*
[48] Anderson *et al.*, 2001*a,b*; Savage, 2001.

8. Development of pharmacist clinical and communication skills training in conjunction with Centre for Pharmacy Postgraduate Education, family planning doctors and Brook representatives.
9. Selection of pharmacies in each primary care organisation for involvement in pre-millennium launch.
10. Launch.
11. Audit and evaluation of project.

Interviews with stakeholders

Introduction

A series of qualitative interviews were carried out with key stakeholders involved in the Manchester, Salford and Trafford community pharmacy emergency hormonal contraception project and public health officials working in the local area. The interviews explored stakeholder perspectives in relation to the community pharmacy EHC service and focused on the scope for future health improvement initiatives. Interviews with participants were recorded and transcribed. Information about the identity of the interviewees is withheld to protect confidentiality.

Perspectives on the community pharmacy emergency hormonal contraception service

Assessments of community pharmacy involvement in emergency hormonal contraception provision were overwhelmingly positive and underline the perception that this was a successful initiative with clear benefits for clients, pharmacists and the Health Action Zone.[49]

> *"It's been a milestone for pharmacy. Not only has it increased pharmacists confidence in delivering an innovative service for women . . .but in the process it has also changed women's ideas about community pharmacy."* [Stakeholder 1]

Stakeholders highlighted the following advantages for service users:

- Women had improved access to emergency hormonal contraception because a broad network of pharmacies provided a dispensing service at a range of appropriate times.
- The service was free and provided in an area with high rates of teenage and unwanted pregnancy, thereby meeting the Health Action Zone requirement that services should have an impact on inequalities in service provision.
- The service required no appointment, was completely confidential, and also involved an assessment of the individual's contraceptive and sexual health needs

[49] These findings replicate those noted by Anderson *et al.* (2001*a*,*b*) and Savage (2001) in their evaluations of the community pharmacy EHC services for Manchester, Salford and Trafford, and Lambeth, Southwark and Lewisham HAZs.

- There was the option of referrals to other health professionals and a health promotion component (distribution of condoms and leaflets for STI services and provision of counselling around contraception where appropriate).

Stakeholders also noted that the service was extremely popular with pharmacists. Advantages for pharmacists included:

- The professional satisfaction of providing a service that addressed both the Health Action Zone agenda and the needs of women clients, whilst also exercising pharmacists' clinical and communication skills.

> *"Doing the right thing, is personally the motivation . . . pharmacists are for ever saying that they want to get involved, they've got the skills but they're under-used . . . Here, pharmacists applied their skills and used their knowledge base…plus they were paid to do so."* [Stakeholder 3]

The successful implementation and operation of the service highlighted the important contribution community pharmacy could make to reducing inequalities in sexual health service provision and having an impact on unwanted pregnancies.

Reasons identified for the success of the emergency hormonal contraception service

Stakeholders were asked to account for the success of the emergency hormonal contraception service. In addition to the benefits of addressing the Health Action Zone's agenda, client need and the agenda of the pharmacy profession, stakeholders also identified a number of organisational factors that, in their view, accounted for the success of the service. Above all, the award of Health Action Zone status provided the organisational scope and financial resources for the service development.

A number of stakeholders referred to the important leadership role played by the project managers in overcoming the administrative and organisational obstacles (such as the uncertain legality of the service) and in taking risks and proving leadership for a project that might otherwise have floundered.

Other stakeholders referred to the importance of the Local Pharmaceutical Committee and the Pharmacy Partnerships group as a pharmacy development forum that assisted the success of the project, and to the importance of a body of committed pharmacy contractors willing to get involved in an innovative service.

The importance of multi-agency working and support for the development of the project, training of pharmacists and the provision of clinical back up was also highlighted as crucial for successful development. In particular, the support of local family planning doctors, the Brook Advisory service and individuals working on the local medical committee were viewed as important to the project's successful development.

Disadvantages and drawbacks of the service

Administrative and organisational drawbacks to the EHC service - noted by stakeholders - included delays in receiving payment for the service and problems with

pharmacists choosing not to supply EHC on moral or ethical grounds. Some women also viewed the protocol requirement to take the product in-store as unnecessary and irritating. However, these were generally of concern to a minority of people.

Of greater concern to participants was the impact of the EHC service on mainstream public health issues, such as sexual health and STIs. Interviewees were concerned that EHC might be used as a regular form of contraception instead of a client's usual method, or would encourage the client not to bother to use her usual method and this might have an impact on STIs. However, there was no strong evidence for this concern, and one participant noted that the British Medical Association was strongly in favour of the service and did not believe there was evidence of a link with STIs. Stakeholders also highlighted the fact that, from the start, the Patient Group Directions protocol had emphasised that this was a sexual health service, rather than simply a means to obtain emergency hormonal contraception.

> *"Of course, I think we've got to be concerned about sexually transmitted diseases and rates of unprotected sex, which is why we specifically built a referral element into the protocol. We are providing a sexual health service*."[Stakeholder 1]

Other stakeholders were more trenchant, suggesting that it was important to have some faith in the common sense of the women who were accessing the service and that, on a simple risk-benefit assessment, it was surely an advantage that women were accessing the service at all.

