



Public Health
England

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VISION, VOICE AND PRACTICE

Building Capacity:

realising the potential of community pharmacy
assets for improving the public's health



Contents

Section	Page
1. Foreward	3
2. Executive summary	4
3. Introduction	5
4. The role of community pharmacy – the evidence	6
5. Methodology	11
6. Perceptions of pharmacy	11
4.a. The view from commissioners	11
4.b. The view from pharmacists	13
7. What is stopping pharmacy from realising its full potential?	15
5.a. Capacity and capability	15
5.b. The tendering process	16
5.c. Commissioning landscape – challenges and opportunities	17
5.d. A lack of awareness	21
8. Conclusion and recommendations	25
9. Appendix	26
10. References	32

Foreword

The future of the NHS remains the subject of fervent discussion across the country, from senior Government officials to healthcare workers and members of the public; ensuring the long-term future and sustainability of this much valued institution is of vital importance to us all.

As the old adage goes, 'prevention is better than cure', and the NHS Five Year Forward View is clear in its assertion that a radical upgrade in prevention and public health is integral to a more efficient and effective health service for the future.

Over the past few decades, public health has already achieved remarkable milestones, from declining smoking rates to the virtual eradication of some infectious diseases. Nevertheless, with rising levels of avoidable illness, such as diabetes and cardiovascular disease, many challenges remain.

With ever-increasing demand on the healthcare system, alongside growing financial pressures, many healthcare professionals are stretched to breaking-point with little capacity to take on additional preventative work. In this climate, it is essential that we look to others in the wider public health workforce who have the expertise, opportunity and capacity to undertake this vital health improvement role.

Few settings are as ready and willing to assume this role as community pharmacy. With a long track record of health promoting interventions, a place at the heart of local communities and most importantly, the trust and support of the public, community pharmacy offers an ideal setting to reach out to the public to improve their health by providing crucial health support and advice. This has been demonstrated by the many examples of innovation and best practice exhibited by pharmacy teams across England. This is particularly true of Healthy Living Pharmacies, with their trained health champions reaching out to communities, making a real difference to people's health and helping to tackle health inequalities.

This joint report between the Royal Society for Public Health and Public Health England, with support from the Pharmacy and Public Health Forum, seeks to build on these examples, taking an in-depth look at the effectiveness of community pharmacy in promoting the public's health and seeking to understand the opportunities and challenges currently faced by pharmacy teams delivering public health services. By canvassing the views of pharmacy team members, local pharmaceutical committee (LPC) chief officers and commissioners, we have sought to provide a unique insight into the place of pharmacy in the commissioning landscape.

Prevention is the key to the future of the NHS; to realise this, however, we need a radical shift in how we view and approach health and healthcare. We hope that this report will provide a snap shot of the progress made so far and, critically, highlight further steps that need to be taken to ensure the full utilisation of pharmacy teams in promoting the public's health.



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Executive summary

- With a workforce in England including approximately 42,990 registered pharmacists and 19,311 registered pharmacy technicians, a community pharmacy teams have considerable potential for promoting the public's health.
- Community pharmacies, numbering roughly 11,647,^a arguably offer an ideal location to reach out to local communities, with qualified teams providing healthy lifestyle advice and services in an accessible and convenient way.
- Through this joint report, the Royal Society for Public Health and Public Health England sought to look in greater depth at the role of community pharmacy in promoting the public's health, particularly exploring what makes pharmacy an appropriate location for health promoting interventions, the opportunities for further utilisation and also the challenges experienced by pharmacy teams.
- For this report, we utilised a survey, semi-structured interviews and focus groups with pharmacy team members, local pharmaceutical committee (LPC) chief officers and commissioners from local authorities, clinical commissioning groups and NHS England.
- Building on previous publications, this report demonstrates the appetite of pharmacy teams for adopting a greater public health role, and the support of commissioners, particularly those in local authorities, for achieving this.
- Many pharmacies across the UK are now commissioned to provide a wide range of public health services and advice, including, but not limited to, smoking cessation services, weight management services and NHS Health Checks. However, this report also highlights the strong feeling amongst pharmacy team members and commissioners alike that pharmacy is currently being under-utilised and indicates a number of challenges to overcome this.
- These challenges include the issue of capacity in terms of insufficient training and lack of appropriate facilities. Our report findings suggest that some pharmacy teams feel they have insufficient time to dedicate to public health, meaning that attending training, participating in meetings and providing public health advice and services can at times be difficult.
- A further challenge is presented by the commissioning landscape itself, with some respondents and interviewees highlighting the comparative absence of pharmacy from this process and the difficulty posed by a perceived lack of pharmacy champions.
- Alongside this, our findings suggest that a lack of awareness and understanding amongst commissioners and the public continues to present a difficulty for both commissioning and service uptake. Consequently, many respondents called for more joint meetings, joint training and a greater focus on communicating pharmacy's health improvement role.

a) Information from the General Pharmaceutical Council

b) Health and Social Care Information Centre. General Pharmaceutical Services, England 2004-05 to 2013-14. Available online at: <http://www.hscic.gov.uk/catalogue/PUB15933/gen-pharm-eng-201314-Report.pdf> (2014, last accessed on 7th July 2016)

Introduction

In 2008, the White Paper, *Pharmacy in England – Building on Strengths, Delivering the Future*,¹ laid out a clear vision for pharmacy, in which it was to become a community hub for leading healthier lives; a location in which the public could not only get their medicines optimised and supplied, but could also receive advice on a wide range of health issues and access to a variety of public health services.

It stated that;

‘Pharmacies will become healthy living centres: promoting and supporting healthy living and health literacy; offering patients and the public healthy lifestyle advice, support on self-care and a range of pressing public health concerns; treating minor ailments and; supporting patients with long-term conditions.’¹

Since then, this movement has continued apace, with many community pharmacies in England, including over 2100 Healthy Living Pharmacies (HLP), with over 3500 qualified health champions,^a pro-actively reaching out to communities from within the pharmacy and through outreach in schools, workplaces and community centres, promoting healthy lifestyles via brief advice, signposting and public health service provision.^{2,3}

The role of pharmacy teams in promoting healthier lifestyles has never been more important; the UK is facing rising levels of obesity, persistent rates of unhealthy behaviours, such as excessive alcohol consumption and smoking, alongside increasing levels of lifestyle-related conditions, such as diabetes, with potentially disastrous consequences for the NHS. This has led to a growing recognition, both within the UK and elsewhere, of the critical importance of prevention. In 2014, the NHS Five Year Forward View, for example, called for a ‘radical upgrade in prevention and public health’.⁴

To achieve this however, we must look beyond the core public health workforce and instead, look to other community assets with both the expertise and opportunity to promote the public's health. This was the motivation behind the Royal Society for Public Health's (RSPH) report, *Rethinking the Public Health Workforce*, published in 2015.

