Community pharmacy: promoting health and wellbeing

Evidence Reviews – Appendix M

Expert Testimony

FINAL

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National Institute for Health and Care Excellence

Expert Testimony

A. Introduction

Expert testimony is an important source of evidence for guidelines. Experts may be called upon when evidence from published literature is insufficient, where there are gaps in published evidence meaning that review questions may not be fully answered or, where information on context or current practice is needed to inform recommendations.

B. Methods

During initial meetings, the Committee were asked to discuss the development plans and to suggest areas that might benefit from expert testimony. Colloquial evidence from expert testimony was used to complement the scientific evidence or provide missing information on context. The committee discussed the options and suggested experts based on their knowledge of the area and the information they needed. They agreed that evidence could be provided by a mixture of testimony from committee members and invited experts. They agreed on a list of individuals that they asked the NICE team to approach as potential providers of testimony. In all cases this evidence was provided orally by an expert and was discussed and considered by the committee. Section C provides the experts written summary of the testimony they provided. A summary of the areas identified is provided below.

Topics covered

Evidence gaps across specific review areas were flagged to the committee and discussed. The committee identified areas which they felt were inadequately covered by literature and were important in the current context. Specifically, the committee agreed that expert testimony based on current practice, resource impact and context was needed to inform recommendations within the following areas:

- An understanding of the baseline minimum requirements for training to provide insight in to how or what resource or practice impacts their recommendations may be making, and how this core training might enable them to deliver interventions.

- How different types of pharmacies (chain vs independent) make decisions about the interventions or services they deliver and whether or not this differs.
- How community pharmacy currently sits within the 5 year forward view to ensure recommendations were developed and framed within the context of a changing system.
- Variation in the effectiveness and cost effectiveness of interventions for different population groups, in particular:
    - Underserved or underprivileged groups who may not access other healthcare services.
- How to deliver interventions which have the potential to address health inequalities and support local population needs.

C. Expert Testimony Papers

1. Current core training of community pharmacy staff

Section A: Developer to complete	
Name:	Adam Mackridge
Role:	Programme Leader for Postgraduate Pharmacy Programmes & Reader in Public Health Pharmacy
Institution/Organisation (where applicable):	Liverpool John Moores University
Contact information:	[redacted]
Guideline title:	Community Pharmacy: promoting health and wellbeing
Guideline Committee:	Public Health Advisory Committee (PHAC) E
Subject of expert testimony:	Training and competencies of community pharmacy staff
Evidence gaps or uncertainties:	What are the core skills and competencies that pharmacists and pharmacy staff have in terms of providing advice, education and/ or behavioural support services to customers. Specifically answering questions in the following areas: 1. What training do community pharmacists in the UK receive on providing behavioural support or advice such as motivational interviewing, motivational enhancement therapy, and client education? 2. How might the characteristics of the individual delivering the intervention (e.g. their job role, competencies or being a health champion) affect the effectiveness or cost effectiveness of interventions delivered in community pharmacy? 3. Are there any examples of best practice you are aware of by staff with different

levels of training that have resulted in measurable improvements in health and well-being in the UK that relate to the scope outcomes?

4. What do you think are the perceptions of customers regarding the community pharmacy staff providing health and well-being services, or, have you received any feedback from people you have trained about how customers feel about pharmacy staff providing health and wellbeing services; and/or how pharmacy staff feel about delivering these services?

Section B: Expert to complete

Summary Testimony:

A typical community pharmacy will be staffed by a range of individuals with different levels of training. Below is a list of the different categories of staff, along with the main focus of their role:

- **Medicines Counter Assistant (MCA)**
  - Provide advice / support at the medicines counter (medicine and product focussed); may also screen for, or provide, services
- **Dispensing/Pharmacy Assistant**
  - Support dispensing service; may also screen for, or provide, services
- **Pharmacy Technician**
  - Support delivery of pharmacy services – emphasis on technical aspects; more often involved in delivery of services than other support staff grades
- **Pharmacist**
  - Responsible for all activities in the pharmacy, including delivery of services and related interventions

In addition to this, Healthy Living Pharmacies have Health Champions in their team, who take primary responsibility for delivery of the HLP programme within that pharmacy. These are normally a dispensing/pharmacy assistant or pharmacy technician. The only other individuals involved in delivery of pharmacy services are students undertaking training relevant to the above roles.

Under their responsibilities as the regulator of pharmacy premises, the General Pharmaceutical Council (GPhC) set minimum training standards for staff involved in the running of a registered pharmacy. The level of training required builds for each level of staff member, from basic medicines/minor ailment

knowledge at the MCA level, through NVQ training for dispensing/pharmacy assistants (level 2) and Pharmacy Technicians (Level 3) to an Undergraduate Masters qualification for Pharmacists. Pharmacy Technicians and Pharmacists are protected terms and individuals practising in these roles are required to register with the GPhC and are subject to further requirements for Continuing Professional Development following their registration. Also, initial training for these roles is directly regulated by the GPhC.