> *"What I think we've got to accept is that women are actually choosing to come to the pharmacy (for whatever reason), rather than risking a pregnancy. This is got to be preferable to them doing nothing, and perhaps having an unwanted baby."* [Stakeholder 6]

Although generally positive about the project, one stakeholder - commenting on the audit data that showed that only around one-fifth of users were aged 19 years or under - questioned whether the service was having the impact that the Health Action Zone desired on inequalities in rates of teenage and unwanted pregnancies.

> *"Of course, it's a success in the sense that it's up and running, pharmacists are taking part, more and more women are using it and it's viewed very positively. But with my public health hat on, I don't know if this is having the effect we wanted. Is it simply the well off, and educated women using it, or are we reaching everyone?"* **(**Stakeholder 6]

The future for community pharmacy: a continued role in improving health and reducing inequalities

An important component of the interviews centred on discussing with stakeholders the scope for future work on public health and health inequalities.

In general, the pharmacy stakeholders were extremely positive about the potential for future pharmacy involvement in public health initiatives. Stakeholders noted that the EHC project demonstrated the effectiveness of the Patient Group Directions route for

the supply of medication related services and that the key advantage of using pharmacy was access to services. It was suggested that the Patient Group Directions supply model could be extended for other services such as nicotine replacement therapy and treatment for eye infections.

> *"Personally, I don't see why we shouldn't be able to supply nicotine replacement therapy using a protocol, or some other means. Pharmacy is opportunistic, isn't it? The customers pass by, see nicotine replacement therapy in the window and think about giving up smoking. Now, between thinking about it and going to the general practitioner or your practice nurse, time has passed. But they might just come into the pharmacy and if it's free . . there is potential there I think.*" [Stakeholder 5]

Positive comments were also received about pharmacy involvement in developing innovative services for drug users such as the supervised dispensing of methadone and the provision of needle syringe exchange schemes. These services were expanded to capitalise successfully on pharmacy as a locally accessible health provider.

Some stakeholders referred to the development of health promotion, although one stakeholder noted that health promotion should be seen as a specialist activity, not simply as an 'add-on' service taken up by all pharmacists. Others referred to the wider public health agenda and the role pharmacy could play in relation to that. One stakeholder noted:

> *"The public health agenda is currently immense, and there is a major potential for pharmacy to get more involved. Pharmacists see 'well' people in addition to the ill. There's major opportunities for leaflets. . . I think things like diagnostic testing, early identification of diabetes, blood pressure monitoring, primary prevention and identification of disease as well. The whole area is massive, and as yet, unexplored."* [Stakeholder 1].

The links between early diagnosis/disease identification, the local nature of pharmacy and the fact that pharmacy sees both the well and the ill was often highlighted. One stakeholder asserted that in order to develop such services community pharmacy would need to think strategically about how to galvanise innovation and change within the profession:

> *"The Health Action Zone service worked because there was money to develop the services and pharmacists got paid for a service they enjoyed doing.* [Stakeholder 4]

It was also pointed out that two-thirds of all community pharmacists were in fact employees and the individual scope for taking part in innovative public health initiatives was relatively limited. It was suggested that the crucial links would be with the larger chains and supermarket pharmacies, which would determine future policy. Finally, a number of stakeholders referred to the medicines management pilot schemes taking place in the UK and the potential public health impact that these might offer.

The non-pharmacy stakeholder was less enthusiastic about the future contribution of pharmacy in public health and considered pharmacy – and other health services – to be able to play only a limited role in reducing health inequalities.

> *"It's difficult for me to see where public health and pharmacy actually coincide. Yes, I can see that the EHC project worked in Salford and Trafford and I can see stop smoking services as a way of reducing health inequalities –- same with methadone. These are public health issues where pharmacy can make a difference…but as a public health specialist taking a social model of health, I'm not sure where else we can go with this."* [Stakeholder two]

In the face of such views, pharmacy may need to think about its connections with the wider public health and health inequality agenda. The arguments raised by this stakeholder highlight a potential tension between a social model of health and one that seeks to provide general health services and pharmacy policy makers may need to address this.

Accident prevention – 7 projects

These projects focused on preventing falls in older people (including promoting bone health and osteoporosis prevention) and child accident prevention (including accidental poisoning). Their main intentions were to give information and to raise awareness. No precise outcome measures were given.

Innovative examples of service provision

UK:

Some projects provided brief training sessions. In Enfield and Haringey, a community pharmacist, a physician specialising in medicine for older people, a physiotherapist and a primary care manager provided training.

International:

In Sweden [13], community pharmacists ran osteoporosis groups in conjunction with the national 'sports for all' association. These targeted women aged 45-60 and aimed to increase physical activity and healthy eating, and provide smoking cessation support. There was a charge to join but in many areas local councils covered some of the costs. A training day was held for pharmacists and 'sports for all' staff. Participating women were given a book and asked to prepare for each meeting by reading a section. The programme involved 14 weeks of biweekly seminars on lifestyle and physical activities. It was evaluated through the women's self-reports of changes. Participants reported that their sense of wellbeing increased, their strength and balance were improved, and they spent more time outdoors and had improved their diet.

In Finland [13], a programme was set up for pharmacies to provide information about the risks inherent in combining medicine and alcohol, and about the appropriate use of medicines. The Finnish Pharmaceutical Society provided window display materials and public information leaflets. Two television public information slots were also provided. A press conference generated substantial local and national publicity for the scheme, and individual pharmacies also held local events. Pharmacists gave over 400 lessons to 13 to 15-year-olds in schools, using materials produced for the project.