Working alongside the Centre for Workforce Intelligence, and supported by Public Health England (PHE), Department of Health and Health Education England, this report sought to map out the ‘wider public health workforce’; a workforce comprised of individuals who may not be public health specialists or practitioners, but have the ability to positively impact health and wellbeing, identifying pharmacy teams as leading the way, alongside four other ‘early adopter’ groups.⁵

There is a growing evidence base demonstrating not only the clear appetite of pharmacists and their teams to adopt this role, the tangible support and trust from the public, but also the effectiveness with which pharmacy is promoting the public's health across the UK. The NHS Five Year Forward View for example, called for greater use of pharmacies in helping patients to ‘get the right care, at the right time, in the right place’.⁴

Nevertheless, in some areas, progress has been slow, with some suggesting that pharmacy teams are being under-utilised, and occasionally overlooked in favour of other service providers.

Through this joint report, RSPH and PHE have sought to understand this variable utilisation of pharmacy, by exploring the challenges and also opportunities experienced by pharmacy teams. As part of this work, we have sought to capture the views of both pharmacy teams and commissioners and provide a snapshot of pharmacy's place in the commissioning landscape. This report provides an overview of the key findings, seeking to raise the profile of community pharmacy for public health commissioners and highlight some key recommendations for the future of pharmacy engagement in public health.

a) Trained in the RSPH Level 2 Award in Understanding Health Improvement.

The role of community pharmacy – the evidence

Embedded within local communities, pharmacy teams come into contact with a large cross-section of the public each year.

Receiving an estimated 1.2 million health-related visits every day, community pharmacies are a central part of a community's social capital, offering support on a range of health issues, and potentially, relieving the burden on over-stretched health services.

Through the Community Pharmacy Contractual Framework (CPCF), health promoting activity is already an integral part of a pharmacy's role, including for example, prescription-linked healthy lifestyle advice and interventions, such as promoting smoking cessation and where necessary, signposting to other health services. Many pharmacies, however, are commissioned by local authorities to deliver public health services above and beyond this, including, for example:

- Weight management service
- Substance misuse service
- Alcohol interventions and brief advice service
- Chlamydia screening and treatment
- Emergency hormonal contraception
- Falls prevention service
- NHS Health Checks
- Stop smoking service

Community Pharmacy Contractual Framework

Three levels:

Essential services: which all community pharmacies in England are required to provide, including -

- Dispensing
- Repeat dispensing
- Electronic prescription services
- Disposal of waste medicines
- Prescription-linked lifestyle advice
- Signposting
- Support for self-care
- Engagement in six public health campaigns a year

Advanced services, including -

- Medicines-use reviews
- New medicine service
- Appliance-use review service
- Stoma appliance customisation service
- Seasonal flu vaccination service

Enhanced services: commissioned by NHS England, including -

- Minor ailments management
- Care home services
- Out-of-hours services
- Supplementary and independent prescribing
- Emergency supply service
- Disease specific medicines management

Source: Pharmaceutical Services Negotiating Committee. Community Pharmacy Contractual Framework. Available online at: <http://psnc.org.uk/contract-it/the-pharmacy-contract/>

The capability of pharmacy teams in promoting the public's health is demonstrated by the Healthy Living Pharmacy (HLP) concept and framework, aimed at ensuring a high standard and consistent delivery of pharmacy-based services. First piloted by seven pharmacies in Portsmouth between 2009-2010, this framework consists of three tiers of commissioning, level 1 – health promotion, level 2 – disease prevention and level 3 – health protection, with each tier progression requiring an increasing level of expertise and complexity of service provision. Since 2010, the concept has been expanded countrywide with more than 2100 HLPs accredited or on route to becoming accredited, and more than 3500 qualified health champions.^{8,3}

Alongside the expansion of pharmacy's public health role, there has also been a growth in the number of studies examining both the effectiveness of services delivered by HLPs and community pharmacy more generally. This report will seek to build on this research, by not only considering the potential of pharmacy, but also highlighting the support required to help pharmacy reach this potential.

Case Study

Healthy Living Pharmacy breast cancer awareness afternoon tea, Marton Pharmacy, North East

“In June 2015, we followed the national Be Clear on Cancer breast cancer awareness campaign in the 70+ age range. We hosted a ladies day in store and gave out teas, coffees and home-made cakes. The event was a one-day event, however we campaigned throughout the month, including putting leaflets on staff notice boards and in pay slips to ensure they had had a check recently too.

Our aim was simply to raise awareness of breast cancer, make people be comfortable to speak openly and allow people to see how we are easily accessible for information. From this event we have built some new relationships, we have encouraged ladies who thought they didn't need to check anymore to start to do so on a regular basis, we even spent time with a grandma and grand-daughter, who was only 6... it was enlightening to be able to speak openly to them both about this topic and the little girl insisted she would get her mum to check when they got home!”

Public trust and support:

Research has firstly, been undertaken into the public's willingness to receive health support in a pharmacy, with several studies demonstrating the considerable receptivity of the public to pharmacy-based services. Opinion polling conducted by the General Pharmaceutical Council with Ipsos MORI, for example, found that almost nine in ten (87%) would trust the health advice of a pharmacist, just behind opticians (88%), dentists (90%) and nurses (91%).⁹

A study conducted by Saramunee et al,¹⁰ which focused on the Sefton area of Liverpool, similarly found that just under two-thirds of participants would consider receiving various types of health check (for example, blood pressure checks) in a pharmacy, declining slightly for lifestyle advice to one in five respondents.

Additionally, service-users consistently report high levels of satisfaction; the evaluation of the HLP Pathfinder programme published in 2013 for example, found that 99% of respondents reported feeling comfortable accessing the service in a pharmacy, 98% stated that they would recommend the service to a friend and 80% reported that the service was 'excellent'.¹¹ A study by Parsons et al,¹² examining a pharmacy-based oral contraception service in Southwark and Lambeth, similarly found that the majority of users were either satisfied or very satisfied with the service and felt comfortable discussing the topic with a pharmacist.