Currently, pharmacists receive extensive training on communication and consultation skills as part of their undergraduate and pre-registration training programmes. In addition, they are able to access a range of postgraduate training in these topics, but behavioural interventions and psychology of behaviour change is covered to a different extent by the different Masters programmes.

The majority of training for the other staff is focussed on the sale and supply of medicines, although Pharmacy Technicians can also access some of the training on consultation skills that are available to pharmacists via the Centre for Postgraduate Pharmacy Education (CPPE).

Staff at all levels can get involved in pharmacy services relating to health and wellbeing and this may take the form of pre-screening of customers to identify eligible individuals, through to full delivery of an intervention. Most commissioned or privately funded services require some level of service specific training, which may include requirements to complete available study programmes provided by others (e.g. EHC), study of the service protocol, competency assessments and bespoke training delivered by the service commissioner/supplier.

References to other work or publications to support your testimony'

- GPhC Standards for the initial education and training of pharmacists (Standard 10)
- GPhC Standards for the initial education and training of pharmacy technicians
- RPS Foundation Pharmacy Framework
- GPhC policy on minimum training requirements for dispensing/pharmacy assistants and medicines counter assistants
- City & Guilds Level 2 NVQ Certificate in Pharmacy Service Skills – Qualification handbook for centres
- Level 3 Diploma in Pharmaceutical Science Qualification handbook for centres
- Level 3 NVQ Diploma in Pharmacy Service Skills – Qualification handbook for centres
- Consultation skills for pharmacy practice: practice standards for England

2. Decision making process by large multiple pharmacy chains

Section A: Developer to complete	
Name:	Margaret E MacRury
Role:	Superintendent for large multiple pharmacy chain
Institution/Organisation (where applicable):	Rowlands Pharmacy
Contact information:	[redacted]
Guideline title:	Community Pharmacy promoting health and wellbeing
Guideline Committee:	Public Health Advisory Committee (PHAC) E
Subject of expert testimony:	Decision making process by large multiple pharmacy chains regarding health and well-being service provision
Evidence gaps or uncertainties:	1. Provide information and insights into how owners/operators of large multi-location pharmacies make decisions about which health and wellbeing services and interventions they provide for the populations they serve 2. Please consider the following categories of intervention or service provision in your response: • awareness raising/information • advice • education • behavioural support services 3. Please also outline relevant details such as commissioning structure or upcoming high-level organisational changes that may influence intervention delivery
Section B: Expert to complete	
Summary Testimony: When the term service is used in this evidence it refers to health and well-being services. Private services are those offered by a multiple pharmacy company and may be free of charge or there may be a charge for the service. Commissioned services are those commissioned locally, usually by the Local	

Authority (LA) but it does include other commissioners such as Clinical Commissioning Groups (CCG)

There are three considerations before a service is delivered; is it appropriate for the local population, does the service fit the strategic direction of the company and is the service viable.

With regard to the service being appropriate for the local population that is determined by demographic information and the Health Profiles published by Public Health England (PHE). As commissioned services, are commissioned locally, they have been selected due to the relevance of the service for the local population. If advice and health promotion activity is being determined by individual pharmacies, they will use the Health Profiles, to ensure that they are meeting a local need.

Private services provided free of charge by pharmacies e.g. blood pressure measurement may be provided across the whole pharmacy estate as it fits with the strategic direction of the business. All other services including locally commissioned and private services offered by the company will be assessed to determine if the service is commercially viable and is it meeting an evidenced need in the local community. Viability will take into consideration; who is delivering the service, the time taken to deliver the service and the associated administration time, the cost of any equipment required and the remuneration. In some instances targets are set with associated penalties for non-compliance, this will also be considered. Once all the information is known, a strategic decision will be taken; is this service appropriate to be provided from this pharmacy, this is not only a commercial decision but a strategic decision.

The commissioning structure is complicated. The main commissioner for public health services is LA's. However, some LA's contract to one provider who them sub-contracts to a number of third party providers including community pharmacies. There are a number of public health services that are commissioned across the country e.g. smoking cessation, however for the same service; the contracts, more importantly the service specifications (what is required to be delivered), the remuneration method and the remuneration etc. vary between commissioners. This can mean that a service which is viable in one area of the country is not viable in another. If national service specifications were used by commissioners, it would make it easier for the commissioners to manage. It would also facility implementation of the service in multiple pharmacy organisations and potentially would create a national network of locations that could be promoted nationally as the accessible port of call for the service, e.g. smoking cessation is delivered by community pharmacy in Scotland and is promoted as the place to go for the service.