Health screening, coronary heart disease and diabetes – 12 projects

Of the health screening projects identified, most involved the identification of high-risk patients from pharmacy medication records, through prescriptions presented and on the basis of over-the-counter purchases. Identification was followed by the provision of advice and information. Indicators for coronary heart disease included the purchase of low-dose aspirin and the presentation of prescriptions for cardiovascular medicines. Two areas reported diabetes initiatives, both of which were short-term and focused on information provision to high-risk groups identified in a number of different ways including patient medication records, over-the-counter purchases and health advice requests.

Innovative examples of service provision

UK:

In Bedfordshire**,** where pharmacists identified patients at risk of diabetic eye problems and glaucoma, participating pharmacies were paid for each referral made to local optometrists (with whom the scheme was developed). No other remuneration information was available.

One project based in Harrow, North London, incorporated an evening of training based on the CHD National Service Framework.[50] Little specific detail of training was given for other screening projects reported through the survey, although all mentioned some form of training.

International:

The Institute for Clinical Pharmacy, University of Basel, Switzerland developed a model for diabetes screening based on existing literature and advice from diabetes and public health experts. This was piloted in two community pharmacies. A triage flow chart was produced to guide pharmacists' testing and referring clients. People with two or more risk factors were offered a blood glucose test (fasting if possible; otherwise values above 5.3 mmol/l prompted a second test in the fasting state). Counselling about risk factors was based on the trans-theoretical model of behaviour change. The Toppharm group of 60 pharmacies piloted the campaign for four weeks in 2000. Of 704 people screened, 7 were found to have insulin dependent diabetes mellitus and 71 non-insulin dependent diabetes mellitus. The model will be further evaluated in a national campaign involving 600 community pharmacies.

In Australia there are plans to involve community pharmacists in primary and secondary diabetes prevention. Based on feasibility studies with 470 community pharmacies in Western Australia, these schemes are likely to focus on anthropomorphic testing (waist and adiposity) measurements, with wider risk factor assessment taking into account age, gender, smoking status and ethnicity. This approach has been shown to be as meaningful as, but less complicated and invasive

[50] *Pharmaceutical Journal* 10 Nov 2001.

than, the testing of other indicators such as cholesterol, blood glucose or glycosylated haemoglobin.[51]

Another major Australian initiative aimed to establish and evaluate a service whereby community pharmacists assessed clients' needs for health information, screening tests and referral. The initial focus was on cardiovascular disease and its risk factors (hypertension, hyperlipidaemia, diabetes, smoking and obesity). The service model developed for this disease was intended to provide a template for other diseases such as cervical cancer (e.g. referral for pap smears) and infectious childhood diseases (e.g. referral for immunisation).[52]

Obesity and weight management – 3 projects

The projects on obesity reported were linked to prescribing guidelines for *Orlistat*.

Innovative example of service provision
UK:
The evaluation of a Bedfordshire Lloydspharmacy weight loss programme concluded that that although there was increased awareness of healthy eating and physical activity they did not know how sustainable such a scheme would be.

International:
One quarter of Danish community pharmacies [13] offer weight management services on a group or individual basis. Pharmakon –the Danish College of Pharmacy Practice – developed the model as part of the Danish Pharmacy Association's Year of the Heart in 1999. Pharmacists and their staff underwent two days training and were issued with an operational manual. Support groups consisted of 10-12 people and were run by a pharmacist and one or two pharmacy assistants. People attended eight 90-minute sessions. The service for individuals included five counselling sessions, of which the first was the longest, with subsequent sessions intended to take 5-10 minutes. No evaluation of the scheme has yet taken place.

Immunisation – 2 projects
Since this survey was conducted, Grampian area in Scotland has reported on a pharmacy based immunisation service. Community pharmacists in the Blackpool area participated in a 'flu immunisation scheme in which they identified 'at risk' patients and referred them for immunisation. The pharmacists used patient medication records to target specific therapeutic risk conditions and prescription age exemption to prompt a discussion with patients. Under the scheme, the pharmacist asked if the patient had booked a 'flu immunisation. If not, information was given and a recommendation made to book an appointment for assessment and immunisation. The community pharmacists were paid a fee for taking part.[53]

[51] Con Berbatis, personal communication.
[52] Ines Krass, personal communication.
[53] Magnus Hird, personal communication.

Grampian Health Board has considered how community pharmacists could contribute to increasing the uptake of 'flu immunisations. In 1992-93 two small projects in the Grampian area demonstrated that community pharmacists could successfully identify 'at risk' patients, either systematically by using patient medical records, or opportunistically when patients made over-the-counter purchases or presented a prescription for dispensing.[54]

Innovative example of service provision
International:
In the US, community pharmacists have been administering immunisations for several years and there are published reviews in the literature.[55] Further experience has shown that community pharmacists, rather than merely acting as an alternative source of provision, are able to reach a group of patients who have not previously participated in 'flu immunisation programmes.[56]

Travel health – 3 projects
Three UK projects on travel health were reported. These included a campaign to provide advice to travellers and a sun-awareness campaign.