Location:

Pharmacies are often at the heart of local communities, based in town centres, high streets, supermarkets and shopping centres, offering people an accessible location, with the added convenience of weekend opening times. Anderson and Thornley¹³ found that 61% of individuals who participated in a pharmacy-based vaccination programme in Sheffield stated that convenience was their primary reason for accessing the service in a pharmacy, as opposed to other possible locations. Participants also praised pharmacy for ease of access and lack of an appointment system. An evaluation of the flu vaccination service in West Yorkshire found that, of the 8046 vaccinations delivered by 181 pharmacies, 17.9% were provided at the weekend or 'out of hours' (before 8am or after 6pm).¹⁴

This convenience was most clearly demonstrated by Todd et al,¹⁵ who found that a staggering 90% of the population live within just a 20-minute walk of a pharmacy, increasing to 99.8% for those in the most deprived communities, thus demonstrating not only the accessibility of pharmacy, but also its potential to target health inequalities by reaching those experiencing disproportionately poor health outcomes and providing support they may not receive elsewhere.

Environment:

The pharmacy environment itself, and the anonymity it offers, may also provide a location that is more conducive to discussing health issues and reaching groups typically seen as 'hard to engage', for whom visiting a GP surgery may be an intimidating experience. The 2013 evaluation of the HLP programme for example, found that 20% of individuals surveyed stated that they would not have accessed the service elsewhere and would therefore, have missed the opportunity to improve their health.¹¹

Effectiveness:

As well as demonstrating public support, there is also evidence demonstrating the effectiveness with which pharmacy teams deliver public health services. One of the most popular pharmacy-based services is smoking cessation - an evaluation of HLPs found that, following their introduction in Portsmouth, there was a 140% increase in successful 'quits', with individuals entering a HLP being twice as likely to set a successful quit date and achieve a four-week non-smoker status as those entering a pharmacy that is not a HLP.¹⁶

These findings are corroborated by a recent evidence review, which found that pharmacy-delivered smoking cessation interventions have proved to be an effective and cost-effective approach when compared with 'usual care'. Pharmacy-delivered weight management interventions were also found to be equally as effective as similar initiatives delivered in other primary care locations.¹⁷

Brown et al¹⁸ also found that pharmacy-based methadone administration services and needle exchange services received high attendance and proved to be a cost-effective approach. An evaluation of HLPs in West Yorkshire similarly found that over half of service-users reported having greater confidence in making healthy lifestyle changes following support from a pharmacy.¹⁹

This research highlights the potential of pharmacy teams for relieving the growing burden on other health care services, particularly GPs, through both the direct provision of services and also, helping to prevent avoidable illness. The review of HLPs in West Yorkshire found that had the service not been available in a pharmacy, 60% of respondents indicated that they would have accessed it from a GP instead.¹⁹

Case Study

Community Pharmacy West Yorkshire Development Academy

“In 2013, the Community Pharmacy West Yorkshire Development Academy was initiated; its aim to develop the skills, learning and resources of all West Yorkshire community pharmacy staff in medicines optimisation, public health and patient wellbeing, with a focus on improving Healthy Living Pharmacies.

The Academy provides face-to-face training, a website, on-line resources and social media, accessible by the whole pharmacy team.

Between April 2013 and February 2016, there were a total of 6669 attendances at 146 events covering 58 different topics, with a survey indicating that attendees found events on diabetes, respiratory and medicines optimisation during Ramadan to be the most useful.*

Feedback for these events has been very positive, with 88% of survey respondents stating that the topics were relevant, 76% feeling that attending the training events improved the service they provided to their patients and 80% of respondents agreeing that attending the events improved their understanding of the topic.”

*155 answered the survey; 100 respondents had attended an event in the last 12 months.

There are equally positive results for pharmacy-based screening. In a study of type-2 diabetes risk assessments, Twigg et al²⁰ found that community pharmacy was an effective location for identifying patients at risk, with almost one-third of the 3427 assessments undertaken between January and September 2013 identifying someone at either moderate or high risk of developing diabetes.

Likewise, an evaluation of NHS Health Checks by Corlett and Krska²¹ found that pharmacy was an effective location for accessing those at risk of cardio-vascular disease. Of 190 health checks delivered in 4 pharmacies, 75% had at least one modifiable risk factor, with 8% having a risk score of more than 20%; 30% were referred to general practice for further tests, half of whom attended, and 74% were offered lifestyle advice, 20% of whom accepted further lifestyle support. Pharmacy offers an ideal location for such opportunistic interventions, with research suggesting that on average individuals visit a pharmacy 14 times per year.²²

Several studies have also highlighted clear advantages for the pharmacies themselves, with many reporting increased motivation and productivity of staff. Firth et al,²³ who examined HLPs in the North of England, found that pharmacies reported improved staff engagement with customers and also, career development opportunities for staff. Similarly, an evaluation of HLPs found that 43% of pharmacies reported increased income, 61% increased demand for services and 80% increased productivity of staff.¹¹

Overall, the evidence to date demonstrates the wide-ranging benefits of pharmacy-based public health services, from clear public support, effective service provision to improved workforce morale and most importantly, potential to improve the public's health.

This report seeks to explore this in greater depth by examining the perceptions of commissioners, the relationships between pharmacy and other healthcare professionals, and critically, the opportunities and challenges posed by the commissioning process.



Case Study Calderdale Alcohol Identification and Brief Advice Service

The Alcohol Identification and Brief Advice (IBA) Service was introduced in May 2013 to raise awareness of the personal health risks of alcohol consumption, through an IBA consultation with a trained member of pharmacy staff.

It identifies the drinking risk category of individuals and provides brief advice to encourage the individual to come to their own awareness of how they could reduce their drinking and their risk level.

Patients who attended the pharmacy were approached and asked to answer a series of alcohol screening questions (AUDIT-C - the Alcohol Use Disorders Identification Test) using a scratch card to determine whether they were more likely to be drinking at higher risk levels.

Over the 12-month period, 19 community pharmacies successfully delivered a high volume of AUDIT-C assessments, roughly 2085 interventions, with approximately 3/4 of these going on to have the full AUDIT screen; 25.7% scored 4 or less, 74.3% scored 5 or more and were offered a full AUDIT screen.



Methodology

The purpose of this report is first and foremost to provide an insight into the views and experiences of pharmacy team members and commissioners. We hope that by highlighting the work already taking place in pharmacies and exploring the realities of the commissioning landscape, this report will help to raise the profile of pharmacy amongst commissioners as a key player in promoting better health.