There is a desire to change the way pharmacy is remunerated; paying less for supply and using the remaining funding to provide more services and improve quality. The imposition of the recent contract settlement has made all pharmacy contractors review their business model. I believe, multiples of all

sizes, both national and regional, will consider moving to a hub and spoke model, where the assembly is done off-site from the pharmacy but supply and service will be linked and provided at the local pharmacy location. This could allow community pharmacy to continue to provide services and deliver health promotion. One commissioned service alone does not provide significant income, however a basket of services could help to ensure community pharmacy can still deliver services under the contract funding cuts.

From a Rowlands perspective we have seen benefits to our business in engaging with the Healthy Living Pharmacy (HLP) principles. Originally the HLP programmes were not uniform across England and as our estate covers Scotland and Wales we did not have an equivalent programme to engage with in the other home nations. As HLP was consistent with the Rowlands strategic intent of improving the health and wellbeing of the local communities we serve, we developed HLP into our Elite programme. This took the HLP criteria and added professional standards, operational standards, and key performance indicators, we then assessed our pharmacies against all these standards. Those pharmacies that met all the standards were awarded the status of Elite, and are reassessed every two years. Our Elite pharmacies proactively engage with the local community to discuss health and wellbeing either within the pharmacy or at external events. They are more likely to achieve a Good grading following a GPhC inspection (achieved by ~25% of all pharmacies), they deliver more services than the average Rowlands pharmacy and deliver better against the companies key performance indicators.

HLP status is now one of the Quality Criteria included in the Community Pharmacy Contract.

The commissioning landscape is changing and it is not clear how this will impact community pharmacy delivering services or who will be commissioning the services in the future. Combination of health and social care budgets e.g. either formally in Manchester of informally in Lancashire has led to changes in the commissioner. Sustainability and Transformation Plans (STP's) are also changing local healthcare landscapes and again this could lead to a change in commissioner and provider of services.

Community pharmacy believes it has a positive role to play in the health and wellbeing of the local community. By linking the supply of medicine to the provision of public health services and advice on wellbeing, allows regular access to the public to a health professional without the need for an appointment.

References to other work or publications to support your testimony' (if applicable):

3. Healthy Living Pharmacies

Section A: Developer to complete	
Name:	**Gul Root**
Role:	**Lead Public Health Pharmacist**
Institution/Organisation	Healthy People Team, Public Health England
Contact information:	[redacted] [redacted] *N.B. Gul Root is the PHE Topic Advisor for this guideline.*
Guideline title:	Community pharmacy: promoting health and wellbeing
Guideline Committee:	Public Health Advisory committee (PHAC) E
Subject of expert testimony:	Healthy Living Pharmacies
Evidence gaps or uncertainties:	Please outline any findings from interventions delivered in Health Living Pharmacies that have been found to be effective (or not effective) in health areas where we currently have not identified any evidence. Please ensure the evidence is in scope for the guideline and fall into the following intervention categories (providing **information**, **advice**, **education** and/ or **behavioural support** services). Please also ensure they cover a health area where there are gaps and have reported quantitative/numerical evidence of effectiveness on an outcome of interest as specified in our scope. If possible please also provide information on: • where the interventions took place (for example was it in a deprived community), • whether there is evidence that the people accessing the service are representative of the local community (so if in a deprived community was it people from that community who accessed the intervention and made beneficial changes).

Section B: Expert to complete

Summary testimony:

One of the most significant developments in community pharmacy in recent years has been the emergence of Healthy Living Pharmacies (HLPs), with:

- Qualified health champions, who have completed the Royal Society for Public Health Level 2 award, *Understanding Health Improvement*, who are enthused and motivated to reach out to their communities, to help them improve their community's health
- Pharmacist or manager having been through leadership training.
- Premises that facilitate health promoting interventions.
- Local stakeholder engagement with members of the public, other health and social care professionals, voluntary organisations, charities, all underpinned by quality criteria.
- A pro-active team culture and ethos, with staff pro-actively promoting health and wellbeing messages within the whole pharmacy team, using every interaction in the pharmacy setting for a health promoting or life-changing intervention, making very contact count.
- Innovative delivery models
- Caters for the public health needs of the community
- Consistent high quality service delivery

Evaluation of the HLP pathfinder work programme, published in 2013 (n=1003) showed that:

http://www.instituteofhealthequity.org/projects/evaluation-of-the-healthy-living-pharmacy-pathfinder-work-programme-2011-2012

- 98.3% of people said they would recommend Healthy Living Pharmacies for health promoting interventions to others
- 99% said they were comfortable to receive health promoting interventions in the pharmacy setting
- 60% of people said they would have gone to a GP for the health promoting intervention they received in the pharmacy
- 21% of people said they would have gone nowhere, missing out on opportunities to improve their health