Innovative example of service provision
International:
The Austrian Chamber of Pharmacists [13] worked with the Institute of Tropical Medicine at the University of Vienna to launch a national campaign focusing on the use of sunscreen in summer and when travelling abroad in winter. The campaign offered individual information and counselling combined with information and advertisements in pharmacy windows. A leaflet and checklist were distributed on holiday needs and taking medicines abroad. Pharmacists used a computer programme to advise about immunisation.

Other projects (18)

Other projects reported included campaigns about mental health, parenting, men's health awareness, and health promotion aimed at local ethnic groups.
In Sheffield eight pharmacies had touch screen information systems that printed information about self-help groups and healthy living. In the Croydon area pharmacists had put up display boards about local authority related topics, e.g., cycling to work and keeping warm in winter. Training in health promotion skills had been provided for counter assistants in the Lothian area in Scotland.

[54] Christine Bond, personal communication.
[55] Anderson, Blenkinsopp & Armstrong (2003).
[56] Dale Christensen, personal communication

Case Study 3: Lloydspharmacy CHAT Centres

Introduction

The development of CHAT (**C**ommunity and local **H**ealth, social and welfare **A**dvice provided informally by **T**rained professionals) centres within Lloydspharmacy is presented as an example of how community pharmacy premises can be adapted to provide health improvement resources and facilities to the public. The study was based on using community pharmacy premises as a public health resource and interviewing a key stakeholder and analysing key documents.

The CHAT centre

The first CHAT centre was set up in Alfreton, Derbyshire, as a result of an information availability survey commissioned by Derbyshire Health Authorities in 1996. Both the healthy and the ill visit community pharmacies and clients frequently request advice on social and health care issues. This survey highlighted the lack of locally available health and welfare-related information.

The aim of the CHAT centre was to provide accessible information and advice, drawing on the skills of a multidisciplinary set of advisers - from both statutory and voluntary agencies - in an informal setting. The advisers - including representatives from Age Concern, Derbyshire Carers, Arthritis Care, social services and the Derbyshire Centre for Integrated Living, health visitors and district nurses - could be seen without an appointment and were available on a regular basis. Community pharmacy was chosen as a suitable venue because of its informal, non-threatening environment. The centre was particularly intended to provide a sign-posting service on social issues and concerns.

To augment this, the CHAT centre also provided leaflets and information on a variety of topics. These included social services, women's health, childcare, elderly care, benefits, welfare rights and young adults. Visitors to the pharmacy were encouraged to take away leaflets and return for verbal advice from an adviser. Advisers were then able to guide visitors toward further advice if necessary. These general sessions were supplemented by specialist events, such as osteoporosis awareness, age concern week, credit unions, your rights and healthy eating.

There are currently nine CHAT centres operating throughout England in Alfreton, Moss Side (Manchester), Burnley, Sandy (Bedfordshire), Netherton, Christchurch, Coventry, Clowne and at Lloyds Head Office (Coventry).

Commentary – motivation and reasons for setting up CHAT centres

The CHAT centres - as conceived by Lloydspharmacy - not only provide free health and welfare resources to customers but have also incorporated a socio-economic model of health. Whilst they recognise that the additional advisory services will add value to the baseline services they provide they also:

> *'Recognise the broader determinants of health, including the socio-economic factors and through a Social Pharmacy approach aim to provide an integrated*

package to help local communities make informed social and health decisions'. [Source: Social Pharmacy, Lloydspharmacy.]

As a key stakeholder explained in an interview, the motivation for this development emerged from the belief that health was influenced by socio-economic factors and that pharmacy could play a much greater role in sustaining and developing local health networks. It was argued that pharmacies are located at the heart of local communities, are accessible to local community members and, crucially, are able to sustain and support equality of access for users.

The social pharmacy concept underpinning this vision has led to a number of networking events and ideas with other statutory and local health and social welfare providers. Lloydspharmacy are also involved in the development and provision of Healthy Living Centres and Education Action Zones, and have funded a health networking conference. They are currently working with the Scarman Trust[57] to raise awareness of their work and to promote health advice and group mentoring, and with the Jewish population in one pharmacy area to support the use of medicines during the period of Passover.

The social pharmacy and CHAT centre model adopted by Lloyds represents a highly interesting and novel approach to public health, particularly with its emphasis on the wider determinants of health and its focus on social care as much as healthcare. At present, there has been limited formal evaluation of these initiatives but they merit further research and evaluation in order to assess their contribution to public health.

Key findings and lessons for future public health initiatives in community pharmacy

1. The Lloydspharmacy CHAT centres offer an ideal opportunity to find out more about public responses to a different layout for consultation areas using premises as a local health resource – particularly relevant given the government's emphasis on total privacy.
2. The model highlights the importance of finding appropriate and accurate sources on which pharmacists can base their advice and information. In this case, the use of a range of local advisers made an important difference to the quality of information given out.
3. This in turn highlights the importance of training – both communication and resource-based – for pharmacists should they be expected to fulfil an information-providing role.
4. The ready accessibility of community pharmacy and the convenience of being able to access advice and information resources without making an appointment also contributed to the success of the project.
5. Economic success? Lloydspharmacy will no doubt evaluate this service in the future.

[57] The Scarman Trust is a national charity committed to helping citizens bring about change in their community. It funds and gives practical assistance to hundreds of people with a 'can do' attitude.