To achieve this, we adopted a mixed methods approach, combining an online survey, semi-structured interviews and focus groups. The survey, which consisted of both quantitative and qualitative questions, was circulated in early January for completion by pharmacy team members, local pharmaceutical committee (LPC) chief officers and commissioners. In total, we received 606 responses (492 from pharmacy team members, 99 from commissioners and 37 from LPC chief officers).^b The survey questions (available in the appendix), which varied according to the type of respondent, were agreed by RSPH and PHE with input from various pharmacy and public health stakeholders represented on the Pharmacy and Public Health Forum.

Alongside this survey, we conducted 57 semi-structured interviews and 2 focus groups (1 with pharmacists and 1 with commissioners). All qualitative data was analysed thematically by the RSPH team.

The survey respondents and interview/focus group participants were a self-selected sample accessed via email through the networks and contacts of RSPH, PHE and members of the Pharmacy and Public Health Forum. As such, this report provides a snap-shot of the views held by some pharmacy team members and commissioners across the UK, rather than a representative cross-section of these groups.

When reading this report, it is important to note that the survey was conducted in the months immediately following the announcement of pharmacy budget cuts, which may be an influencing factor in our results.



b) Please note, 22 pharmacists answered that they had commissioning responsibilities and so, answered both the pharmacy team and commissioner survey.

Perceptions of pharmacy

The view from commissioners

The evidence to date demonstrates the potential of pharmacy for effectively promoting the public's health, reaching those most in need of health support and helping to relieve the ever-increasing demand on other healthcare services.

This report bolsters this research by further demonstrating the trust that commissioners place in pharmacy. We received responses from across the commissioning landscape – 55.56% of which were from local authorities, 20.20% from clinical commissioning groups and 13.13% from NHS England (11.11% - Other).

As demonstrated by the table, on the next page, when asked to rate the effectiveness with which pharmacies deliver various services, the majority of respondents viewed pharmacy as an effective provider. For example, 58.24% of respondents answered that community pharmacy is an effective provider of the flu vaccination service. Similarly, 74.47% and 64.44% respectively view community pharmacy as an effective provider of emergency hormonal contraception and substance misuse services. When only considering those who currently commission pharmacy to provide these services, the proportion who considers them to be an effective provider rises yet further, to 79.1% for flu vaccinations, 85.36% for emergency hormonal contraception and 80.55% for substance misuse services.



Table one: commissioner survey - how effectively do you feel community pharmacies provide the following public health services (if you commission the service locally)?

	Completely ineffective	Somewhat ineffective	Neither ineffective nor effective	Somewhat effective	Completely effective	Do not commission that service from community pharmacy	Don't know	Total	Weighted Average
Weight management service	2.22% 2	4.44% 4	4.44% 4	13.33% 12	10.00% 9	54.44% 49	11.11% 10	90	5.32
Minor ailments service	2.22% 2	2.22% 2	2.22% 2	21.11% 19	17.78% 16	38.89% 35	15.56% 14	90	5.29
Substance misuse service	1.11% 1	2.22% 2	2.22% 2	30.00% 27	34.44% 31	20.00% 19	10.00% 9	90	4.94
Alcohol intervention and brief advice service	2.15% 2	5.38% 5	6.45% 6	21.51% 20	7.53% 7	43.01% 40	13.98% 13	93	5.12
Flu vaccination service	0.00% 0	1.10% 1	4.40% 4	20.88% 19	37.36% 34	26.37% 24	9.89% 9	91	5.13
Other immunisation	0.00% 0	2.30% 2	9.20% 8	3.45% 3	11.49% 10	56.32% 49	17.24% 15	87	5.62
Chlamydia screening and treatment	2.11% 2	4.21% 4	6.32% 6	32.63% 31	20.00% 19	24.21% 23	10.53% 10	95	4.79
Emergency hormonal contraception	0.00% 0	1.06% 1	3.19% 3	26.60% 25	47.87% 45	12.77% 12	8.51% 8	94	4.94
Falls prevention service	3.37% 3	2.25% 2	5.62% 5	1.12% 1	4.49% 4	66.29% 59	16.85% 15	89	5.67
NHS Health Checks	4.35% 4	2.17% 2	7.61% 7	22.83% 21	14.13% 13	42.39% 39	6.52% 6	92	4.93
Stop smoking services	0.00% 0	6.45% 6	5.38% 5	33.33% 31	32.26% 30	18.28% 17	4.30% 4	93	4.63

Likewise, our semi-structured interviews highlighted the strengths of pharmacy that are recognised and valued by commissioners; including accessibility, extended opening hours and convenience. The breadth of locations in which community pharmacy provides services is demonstrated by our pharmacy team survey - over 30% of respondents stated that they provide services outside the pharmacy, including care homes (21.54%), in people's homes (4.88%), workplaces (4.88%) and schools (3.86%).

One commissioner also highlighted the benefits of having a pharmacy team that reflects their local community; an important characteristic for engaging with their customers;

‘The independents, I find, tend to really reflect the community...there are 100s of languages spoken, it's incredibly ethnically diverse, members of the community will go to a pharmacy that reflects their community, culture and language.’

Additionally, several commissioners recognised the advantage in terms of ease of setting up a new service when having a provider that is already familiar with issues of governance;

‘[Pharmacies are] familiar with governance, with safety, with medicines utilisation, that kind of thing, so they can provide something more professionally than pretty much every other setting out there.’

The view from pharmacists

These views are reflected in the responses we received from pharmacy teams themselves, with the majority feeling that they are indeed viewed as capable of providing services. Our responses indicate that overall, pharmacy teams feel they have the support and trust of the public, with over three-quarters of respondents stating that the public view them as either ‘somewhat’ or ‘completely’ capable.

This figure remains consistently high for a number of other bodies/organisations, with well over half of pharmacy team respondents answering that CCG commissioners, local authority commissioners, GPs and NHS local teams view them as either ‘somewhat’ or ‘completely’ capable. The proportion who feel that they are viewed as incapable is slightly higher for GPs and local medical committees, both at just over 20%, but nevertheless, these responses indicate that the pharmacy team respondents feel they are generally viewed positively in their public health role.



Table two: pharmacy team survey - In your opinion, to what extent do you feel that the following individuals/organisations view community pharmacy as being capable in providing public health services?