The Community pharmacy offer for health

- Most people go into a pharmacy because they have a health issue
- CPs are more accessible that other health professionals with 1.2 million health related visits everyday
- Some health risk behaviours are more prevalent in people with long term conditions e.g. inactivity
- Community pharmacy teams see many people with long term conditions as they come to collect their repeat prescriptions
- CP teams see people in every state of health and are well placed to play a critical role in the prevention of ill health, early intervention and management, supporting people to stay well

Background

- Until summer 2016, all 3 levels of HLPs were accredited locally by commissioners, initially by PCTs and now LAs resulting in variation of implementation of HLPs, quality criteria and monitoring
- PHE announced move to a profession-led self-assessment process for level 1 HLPs summer 2016
- An HLP registry was established at the Royal Society for Public Health (RSPH), following a formal tender process for a quality assurance process for the profession-led self-assessment process for level 1 HLPs, funded by PHE.
- NHS England announced in February 2017, the inclusion of Level 1 HLPs as one of the criteria for eligibility of the quality payment, which should result in further acceleration

- Since January 2017, 937 pharmacies have registered as level 1 HLPs with the RSPH. The expectation is that the number of pharmacies registered as level 1 HLP will increase significantly by November 2017 when the next quality payment is due. LAs are also implementing HLPs at Levels 2 and 3,

Results from HLP Pathfinder evaluation 2013 showed (Examples of outcomes/outputs form HLPs)**:**

Smoking

- Anyone walking into a Healthy Living Pharmacy was twice as likely to set a quit date and go ahead and quit compared to a non HLP
- Stop Smoking Services - effective and potentially cost effective
- Pharmacy staff performed as well as pharmacists in terms of quits, making the service more cost effective potentially
- Better use of skill mix
- Targeted MURs for respiratory disease identified smokers, a significant proportion of whom went ahead and set quit dates

Sexual health services

- Young women were content to access EHC and associated sexual health services e.g. chlamydia screening and treatment, condom provision
- HLPs delivered more of these services than non HLPs and
- Advice on safe sex was provided in a majority of interactions on EHC and chlamydia screening
- HLPs were more successful at engaging clients in wider sexual health services.

Alcohol interventions

- Pharmacy staff were able to discuss levels of drinking in a non-threatening way
- Customers were able to discuss their concerns with the pharmacy team who felt equipped to deal with the questions
- Pharmacy teams are able to signpost people to other services

Weight management services

- The weight management service was evaluated in Portsmouth
- The service was targeted at a local health need

- Demonstrated acceptability of the service in a CP setting
- Over 40% completed the 6 month course
- Over 25% of participants lost at least 5% of their body mass, in line with NICE guidance

Examples of good practice

Bedminster Pharmacy, Bristol

- One of the first HLPs in the South West
- The pharmacy team is actively engaged in providing healthy lifestyle advice to empower people to make positive changes to improve their health
- Focused on men's health including services tailored to young people.
- Lead pharmacist uses the talents and resources of his diverse team to serve his community, with support from the local council

West Yorkshire

- Pharmacy teams go out of their way to support vulnerable people
- Established a patient participation group (PPG), which drives development of new services such as a weight management group
- Healthy cook book written with recipes from the PPG
- Organised 'family and friends' health walks

Marton Pharmacy, Teeside

- Provides a Healthy Heart service and dietary advice
- Encourages the public to get active, for example by attending park runs
- Provides stop smoking services and an alcohol brief advice service

HLPs the way forward

- PHE announced the move from a totally commissioner led process for all 3 levels of HLPs to a profession-led self-assessment process for level 1 HLPs, with a proportionate QA process – summer 2016
- With enablers, underpinning quality criteria and compliance with a self-assessment process
- The Royal Society for Public Health (RSPH) has been funded by PHE to lead on a proportionate QA process pilot, which also includes the establishment of a registry of community pharmacies that have progressed to the profession-led process for level 1 HLPs since January 2017, following a formal tender process.
- Levels 2 and 3 will still be commissioner-led
- In February 2017, NHS England announced the establishment of a quality payment for level 1 HLPs, which is already helping with acceleration of implementation of HLPs

References to other work or publications to support your testimony' (if applicable):
Evaluation of the healthy living pharmacy pathfinder work programme 2011-2012 Evaluation of the West Yorkshire Healthy Living Pharmacy Programme 2014 An Evaluation of the Tees Healthy Living Pharmacy Pilot Scheme 2013 Prevention and Lifestyle Behaviour change: a competence framework and Healthy Living Pharmacy Framework: the competences