Discussion

According to the survey, innovative projects in community pharmacies cover a wide range of health topics but are highly concentrated in a small number of topic areas. Just three topics – smoking cessation, sexual health (predominantly emergency hormonal contraception provision) and drug use – account for 75% of the UK projects reported. However, the survey response rate was 64% after one reminder and is therefore likely to underestimate the true level of activity. The Pharmaceutical Services Negotiating Committee and National Pharmacy Association project information lists identified a number of additional projects but did not include many of the projects identified through the survey.

The profile of project activity generally reflected areas in which community pharmacies can contribute to the achievement of NHS health improvement targets and, consequently, to reductions in health inequalities. Broad local targets, established on the basis of national strategies, were adapted to respond to specific local needs and circumstances.

The activities reported in the UK fall into two broad categories. The first of these involved direct service provision – usually in the form of treatment for existing conditions (e.g. smoking cessation, supply of emergency hormonal contraception, supervised methadone administration). Case Studies 1 and 2 fall into this category. Such services were developed jointly with the relevant local agencies in primary, community and secondary care, and the existence of national targets often provided the impetus for funding. They tended to involve the selection of a sub-sample of pharmacies to participate, particularly for the introduction of a new service. A targeted approach was used. In particular, for feasibility studies and for providing coverage of specific areas on the basis of socio-economic need, or filling a gap in the existing service provision.

The second category involved the provision of information and advice on specific health topics. These were usually as a preventative or screening measure and often as part of a wider local strategy – with the primary objectives of increasing uptake of other services (e.g. family planning, cervical screening) and raising awareness on specific health issues (e.g. chlamydia infection). Case study 3 – Lloydspharmacy CHAT centres – fell into this category, although the centres were considerably more proactive and readily available than most information services. These projects - particularly for health information campaigns - tended to invite all community pharmacies to participate, although they may also have had a pilot phase or targeted specific areas. Funding for these projects was more difficult to obtain unless they could form part of a broader public health initiative.

Almost all the projects required the pharmacist to have contact with and impart some form of advice or information to the patient. Also, certain projects – such as health screening initiatives – may have begun with information and advice but then involved into some form of follow-up testing, carried out by the pharmacist. For example, blood sugar testing for diabetes. The distinction was primarily one of emphasis. However, it will affect aspects such as the training required for pharmacists to

participate in, and public acceptance of, the services. It may also affect factors such as the funding available for services and the willingness of pharmacists to participate.

Location

All these projects take advantage of the exceptionally easy access to health advice afforded by community pharmacies. The case studies illustrate the vital role pharmacy can have in improving access to services because of its position as a community-based health provider. Better access to and local provision of EHC is important because of the 72-hour time period of effectiveness. Methadone users require a daily dose of their substitution therapy so services based in local areas facilitate take-up. Information and services obtained through pharmacies are generally easier to access than having to make an appointment with a general practitioner. This convenience factor may encourage users to ask for advice over less pressing but potentially serious health issues.

The non-pharmacist stakeholders interviewed in Case Study 2 explained how pharmacy's contact with both the healthy and the sick allows it a unique role in the early diagnosis and identification of disease. Public use of community pharmacies is almost universal and, although use is currently still low for general health advice, it is higher among women, respondents with young children and lower socio-economic groups.[58] This suggests that pharmacies can make a valuable contribution as an information source in the quest to combat health inequalities. Community pharmacy can also fill gaps in service provision from other sources. For example, in the Calderdale and Kirklees district, a smoking cessation initiative[59] aimed to recruit pharmacies in areas not covered by the existing smoking cessation advisors.

Sensitive Stigmatising / Sensitive Issues

Services providing emergency hormonal contraception and supervised consumption of methadone may be associated with a degree of stigmatisation and/or sensitivity for users. This may be exacerbated when the service is provided through specialist agencies because it is identifiable by location. As a generic health provider, community pharmacy does not carry the same stigma, although in the Glasgow case study a high proportion of methadone users did appear to have some concerns about being judged by other pharmacy users.

This reduction of stigma could apply equally to direct service provision and to advice giving for sensitive topics. However, concerns about privacy and confidentiality would have to be addressed first. While most pharmacy users perceive there is sufficient privacy in the pharmacy to discuss even sensitive subjects,[60] around a fifth of users of emergency hormonal contraception, osteoporosis screening and head lice management services had some concerns about privacy.[61]

[58] Blenkinsopp, Anderson & Armstrong, (2003). p.41.

[59] Blenkinsopp, Anderson & Armstrong, (2003). p.35.
[61] Blenkinsopp, Anderson & Armstrong, (2003). p.35.

Consultation Areas

Lloydspharmacy's CHAT centres have selected a model for consultation areas that place the user in the centre of the pharmacy. Government recommendations, meanwhile, in *Choosing Health through Pharmacy: A Programme for pharmaceutical public health 2005-2015* [62] - state that under the new contractual framework for community pharmacy, a consultation area for confidential discussions is required to provide medicines-use reviews (MURs) advanced services. And some locally enhanced services will also require private consultation areas or consultation rooms with additional facilities.

In reality the most appropriate consultation area will depend on the service provided and probably also on the client accessing the service.

Training

Training was provided for 65% of projects identified by the survey and was often a prerequisite for pharmacists to be able to provide the service. Both project organisers and participating pharmacists showed a high degree of commitment to training. However, respondents often provided little detail about the level and extent of training, and details of reimbursement schemes for attending pharmacists were given only in a few cases.