	Completely incapable	Somewhat incapable	Neither capable nor incapable	Somewhat capable	Completely capable	Don't know	Total
Clinical commissioning group commissioners	4.08% 20	11.22% 55	12.45% 61	40.00% 196	16.73% 82	15.51% 76	490
Local medical committee	5.54% 27	14.99% 73	16.43% 80	25.26% 123	10.06% 49	27.72% 135	487
Director of public health	5.18% 25	10.97% 53	13.46% 65	28.99% 140	15.32% 74	26.09% 126	483
Local authority commissioners	3.12% 15	8.73% 42	13.31% 64	35.34% 170	17.46% 84	22.04% 106	481
Members of the public	1.65% 8	3.50% 17	9.47% 46	39.30% 191	39.09% 190	7.00% 34	486
GPs	4.12% 20	16.87% 82	14.20% 69	41.77% 203	15.02% 73	8.02% 39	486
NHS England local team	2.90% 14	9.34% 45	11.20% 54	38.80% 187	20.33% 98	17.43% 84	482
Local elected officials	3.98% 19	8.60% 41	22.01% 105	20.55% 98	8.39% 40	36.48% 174	477
Health and wellbeing board	1.86% 9	6.82% 33	15.08% 73	27.48% 133	15.91% 77	32.85% 159	484

In spite of this, our report findings also indicate that there is strong feeling amongst pharmacists, LPC chief officers and commissioners alike that pharmacy is being under-utilised in the provision of public health services.

Less than one in five of our pharmacy team respondents (18.50%) felt that pharmacy is being fully utilised, with almost three-quarters answering negatively to this question (74.19%). Similarly, over three-quarters of commissioners (75.76%) and 100% of LPC chief officers felt that pharmacy is not being fully-utilised.

There is some variation however, according to whether respondents are based in Healthy Living Pharmacies (HLPs) or not, with a smaller proportion of those based in HLPs feeling that pharmacy is currently under-utilised. Almost 82% of pharmacy team members in non-HLPs stated that pharmacy is not being fully utilised compared with 63.87% of those based in HLPs.

This is reflected in the number of HLP respondents indicating that they provide various public health services; with regard to weight management services, for example, 38.89% of HLP respondents stated that their pharmacy does not provide this service, compared with a considerably higher 60.82% of non-HLP respondents. Similarly, 53.21% of HLP respondents stated that their pharmacy does not provide chlamydia screening and treatment, compared with 69.28% of non-HLP respondents.

Nevertheless, overall, there is a strong feeling amongst respondents that pharmacy could be doing more to promote healthy lifestyles. As will be discussed in the following sections, our findings indicate that, whilst pharmacy is generally viewed in a positive light, there are a number of issues faced by community pharmacies that are impeding their public health role; these include issues around capacity, the tendering process, public awareness and also, challenges within the commissioning landscape.



What is stopping pharmacy from realising its full potential?

Capacity and capability

Within pharmacy, there is palpable enthusiasm for taking on a greater role in promoting health, and also a desire for greater recognition of the work many pharmacies are already doing in this area. Several of our interviewees praised the impact of this work on pharmacy team motivation; one health champion based in a HLP stated that *'when they've had the training, the appetite for them to go and make a difference, and the ripple effect in their communities is massive...they're inspired'*.

However, our report findings highlight a number of challenges faced by pharmacy teams in achieving this. For many respondents, both within pharmacy and commissioning, capacity issues in terms of insufficient staff numbers, staff training and pharmacy facilities pose a challenge.

Around half (50.95%) of pharmacy team respondents felt that insufficient staff numbers were a barrier to greater utilisation. To a lesser extent, pharmacy team respondents also recognised that a lack of training may be an issue, both in terms of staff not yet being trained (36.78%) and training simply not being available (23.98%). One pharmacist stated that *'there are many things pharmacists can contribute to make a difference if resources and training are available'*. This concern was reflected in the findings from our commissioner survey, in which 44% of respondents stated that may be a reason for under-utilisation.

For commissioners, as would be expected, skills and training are a primary concern when choosing potential providers – almost four out of five commissioners stated that this influences their decision when commissioning pharmacy, above location (74.75%), accessibility (76.77%) and demonstrated capability (66.67%), with one commissioner stating that *'a lack of pre-requisite training being in place before contract start date'* is a concern when commissioning pharmacy teams.

The issues of staff numbers and insufficient training are inextricably linked, and are indicative of a wider issue of pharmacy teams having a lack of time to dedicate to public health, be it in terms of undertaking training, providing services or attending meetings.

One pharmacist stated that;

'in order to train to provide a new service, pharmacists are expected to do most of that training in their own time, often professional meetings can't be attended due to early start and [being] too far away.'

Similarly, one council-based commissioning advisor stated that;

'it's whether the pharmacy has the capacity to take on the training, allocate an individual to become a specialist...and hence do the training, and also release members of the team.'

Alongside this, readiness of pharmacy facilities seems to be an area of concern. Just under one-third of respondents felt that a lack of space may be a challenge and for several of our interviewees, the IT infrastructure within pharmacies can sometimes be of an inadequate standard for delivery of public health services, with some commissioners finding that data collection or simple tasks like use of email or Microsoft Office was not always possible.

It is clear that for pharmacies to undertake public health work, it requires a pro-active, motivated team and also, financial investment. However, throughout the interviews, many pharmacy team members voiced frustration at what they feel is a comparative lack of remuneration for their public health work, with many highlighting the low profit margins for delivery of these services, and the challenge this poses when having to fund staff training or recruitment of new staff themselves. One pharmacist stated that *'very few public health services are commissioned locally and fees are generally poor. There is little incentive to get engaged'*.

Many pharmacies are facing uncertain times ahead; the growing financial concerns, particularly the budget cuts announced in December 2015, could potentially exacerbate the current capacity issues. Our findings highlight a clear need for both commissioners and the pharmacy profession alike to consider what additional support pharmacy teams require to realise their full public health potential.

The tendering process

The 'type' of pharmacy seems to be an important factor influencing a pharmacy's approach to public health. Community pharmacies operate under a range of different business models, from small independent pharmacies (less than 5 chains) to the large multiple (more than 200 chains) pharmacies, often based in high street shops or supermarkets.

Our interviews indicated that for some based in large multiple pharmacies, there seems to be a disconnect between the enthusiasm and willingness of pharmacy teams, and the understanding and awareness of those in head office.

One health champion for example, stated that *'I think some companies are massive barriers, I do work for a large multiple myself. It is hard for me, the top of my chain, for them to understand what HLP is'*.