4. Decision making process by independent pharmacies

Section A: Developer to complete	
Name:	Fin Mc Caul
Role:	Pharmacist and MD of a large independent pharmacy.
Institution/Organisation (where applicable):	Prestwich Pharmacy, [redacted]
Contact information:	[redacted]
Guideline title:	Community Pharmacy promoting health and wellbeing
Guideline Committee:	Public Health Advisory Committee (PHAC) E
Subject of expert testimony:	Delivering services within Community Pharmacy: The Decision making process by independent pharmacies (non-chain or multi outlet/national) regarding health and well-being service provision
Evidence gaps or uncertainties:	1. How do independent pharmacies make decisions about which health and well-being services and interventions they provide for the population they serve 2. How to make the services offered more effective, and your perception of the acceptability of these services for your community 3. The staff members who deliver interventions and whether that differs due to the intervention type or other factors 4. In addition any information or expertise you can offer on factors such as: • commissioning structures and interaction with wider primary care colleagues needed to support adoption of these approaches • costs and benefits or resource impact of delivering these approaches • organisational changes or other factors that may influence adoption of these approaches

Section B: Expert to complete

Summary testimony:

When we describe or use the term service within community pharmacy it is broadly broken down into two different types, those provided “free” (NHS and LA) and those paid (private) for by patients and customers directly. We have been focused on delivering services for the last 15 years and see these interventions as something that can make a real difference to patients and customers. We believe that our pharmacy is one of the more successful pharmacies for delivering services in England.

The commissioners of the “free” services are the NHS (national and local area teams), the CCG’s and the Local Authorities. The Public Health services that are included here are Flu Vaccinations, Stop Smoking Services (SSS), Emergency Hormonal Contraception (EHC), National Diabetes Prevention Program, Supervised Consumption and Syringe Exchange, Chlamydia screening & treatment as well as CCG based services like Minor Ailment Schemes and improving medication understanding and adherence (MUR’s and NMS). We also offer support and detection services like free Blood Pressure measurement. We find this helps patients understand their medication better and has also been used to detect AF (we use a NICE recommended BP machine). Private services where patients and customers pay personally for the intervention include: weight loss, chiropody, hearing testing and the provision of a hearing aid, counselling and CBT therapy and mindfulness.

We determine a need for the services either through the service being offered by Public health and the Local Authority, by looking at the Pharmaceutical Needs Assessment and or the JSNA, or by seeking requests from patients and customers. We will also understand the strengths of the team and if a pharmacist or staff member has a keen interest and a service can be developed this would be an option. Sometimes we will see to have a trial an error approach to the provision of services – if the patients and customers like them we would develop further from there.

However, there are real challenges in running a lot of services. Not just from a viability perspective, also from the understanding and acceptance of patients and customers, as well as the ability of staff to manage and promote/help patients understand.

From our experience there are some key elements to delivering successful services:

Uniformity- a service needs to be the same, or very similar across a wide patch (e.g., Greater Manchester v's Bury) – this enables wider awareness and uptake from patients and staff alike.

Simple and Consistent- The service needs to be simple to run, this will enable consistency across a wider patch. Commissioners quite rightly often want more, or better value. However, if the core product is not delivered then this will cause the service to fail.

Mechanisms for holding to account- This is both from a commissioner perspective and within the pharmacy. We hold staff members to account for delivering services – each staff member owns a service.

2-3-4 way agreements- Between the purchaser (i.e. PH or CCG), the provider (CP) and the patient – helps the patient buy in and accepts this is not a "free" service.

Appropriate training and support- Currently most training given as a one off and CP left to deliver. This does not work in any change process and is a critical element of success for ongoing uptake and delivery of services.

Tools to succeed- Marketing and promotional materials are required.

Celebrate success- Nothing gains more success that celebrating success.

Current commissioning provides for very little if any of the above, with some notable exceptions.

We look at the whole team when delivering a service. While one person will own and be responsible for the service, it is only with a team approach that we can deliver both quantity and quality. We have a focused approach on health promotions with regular, featured messages that we try and keep as simple as possible. We try and promote health/lifestyle changes rather than services – this helps both staff and patients have different conversations. We have trained different members of the team on Brief Interventions, Motivational Interviewing and Shared Decision Making. This has aided improved quality in both the discussions with patients and in outcomes – e.g., improved and sustained weight loss and smoking quits.

I have no doubt community pharmacy is the best place to deliver health and wellbeing services. However, for the success of these services to improve some changes are required.

Commissioning should take place with an eye on outcomes rather than activity and should be commissioned with support – potentially using the local Pharmaceutical Committee to train and deliver the service.

Understanding need to be given to the CCG and PH split in terms of cost and benefit – particularly relevant to SSS. There are added cost benefits to including CP in this role. This has been highlighted in the PWC report.