A number of projects mentioned using training material provided by the centrally funded national Centre for Pharmacy Postgraduate Education, such as their Drug Misuse programme. Others used training courses prepared by local authorities. It appears that some project co-ordinators also prepared their own training schemes but further details were not available.

In addition, the evidence base indicated that most pharmacists would feel more comfortable providing information on sensitive issues if they had received training. Particularly training that focused on communication skills and imparting appropriate information.
Reports 1 and 2 of the evidence base[63] make it clear that training - (specifically in smoking cessation) increased knowledge, self-confidence and positive attitudes of pharmacists and their staff. In addition, the training needed for pharmacists involved in drug use programmes included skills in translating technical terms into a more appropriate language for drug users. Report 2 also noted that the public had a high desire to access advice on contraception and sexual health from community pharmacists but rarely asked directly, and pharmacists were reluctant to offer it.[64]

[62] Choosing Health through Pharmacy: A Programme for pharmaceutical public health 2005-2015 (Department of Health 2005)
[63] Anderson, Blenkinsopp & Armstrong, (2003); Blenkinsopp, Anderson & Armstrong, (2003).
[64] Blenkinsopp, Anderson & Armstrong, (2003), pp.16–20.

Likewise, the RPSGB's interim report,[65] highlighted as key enabling/blocking factors both the extent to which pharmacies made full use of the skills of their whole practice team through delegation and training, and also pharmacists' levels of pro-activity and confidence in approaching patients and doctors. Active involvement of trained staff was a common feature among successful projects.[66]

There was some evidence of multidisciplinary training for the projects identified. This was important because we found in Report 2 that joint training improved the extent of sustained joint working between community pharmacists and other members of the primary healthcare team.[67] This was because it helped to break down the traditional isolation of pharmacists, which was mentioned frequently in the case studies' stakeholder interviews. The survey showed that smoking cessation training was often carried out in multidisciplinary groups – a reflection of the projects' close links with broader local and national strategies. Training in emergency hormonal contraception (EHC) provision in Case Study 1 was provided by family planning experts and covered both clinical knowledge and communication skills. Training for a project in Coventry to provide free pregnancy tests[68] was provided by the Family Planning Association,[69] a trained GP and a teenage pregnancy co-ordinator. Training for an accident prevention project in Enfield and Haringey[70] included input from a pharmacist, physician, physiotherapist and primary care manager.

Networking / Linking community pharmacists with national and local strategies

Partnership working with other healthcare professionals provided pharmacists with clinical support and assistance, particularly for the EHC schemes, which were developed in tandem with GPs and local sexual health service providers. Smoking cessation services were also developed alongside other providers. In particular, NHS stop smoking services and GPs. Croydon Local Pharmaceutical Committee worked in partnership with the local authority to provide information boards on topics such as keeping warm in winter. Partnership working is, of course, fundamental to the Lloydspharmacy CHAT centres, which rely on a range of health professionals to provide advisory services.

Pharmacy organisations and integration within the NHS

At a national level, the main pharmacy organisations have begun to focus their efforts on integrating pharmacy into national health improvement strategies. (Public Health: A practical guide for community pharmacists 2004).

PharmacyHealthLink is an independent, registered charity that aims to promote and improve the public's health through pharmacy. In addition to research, the charity

[65] Tann & Blenkinsopp, (2003).
[66] Tann & Blenkinsopp, (2003), pp.1–2.
[67] Blenkinsopp. Anderson & Armstrong, (2003). P.50.

[69] The *fpa* (formerly The Family Planning Association) is a registered charity working to improve the sexual health and reproductive rights of all people throughout the UK. It works with the public and professionals to ensure high quality information and services are available to everyone who needs them.

works on forming networks and coalitions to develop and influence policy, and on providing appropriate training and information to encourage pharmacist involvement in health improvement initiatives and public health. All this work is carried out in the context of national health strategies and agendas.

In addition, the Pharmaceutical Services Negotiating Committee (PSNC) pressed for a strong public health element to the new pharmacy contract and the National Pharmacy Association's (NPA) NHS Service Development Department (created in 1994) responds to the challenges of the changing structure and administration in the NHS. It aims to secure an expanded role for the community pharmacist in the provision of healthcare, to work with local pharmacy leaders to secure adequate funding for that role, and to facilitate the development of services locally. The Royal Pharmaceutical Society of Great Britain includes among its remit responsibility for promoting good practice and providing support for improvement. Its report, *Pharmacy in a New Age*, which responded to changes at a national level also placed substantial emphasis on the public health function of community pharmacy.

Policy changes have also played a part in encouraging community pharmacy involvement in public health initiatives. Health Improvement Plans mention pharmacy with increasing frequency and in Health Action Zones pharmacists have looked carefully at local targets and funding sources and identified ways in which community pharmacy can contribute.

At a local level, successive Government strategies have provided formal opportunities for community pharmacy to become more closely integrated with other players in the healthcare team. For example, in October 2002, Primary Care Trusts in England assumed responsibility for developing community pharmacy services in their locality. Local bodies such as local pharmaceutical committees can lend weight to potential initiatives, particularly where these are compatible with local and national strategic priorities and guidelines. They can also help bridge the gap between individual pharmacists and local health commissioning bodies, ensuring that the needs of both are met. In Glasgow, the Area Pharmaceutical Committee provided the organisational and professional support to liaise with individual pharmacists about their involvement in drug misuse issues and to link with the needs of the Health Board.