This is of particular concern given that over half of pharmacy respondents (54.60%) indicated that tender applications are dealt with by head office.

Our findings indicate that independent pharmacies appear more likely to provide public health services. Of those based in large multiple pharmacies, 70.69% stated that they do not deliver chlamydia screening, 39.19% stated that they do not deliver stop smoking services and 16.76% stated that they do not deliver emergency hormonal contraception, compared with 36.49%, 19.74% and 6.76% respectively for independent pharmacies. Similarly, 62.34% of independent pharmacy respondents indicated that they were based in a HLP or a pharmacy working towards HLP status, compared with 38.36% of those based in a large multiple.

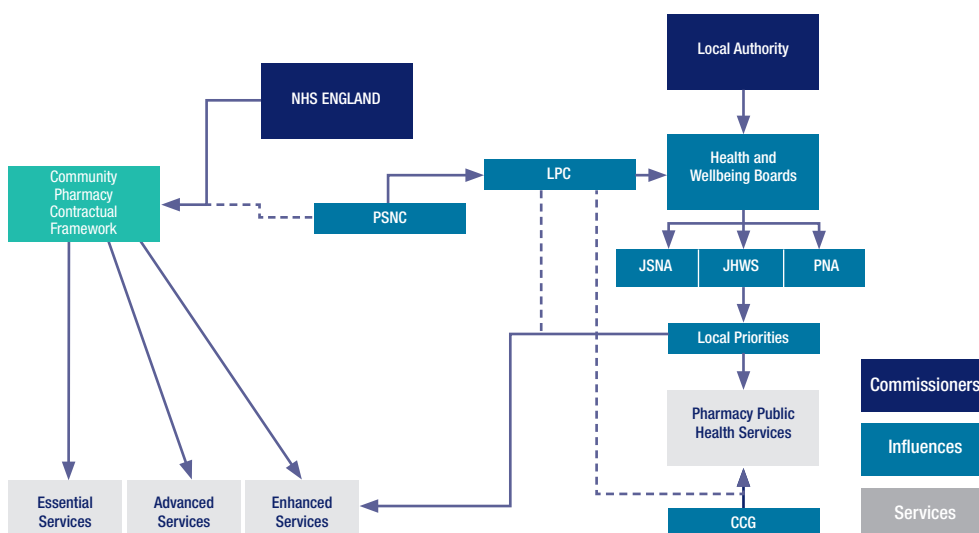
Commissioning landscape – challenges and opportunities

Whilst capacity issues and training needs are an ongoing concern for many pharmacies, it seems that in some areas, an issue of equal concern is the relative exclusivity of the commissioning process itself.

Our report findings indicate that the commissioning process is viewed by some as a barrier to the commissioning of public health services from community pharmacies, with some feeling that a lack of pharmacy integration in the commissioning process presents a challenge.

As demonstrated by figure one, the commissioning landscape is highly complex— particularly for pharmacy, and even more so since the move of public health to local authorities in 2013. Pharmacists have to navigate a complex landscape of clinical commissioning group (CCG), local authority and NHS England commissioners, each with differing responsibilities and procedures.

Figure one: the commissioning landscape (Source: Royal Society for Public Health, 2016) -



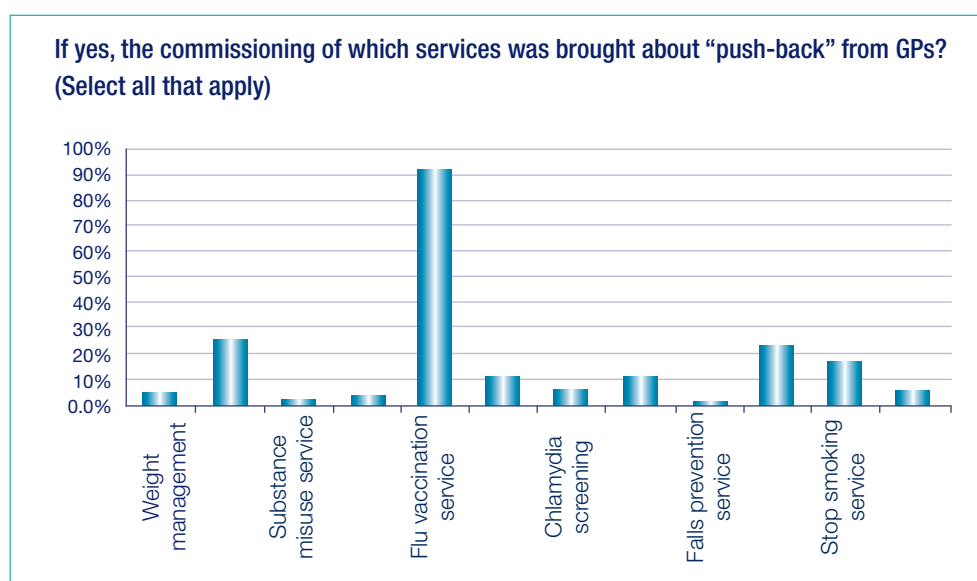
Relationships with key stakeholders:

Our findings indicate that pharmacy team members from both HLPs and non-HLPs view relationships with commissioning organisations and other healthcare professionals as generally positive, with less than 6% of respondents stating that they have poor relationships with GPs, CCG commissioners, NHS England local teams, local authority commissioners or directors of public health. Nevertheless, some pharmacy team members clearly feel at a disadvantage in the commissioning landscape and voiced frustration at the comparative absence of pharmacy from this process.

Pharmacies currently operate in a commissioning landscape that is GP-led, with little incentive for co-operation. Whilst GPs do not have any commissioning responsibilities for public health, their pre-eminence in commissioning structures is viewed by some pharmacy team members as a challenge for greater utilisation. Roughly 30% (29.67%) of pharmacy team members answered that they had experienced 'push-back' from GPs, with 31.71% of respondents answering 'no' to this question and a further 38.67% answering 'don't know'.^c

Of those who experienced push-back, this is largely in relation to the flu vaccination (91.78%), followed by the minor ailments service (24.66%), which whilst not a public health service, supports individuals with self-care, with potential to relieve the burden on other primary care services and NHS Health Checks (22.6%).

Figure two: pharmacy team survey - if yes, the commissioning of which services has brought about 'push-back' from GPs? (Select all that apply)



There is some variation between HLP and non-HLP respondents, with those based in HLPs being less likely to feel they have received push-back and tending to view relationships with other organisations more positively. Of those based in HLPs, 26.89% felt that they had received push-back from GPs, compared with 33.71% for those based in non-HLPs.