Use a national specification with local adoption and minimal changes.

Healthy Living Pharmacy has made a difference to CP. We have operated as a HLP pharmacy in our ethos for the last 20 years, before HLP was really named as such. From our experience is takes time for patients to change behaviours.

Linking these interventions to medicine supply is a good opportunity, not just intervene, to impact on patients. Often it is when they are most open to change messages and to accepting support from a trusted health professional.

References to other work or publications to support your testimony' (if applicable):

5. Community pharmacy & health inequalities

Section A: Developer to complete	
Name:	Adam Todd
Role:	Academic
Institution/Organisation (where applicable):	School of Pharmacy, Newcastle University
Contact information:	[redacted]
Guideline title:	Community pharmacy to promote health and wellbeing
Guideline Committee:	Public Health Advisory Committee (PHAC) E
Subject of expert testimony:	Community pharmacy & health inequalities
Evidence gaps or uncertainties:	Please provide information, evidence and your expert opinion on: 1. Variation in the effectiveness and cost effectiveness of interventions for different population groups, in particular underserved or underprivileged groups. 2. How to deliver services which have the potential to address health inequalities within community pharmacy

Section B: Expert to complete

Summary Testimony:

Health inequalities remain a significant challenge for our society: for example, in the small borough of Stockton-On-Tees in the North of England, the gap in male life expectancy between the most affluent and deprived areas is 16 years. [1] Beneath these figures lie significant differences in health behaviours: evidence shows smoking cigarettes, unhealthy eating and excessive alcohol consumption is more common in deprived communities, compared to more affluent ones. As these behaviours are major risk factors for developing certain diseases, individuals living in deprived areas are more likely to die from liver disease, cardiovascular disease and some cancers.

In addition to these unhealthy behaviours, there are also other factors that influence health, including the biological, social and political determinants.[2] In the model proposed by Dahlgren and Whitehead, access to good healthcare is considered an important social determinant of health.[2] Having equitable access to healthcare is challenging in the context of heath inequalities, as the Inverse Care Law, first published by Tudor Hart in the 1971, states "the availability of good medical care tends to vary inversely with the need for the population served", meaning people living in the most deprived areas of our society have poorer access to healthcare, compared to those living in most affluent areas.[3] Research suggests that the Inverse Care Law is still problematic in our society, with recent examples including the uptake of childhood vaccination [4], GP consultation times [5], waiting times for surgery,[6] and the management of depression.[7]

Research has shown that community pharmacies are different, and do not follow the model of the Inverse Care Law: in fact, community pharmacy distribution is the opposite of the Inverse Care Law, a finding termed the Positive Pharmacy Care Law – whereby access to community pharmacies is greatest amongst our most deprived communities. [8] Indeed, in the most deprived areas in England, almost 100 per cent of the population can reach a community pharmacy within 20 minutes walk. Community pharmacies are also more accessible than GP practices, making them the most accessible healthcare provider in England.[9]

Other qualitative work suggests that, in addition to physical accessibility, other factors are important when a person uses, or thinks about using, a community pharmacy for healthcare and public health services; the research also notes a number of contrasting differences when compared to accessing GP services:[10]

- Relationships (people form a relationship with the pharmacist that is perceived as different to a patient/doctor relationship; people using community pharmacies do not consider themselves as 'patients')

- Time (people believe pharmacists have more time to speak about certain things – often those associated with unhealthy behaviours, such as smoking, compared to other healthcare providers, such as GPs)

- Empowerment (as a community pharmacist was available without an appointment, people felt empowered to look after their own health)

- Awareness (many people are unaware of the extended role of the community pharmacy, and this was perceived as a barrier to accessing their services)

To consider public health services delivered in a community pharmacy setting, it is known that smoking cessation services are effective, weight management

services have a mixed evidence base, while there is no evidence for alcohol reduction services delivered in such a setting[11]

In view of the reach of community pharmacy – particularly in the most deprived areas – these services, therefore, have the potential to reach people that other healthcare providers cannot.

Considering that 'unhealthy behaviours' are more common in deprived communities, using community pharmacies as a platform to deliver public health services targeting these behaviours has the potential to reach people that need care the most, and thus potentially impact on health inequalities.

At present, however, and despite this potential, it is not yet known how the effects of community pharmacy services are influenced by the type of person using it (for example, how ethnic group, age, or socio-economic status of a person influences the effectiveness of the intervention).

This is an important area for future research, as it will help determine if community pharmacy services can be used through either targeted (i.e. interventions used exclusively for low socioeconomic status groups) or gradient approaches (i.e. universal interventions that work better for low socioeconomic status groups) to potentially tackle inequalities in health.