Other bodies such as the Pharmacy Development Groups (an initiative of the Royal Pharmaceutical Society of Great Britain) also provide a valuable forum for sharing information and ideas about current and future projects, and can help to co-ordinate efforts to get new initiatives off the ground. The organisation of pharmacists into a Pharmacy Steering Group within the Manchester, Salford and Trafford Health Action Zone provided a forum for discussion and debate about how to take forward the Health Action Zone priorities, and a unified voice to present ideas to Health Action Zone officials. In both these cases, and that of the Glasgow Area Pharmaceutical Committee, the groups played a key role in building partnerships with local authorities – the Health Action Zone in Manchester and the Greater Glasgow Health Board/ Glasgow Drug Problem Service in Glasgow.

Individual leadership

Case Study 1 demonstrated the importance of strong leadership and good project management to champion the cause. All those interviewed constantly reiterated the value of strong leadership. Particularly with innovative projects, there can be formidable barriers to overcome at the outset – not just logistical but also political and inter-professional. Pharmacy has traditionally been isolated from other health professions. So skilled and motivated 'champions' within the profession can help to overcome these difficulties. These key individuals can build links with other healthcare providers with a potential highly positive knock-on effect for concurrent and future projects. The ongoing developments augmenting and extending the provision of drug use services in pharmacy for the Glasgow Case Study corroborated this, as did the experience of providing EHC pilot services in Manchester, Salford and Trafford and Lambeth, Southwark and Lewisham.

Fees and funding

The availability of funding (for example from Health Action Zones and central smoking cessation and drug misuse funding) clearly influenced UK patterns of activity. Pharmacists were paid for taking part in 60% of the projects surveyed and these were most likely to be projects such as smoking cessation, sexual health and drug misuse, where national funding was available.

In Case Studies 1 and 2, participating pharmacists emphasised their enthusiasm for what they perceived was a necessary contemporary health service with an important impact on public health. However, it was also clear that the fees pharmacists received for the supply of services in each case were also an important motivation for their participation – a finding collaborated by the Royal Pharmaceutical Society's report.[71]

In determining the scope of health improvement, consideration must be given to the commercial/business environment and the extent to which financial risk might impinge on the willingness of pharmacy to be more heavily involved in initiatives of this kind. Two-thirds of pharmacists are actually employees and the individual's scope for initiating or taking part in health improvement initiatives is relatively limited. As one stakeholder in the case studies suggested, pharmacy multiple chains can have a large influence on future policy.

Pharmacists' reliance on funding meant that this was a critical factor for the success of Case Studies 1 and 2. Funding was available primarily because both drug misuse and EHC are high profile public health issues with important implications for social care and – in the case of the Glasgow work – crime and public order. Funding bids were supported by thorough evaluation research, audits and the development of clear guidelines and service contracts with the commissioning agencies, all of which were important elements in demonstrating successful outcomes. If the wider provision of these services is to ensue, then funding needs to be available to support these initiatives at a national, as well as at a local level.

[71] Tann & Blenkinsopp, (2003). p.2.

Outcome measures and evaluation

Only half of the projects identified specified outcome measures in their responses. These measures ranged from full academic evaluations to the collection of minimal data requirements – for example, four-week quit rates for smoking cessation or numbers of clients accessing a particular service. Many of the projects identified by the survey had not been properly evaluated. Less than a third reported some results, and evaluation reports or summaries were received from just 3.2%.

The relevance of evaluation to secure funding has already been mentioned. Also, if pharmacy-based projects are to receive recognition when they have an impact on local health targets, they must be properly evaluated and robust evidence of outcomes provided. A successful pilot initiative (which has been demonstrated to be successful, preferably through independent evaluation) is highly influential in determining the uptake and role-out of this type of service within the NHS. For example, many primary healthcare organisations have now taken up the EHC models that were developed in Manchester and in Lambeth Southwark and Lewisham.

Conclusion

Overall the survey showed a reasonable level of community pharmacist involvement in local health improvement work, with the potential for developing and implementing new services on a more widespread basis.

Compared with previous surveys, [72]community pharmacy has clearly begun to engage with the new NHS agenda and many areas have built working partnerships with key local stakeholders. High awareness of developments in the health service was identified as a common trait among innovators by the RPSGB report on innovation.[73]

Smoking cessation, sexual health and drug misuse were the most commonly reported areas of activity. Service design, delivery and remuneration varied between Health Authority areas. Examples from Europe, Australia and North America offer models for diabetes, lipid management, weight management and immunisation schemes that could be adapted and used as the basis for service development in the UK.

There are several key public health areas for which very few projects were identified that have considerable potential for pharmacy participation. For example; obesity programmes would contribute to the national target of reducing coronary heart disease and stroke death rates in people under 75 years of age by at least 40% by 2010.[74] And reduction of overweight and obesity also appears in the cancer plan and is highly relevant to inequality reduction. Similarly, every Primary Care Trust should have

[72] Anderson, C Community pharmacy Health promotion activity in England: a survey of policy and practice. *Health Education Journal* 1996; **55**: 194-202

Anderson C Guidance for the development of health promotion by community pharmacists *Pharm J* 1998; **261**: 771-775

[73] Tann & Blenkinsopp, (2003), p.2.