Our report findings indicate however, that pharmacy teams do not appear to have the same issues with their local authority commissioners, with just 11.6% of respondents viewing them as 'uncooperative' in the commissioning process. Given that local authorities commission the majority of public health services provided by community pharmacies, this is a hugely positive finding.

These findings are reflected in our semi-structured interviews, with many feeling that local authority commissioners generally have a better understanding of pharmacies and tend to be more supportive than their CCG and NHS counterparts. This seems to be in part due to more regular meetings and in a couple of locations, the presence of a pharmacy advisor/expert within the local authority.

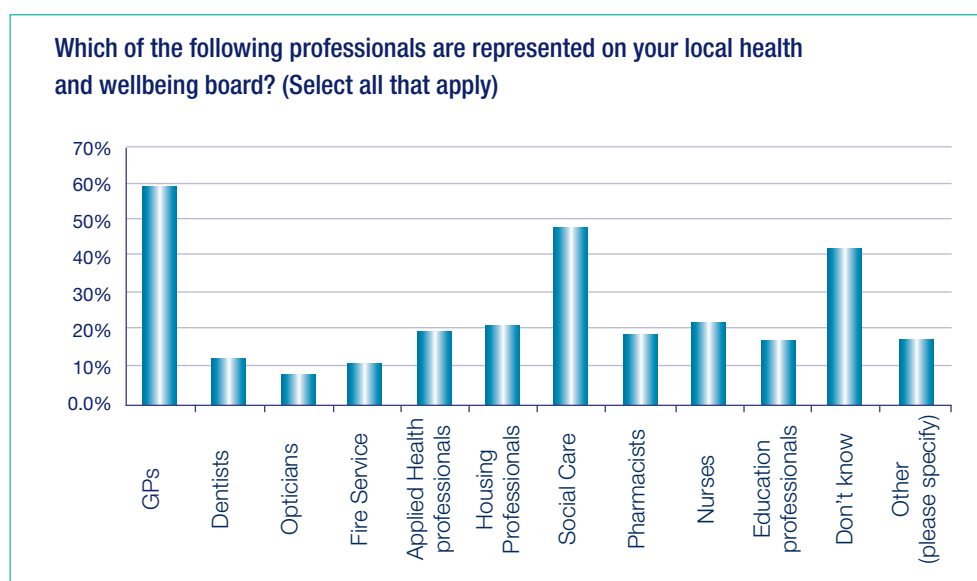
Lack of representation:

Whilst overall, relationships tend to be positive, there is clear frustration with the relative exclusivity of the commissioning process. One LPC chief officer for example, stated that *'we've got no official place at any table, be it NHS England, be it county council, and we're not on CCGs'*.

c) Pharmacy team question - Has your pharmacy experienced any "push-back" (in terms of negativity or attempts to stop commissioning) from GPs in relation to the commissioning of public health services?.

A clear example of this is the membership of health and wellbeing boards; whilst not having any formal commissioning responsibilities, health and wellbeing boards have a role in shaping local commissioning priorities. Less than one in five (18.18%) of commissioner respondents stated that their local health and wellbeing board has a pharmacy representative, whereas 58.59% stated that their local board has a GP representative, 47.47% social care representative, 20.20% for housing professionals and 19.19% for allied health professionals.^d

Figure three: commissioner survey - which of the following professionals are represented on your local health and wellbeing board? (Select all that apply)



Previously, calls have been made for pharmacy representatives to be included on these boards as non-statutory members. Our semi-structured interviews however, uncovered ambivalence from both pharmacy representatives and commissioners about the need for such a place. Some felt that this was crucial for the future of pharmacy; one respondent based in a pharmacy head office for example, felt that without such representation *'it doesn't put anyone from the profession there at the heart to influence on those conversations and to actually highlight the resource that is out there'*.

Whilst others felt that the boards have only limited influence, highlighting the ability of individuals to attend the meetings as observers and stressing the need for pharmacists to engage more directly with commissioners and influence the documents and agendas presented to the board.

What is clear however, is that when faced with this absence from commissioning structures, strong local leadership and championing of pharmacy interests is vital. Many respondents stressed that it is crucial for pharmacy leaders, particularly LPCs, to be proactive, to engage with commissioners and also, motivate their local pharmacy teams. One LPC chief officer stated that *'I understand that community pharmacy is not the top of their list, but the problem is, it's not top of anyone's list, unless by local determination you can get it there'*.

d) Health and wellbeing board core statutory membership includes; one elected representative, representatives from CCGs, local authority directors of adult services, children's services and public health and a representative from the local healthwatch. As required, a representative from the NHS Commissioning Board will also attend. (Department of Health. The general duties and powers relating to health and wellbeing boards. Available online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/144020/General-health-and-wellbeing-board-duties-and-powers.pdf (last accessed 25th May 2016)

More than a third of pharmacy respondents however, stated that they do not feel their LPC champions their interests. Several interviewees, from both pharmacy teams and commissioning, instead felt that the voice of pharmacy can at times feel fragmented, with one local authority commissioner stating that *'you need the right skills to have the right conversations, to be able to understand how to lead, and unfortunately there is a lack of skills within the LPC to be able to do this'*.

This finding is repeated for other organisations, suggesting a lack of organisations/bodies seen to be promoting the interests of pharmacy. One pharmacist commented that there *'seems to be very little championing locally'*.

This lack of championing is closely linked to issues of capacity. LPCs are the committees, recognised under the NHS Act 2006 and formed of representatives from local pharmacy contractors, tasked with representing the interests of pharmacy in a local area. LPCs are therefore, a key point of contact for other organisations, such as NHS England and local authorities, and a source of support and guidance for local pharmacy contractors and a voice more generally for the interests of community pharmacy.²⁴

With a largely unpaid membership in many areas, the strength and effectiveness of this representation can be patchy, and greatly dependent on the time available to LPC members outside of their other employment. This difficulty is compounded by the complexity of the commissioning landscape, with one of our interviewees stating that their LPC covers five CCG areas.

One LPC chief officer, when discussing their positive relationships with CCG commissioners stated that there is a *'big advantage that there is just one CCG, I know in some areas there is more than one... and can be difficult for LPCs to build and maintain relationships'*. Without an automatic place within commissioning structures, pharmacies can at times face an uphill struggle to have their voices heard.