References to other work or publications to support your testimony' (if applicable):

[1] Bambra C. Health divides: where you live can kill you. Policy Press. 2016. Bristol. ISBN: 978-1447330356.

[2] The Dahlgren-Whitehead rainbow. Available at: http://www.esrc.ac.uk/about-us/50-years-of-esrc/50-achievements/the-dahlgren-whitehead-rainbow/ (accessed 15.08.2017)

[3] Tudor Hart J. The inverse care law. *Lancet.* 1971;***297***:405–412.

[4] Lynch, M. Effect of practice and patient population characteristics on the uptake of childhood immunizations. *Br J Gen Pract.* 1995; **45**(393): 205–208.

[5] Stirling AM, Wilson P, McConnachie A. Deprivation, psychological distress, and consultation length in general practice. *Br J Gen Pract.* 2001; **51**(467): 456–460.

[6] Pell JP, Pell AC, Norrie J, Ford I, Cobbe SM. Effect of socioeconomic deprivation on waiting time for cardiac surgery: retrospective cohort study. *BMJ.* 2000;**320**(7226):15-8.

[7] Chew-Graham CA, Mullin S, May CR, Hedley S, Cole H. Managing depression in primary care: another example of the inverse care law? *Fam Pract.* 2002;**19**(6):632-7.

[8] Todd A, Copeland A, Husband A, Kasim A, Bambra C. The positive pharmacy care law: an area-level analysis of the relationship between community pharmacy distribution, urbanity and social deprivation in England. *BMJ Open.* 2014;**4**(8):e005764.

[9] Todd A, Copeland A, Husband A, Kasim A, Bambra C. Access all areas? An area-level analysis of accessibility to general practice and community pharmacy services in England by urbanity and social deprivation. *BMJ Open.* 2015;**5**(5):e007328.

[10] Lindsey L, Husband A, Steed L, Walton R, Todd A. Helpful advice and hidden expertize: pharmacy users' experiences of community pharmacy accessibility. *J Public Health.* 2016 Sep 2. [Epub ahead of print, doi: 10.1093/pubmed/fdw089]

[11] Brown TJ, Todd A, O'Malley C, Moore HJ, Husband AK, Bambra C, Kasim A, Sniehotta FF, Steed L, Smith S, Nield L, Summerbell CD. Community pharmacy-delivered interventions for public health priorities: a systematic review of interventions for alcohol reduction, smoking cessation and weight management, including meta-analysis for smoking cessation. *BMJ Open*. 2016;**6**(2):e009828.

6. Five year forward view for Pharmacy

Section A: Developer to complete	
Name:	Jane Devenish
Role:	Practitioner
Institution/Organisation (where applicable):	Well Pharmacy
Contact information:	[redacted]
Guideline title:	Community Pharmacy: promoting health and wellbeing
Guideline Committee:	Public Health Advisory committee (PHAC) E
Subject of expert testimony:	Five year forward view for Pharmacy
Evidence gaps or uncertainties:	How does community pharmacy sit within the NHS 5 year forward view In particular: 1. What are the strands of the Community Pharmacy Forward View (CPFV) which fit within our areas of effectiveness evidence (see key issues and question [section 1.5] in the scope)? 2. What change in current practise will the CPFV require 3. How does the provision of public health and health promotion services in a community pharmacy setting fit within the plan?

Section B: Expert to complete
Summary Testimony: The Community Pharmacy Forward View (CPFV), published in September 2017, sets out the common vision from community pharmacy owners and leaders on how they believe they can improve the health of the population and respond to the challenges currently facing health and social care. It is an initial vision, framework for change and commitment from those stakeholders to working differently and more effectively and was published to stimulate discussion and development from others within the health and social care system. It has deliberately been kept achievable and realistic, with everything

described being delivered or developed today, with a view that greater consistency is need to effectively support the health and social care systems.

Three core domains are laid out that describe the future role of community pharmacy:

1. The facilitator of personalised care for people with long-term conditions
2. The trusted, convenient first point of call for episodic healthcare advice and treatment
3. The neighbourhood health and wellbeing hub.

The four areas of effectiveness evidence being examined by the committee would be supported by all 3 domains in the CPFV, with public health not sitting on its own in the vision, but integrated into the care that the sector expects to be able to provide to every patient, every day.

Raising awareness of health promotion campaigns

The CPFV suggested that, “Everyone will be able to rely on a community pharmacy to provide information and advice about healthy lifestyles in a safe, professional and friendly environment”

Providing education and advice on how to keep healthy

Trained colleagues in community pharmacy will be able to help patients and the public to make sense of the vast amounts of information available, so that it is relevant and personalised. “Anyone can access high quality, personalised support for lifestyle and behaviour change” and staff will be “Familiar with range of products and devices that people use to help them keep well, and trusted to provide evidence-based advice to maximise benefit and align with other services”

Offering behavioural support for self-care to promote health behaviour change.