[74] Department of Health, (1999), p.2.

schemes in place so that older people can get more help from pharmacists in using their medicines.[75]

Significant progress has been achieved since the 1998 survey of activity[76] but it is unclear to what extent primary care organisations will use community pharmacy services to help them meet their health improvement targets in the future and how their performance will be assessed. However, the changes made to the structure of the national pharmacy contracts to support the extended public health role of community pharmacy will certainly facilitate this, thereby reducing the amount of local variation and hence expectations of services available to pharmacy users

[75] Department of Health, (2001), p.27.
[76] Anderson C Guidance for the development of health promotion by community pharmacists *Pharm J* 1998; **261**: 771-775

Recommendations for the successful implementation of public health initiatives in community pharmacy

This research enabled a number of common factors in local health improvement initiatives to be identified that appear to be influential on the success of an initiative.

1. Stating and utilising the advantages of involving community pharmacy

The successful projects described above generally take advantage of a number of factors unique to pharmacy. These include:

a) Community pharmacy's role as a generic health provider. This helps to eliminate potential stigma for sensitive health topics, such as supervised methadone consumption.
b) Community pharmacy's contact with both the sick and the healthy. This allows pharmacists to contribute to preventative efforts such as screening, as well as providing treatment for those who need it.
c) A large local network of pharmacies to facilitate access and opening times to suit patients / customers for their convenience. This is important for projects requiring the patient to make regular visits (e.g. supervised consumption of methadone) or visits at short notice (e.g. emergency hormonal contraception).
d) Where possible, local bodies working on public health issues should initiate and design projects specifically to take advantage of this potential that makes pharmacy a valuable contributor for a wide range of health topics.

1. Planning

In particular Case Studies 1 and 2 illustrate the importance of the following factors:

(a) Sourcing and securing dedicated funding.
(b) Building a committed network of participating pharmacies.
(c) Seeking the support of other health professionals.
(d) Supporting and promoting local pharmacy leadership (project champions)
(e) Facilitating multi-agency networking, partnerships, including service users.

- The chances of obtaining funding are significantly increased by tapping into national agendas and selecting a target that is already an NHS priority, and by making clear in any funding proposals exactly how the project will contribute to meeting both local and national targets.

- Alternative sources of funding may be useful but may be a 'one-off' such as the Royal Pharmaceutical Society's *Pharmacy in a New Age* programme. This may, for example, provide the possibility to employ a programme leader – a vital contributor to project success – to 'kick-start' the project, but longer-term funding will be needed for sustainability.

- Remuneration systems clearly encourage participation and should be set-up where appropriate funding permits. Fees should be arranged in such a way as to reward longer-term commitment and better quality provision of services.

- Pharmacists can also be encouraged to participate through the selection of health topics that are specifically relevant to their local areas and their clients.

- The support of the right organisations and other healthcare professionals is crucial to success and they will need to be consulted and involved early on in the project.

- Using local bodies, such as the Local Pharmaceutical Committees or Pharmacy Development Groups, can provide valuable support for seeking funding and establishing contracts for service provision.

- Approaching local health service commissioners using the language and referring to the targets that they are interested in.

- Knowing the details of the local Health Improvement Programme and identifying relevant topic areas.

1. Implementation

a) Use written patient contracts where appropriate, for example in drug misuse services.
b) Provide a private consultation area in the pharmacy.
c) Carry out careful and thorough evaluation of the service, including users' views.
d) Arrange multidisciplinary training where possible.

- All pharmacy public health initiatives involve interaction with the public and some element of advice and information provision. As the advice-giving role of community pharmacists on general health issues is not widely recognised or utilised,[77] schemes that encourage the public to approach pharmacists may require additional training to encourage pharmacists to be more proactive. Communication skills should constitute a substantial part of any training provision as this will better prepare the reticent pharmacist for contact with the public, will reassure unconfident service users and will translate into better service provision.

- Patient contracts are an effective way of emphasising the commitment inherent in participating in a given scheme.

- Efforts should be made to provide the appropriate environment to facilitate the type of consultation that patients/customers want with their pharmacist. The Case Studies in Report 2 of the evidence base indicate that privacy and confidentiality remain concerns for a significant number of users of pharmacy services and may

[77] Blenkinsopp, Anderson & Armstrong, (2003). p.40.

discourage some people from coming forward.[78] Publicise the pharmacist's duty to ensure confidentiality.

- Efforts should also be made to reduce the stigma associated with certain treatments such as emergency hormonal contraception and methadone by being sensitive to the issues involved. And in particular by providing appropriate privacy, confidentiality and a non-judgemental manner.

- Build careful record keeping into the original project design.

- Outcome measures should be made clear from the start and should reflect government targets wherever possible to allow for later collation of evidence.

- Funds must be allocated in advance to allow for thorough evaluation, and results should be publicised, at least locally. Independent evaluation is always preferable where funding allows.

- Guidelines for service provision should be established in advance and audit should be carried out.

- Training should be consistent to provide a high quality evidence based service. Nationally recognised standards should be used wherever possible but training should also be adapted to specific local projects and to pharmacists' needs.

- Strong signage in pharmacies and other displays of materials encouraging clients to approach the pharmacist should also be used.

[78] Blenkinsopp, Anderson & Armstrong, (2003). p.35–36.

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