The CPFV would see pharmacy staff as being, “Supportive and knowledgeable, and will help (the public) to take their own decisions” and of course links into offering, “high quality, personalised support for lifestyle and behaviour change”.

Referral or signposting people to other services or support.

The CPFV sets out its vision that community pharmacy should enjoy, “Great connections with other organisations that support health, wellbeing and independence – ranging across local community groups, charities, places of worship, leisure and library facilities”

Change will be needed to realise the CPFV. A subsequent paper ‘Making it Happen’ relating to the implementation of the vision was published earlier this year. It elaborates on how we should be able to deliver on this vision of integrated community care by breaking down the path to the CPFV into stages and summarises the types of actions that could be required to move from one stage to the next.

The changes identified by the community pharmacy owners and leaders relate to:

- **Capability:** Workforce development, national standards and commissioning models

- **Capacity:** Improved consistency and new ways of working
- Integration: Local leadership, relationships with partners and commissioners
- **Change management:** to normalise the use of pharmacy to deliver public health interventions to the public, integration with other partners, to ensure that any programme is achievable and well planned.

Community Pharmacy has made a great start in many of these areas by the wide-scale adoption of the Health Living Pharmacy framework and is open to working with partners within health and social care to develop our contribution further.

The committee asked whether there was specific money set aside to make the CPFV a reality. There is not a specific pot of money for this development, it is a paper setting out the sector's views. However, when the funding for community pharmacy was cut for 2017-18, a Pharmacy Integration Fund was set up to support the transformation of pharmacy, including the integration and development of a modern community pharmacy service. It would be reasonable to expect that the sector would support the use of this fund to make the changes that it suggested in the CPFV. In addition, system-wide funding should include pharmacy and be available to support the CPFV domains where greater integration and development would support the wider health and social care system.

References to other work or publications to support your testimony' (if applicable):

https://cpfv.info/

Pharmacy Voice, Prescribing Services Negotiating Committee & Royal Pharmaceutical Society. Community Pharmacy Forward View. Last accessed Oct 2017. https://futureofpharmacyblog.files.wordpress.com/2016/09/cpfv-aug-2016.pdf

Pharmacy Voice, Prescribing Services Negotiating Committee & Royal Pharmaceutical Society. Community Pharmacy Forward View Part II – Making it Happen. Last accessed Oct 2017. https://futureofpharmacyblog.files.wordpress.com/2017/01/cpfv-making-it-happen.pdf

3. Expert Testimony and Evidence

Expert Testimony	Gaps addressed	Recommendations supported
1: Training and competencies of community pharmacy staff	Core skills and competencies that pharmacists and pharmacy staff have in terms of providing advice, education and/ or behavioural support services to customers	1.1.2; 1.1.3
2: Decision process by large multiple pharmacy chain regarding health and well-being services provision	Provide information and insights into how owners/operators of large multi-location pharmacies make decisions about which health and wellbeing services and interventions they provide for the populations they serve Please consider the following categories of intervention or service provision in your response: • awareness raising/information • advice • education • behavioural support services Please also outline relevant details such as commissioning structure or upcoming high-level organisational changes that may influence intervention delivery	1.1.2; 1.1.3; 1.1.4; 1.5.1
3: Healthy living pharmacies	Findings from interventions delivered in Health Living Pharmacies that have been found to be acceptable or accessible by members of the public (qualitative evidence only).	1.2.1; 1.1.3, 1.1.4; 1.1.7.
4: Decision making process by independent pharmacies	How do independent pharmacies make decisions about which health and well-being services and interventions they provide for the population they serve How to make the services offered more effective, and your perception of the acceptability of	1.1.1; 1.1.7; 1.5.1

	these services for your community The staff members who deliver interventions and whether that differs due to the intervention type or other factors In addition any information or expertise you can offer on factors such as: • commissioning structures and interaction with wider primary care colleagues needed to support adoption of these approaches • costs and benefits or resource impact of delivering these approaches • organisational changes or other factors that may influence adoption of these approaches	
5: Community pharmacy & health inequalities	Variation in the effectiveness and cost effectiveness of interventions for different population groups, in particular underserved or underprivileged groups who may not access other healthcare services. How to deliver interventions which have the potential to address health inequalities in community pharmacies	1.1.4, 1.4.2, 1.4.3
6: Five year forward view for Pharmacy	Horizon scanning to identify and anticipate system changes and opportunities to the recommendations are consistent and consider the 5 year forward view. The consider how the development of community pharmacies as health and wellbeing hubs within existing and newly developing care and	1.1.1; 1.5.1

	referral pathways may prepare community pharmacy to meet the challenges of future service provision.	