A lack of awareness:

For many pharmacy team members, a further challenge is the resulting lack of awareness from commissioners, GPs and the public alike of the services provided by pharmacies; one pharmacist commented that *'very few of the members of these groups have any idea what pharmacies already do and what more they can do'*.

Similarly, a LPC chief officer voiced concern that *'there is still an awful lot of people who don't understand what community pharmacy does...the public doesn't understand, and when I meet new stakeholders in commissioning, I spend probably the first half an hour trying to tell them what community pharmacy does'*.

This lack of awareness seems to also be an issue for the Healthy Living Pharmacy concept, with one LPC chief officer stating that *'commissioners who are new to commissioning public health don't 'get' pharmacy, so they don't 'get' healthy living pharmacies'*.

Some interviewees however, felt that the brand was beneficial in terms of increasing team motivation and confidence. One health champion stated that *'it's almost like having a trusted brand – it gives you that feeling of being one step ahead, and going one step further'*. One LPC chief officer observed that 'where it has worked is when there has been ongoing engagement with the commissioner'.

Some of these challenges, our report findings indicate, may ultimately be the result of a lack of interaction and communication. To overcome some of the barriers existing between pharmacy team members and both GPs and commissioners, many called for more joint meetings or even joint training; one pharmacist for example, called for *'meetings between doctors and pharmacists every two months to discuss how we can work together more to benefit patients'*.

Likewise, another pharmacy team member called for *'well publicised networking events where pharmacists and GPs can sit down and discuss common goals and find ways of ensuring continuity of messages to patients'*.

One health champion based in a HLP highlighted the potential benefits of this approach; *'once we had a chat, they [GPs] realised that we need to work in unison for the health of the public out there, so we started doing the same campaigns...the public started seeing the same messages in the pharmacy and they started to then refer into us'*.

For some respondents, there seems to be a missed opportunity for more collaborative working between GPs and pharmacists, particularly around signposting; one pharmacist for example, called for more *'cross-referrals from general practice to pharmacy for MUR's, flu vaccines and other services'*.

Many welcomed the move to base pharmacists within GP practices, voicing a hope that this would enhance communication and understanding between professions. NHS England is investing £300 million over the next five years to the Pharmacy Integration Fund, which could help even greater integration.

Our report findings indicate that this move may indeed be beneficial for relationships; 77.92% of respondents who indicated that they were based in GP surgeries stated that they have 'positive' relationships with GPs, compared with 56.80% of those based in community pharmacies. Although, pharmacists based in GP surgeries may have a reduced ability to reach out to groups that rarely access primary care services compared with those based in community settings.

Culture change required?:

Many pharmacy team members also stated that public awareness and public understanding of pharmacy remains low. This is reflected in the commissioner survey, with 42.86% of those who have de-commissioned public health services from pharmacies indicating that lack of public uptake was a major reason.

An opinion poll conducted in March 2016⁶ demonstrates that public awareness of pharmacy-based services varies greatly according to the service in question, and for some services, continues to lag behind that for GPs. As the table on the next page demonstrates, awareness ranges from a positive 74% for the treatment of minor ailments to 44% for NHS Health Checks. Whereas, awareness of GP-delivered services is consistently high, declining slightly for emergency hormonal contraception.

Table three: opinion polling – In England, which of the following locations, if any, do you think offer each of the health improvement services below?

Profession	Emergency hormonal contraception	Stop smoking service	Flu vaccination service	Treatment of minor ailments	NHS Health Check	Advice diet and nutrition
Local pharmacy	48%	64%	51%	74%	44%	50%
GP surgery	64%	80%	90%	73%	86%	78%
Hospital	32%	30%	24%	20%	29%	30%

The opinion polling demonstrates a lack of awareness of HLPs; when asked if they had previously heard of a HLP, 81% answered no, with 14% answering yes to this question. Whilst this figure appears low, it is encouraging that there is some recognition of the HLP concept, considering the number of HLPs compared to non-HLPs (2100 versus 11,647). Awareness seems to be slightly higher amongst younger respondents; 18% of 18-24 year olds and 19% of 25-34 year olds had previously heard of HLPs, compared with 12% for participants in the 45-54, 55-64 and 65+ age categories.

Many of our interviewees called for a greater focus on communication, particularly at a national level; one health champion for example, stated that *'if there was advertising, more signposting to pharmacy, we could do so much more...The public aren't aware of what we do...sometimes the GPs aren't, and local authorities, of how much pharmacies could do'*.

Although for many of our respondents, this issue goes beyond a lack of marketing and instead, reflects the primacy of GPs in the public mind-set, with the majority viewing pharmacy as a location for the dispensing of medicines.

One pharmacist commented that the; *'majority of patients pharmacy as a medicines dispenser and regard their GP as the healthcare provider'*. One LPC chief officer stressed the fundamental need for cultural change, lamenting that pharmacy is *'ubiquitous on the high street, but not ubiquitous in the media'*.

The patchy nature of service provision in pharmacy means that the message of 'visit your pharmacy' can be a difficult one to convey to the public. Several respondents felt that there is a strong case for a core set of nationally commissioned public health services based in pharmacy; such a move would arguably aid the public's understanding, enhance campaign co-ordination with a shared set of national resources and key messages and undoubtedly, make communications easier. One LPC chief officer commented that *'we should have six nationally driven public health campaigns, that pharmacy is required to support, they are adequately provided with resources for that'*.

The need for a change in the public's approach to accessing health advice is clearly demonstrated by the opinion poll data. As the table below demonstrates a larger proportion of people view their GP surgery as the 'go-to' location for public health advice and services. The only area for which this trend is reversed is for the treatment of minor ailments, with 46% of respondents stating that they would go to the pharmacy for such support, compared with 29% for GP surgeries. There is also a notable tendency of respondents to self-treat via the internet

e) By Populus, commissioned by RSPH.

Table four: opinion polling – imagine you needed to access each of the below services. Where would you be most likely to go to receive each of the below services or health-related advice?

Profession	Advice on diet and nutrition	Services related to minor ailments	Advice on alcohol consumption	Stop smoking service	Advice on sexual health	Emergency hormonal contraception	Flu vaccination	NHS health check	Support on substance misuse
Local pharmacy	10%	46%	7%	24%	5%	29%	12%	12%	5%
GP surgery	37%	29%	37%	44%	50%	38%	75%	74%	48%
Hospital	34%	12%	31%	14%	20%	4%	4%	4%	12%

The polling also indicates however, that the reluctance of participants to visit their local pharmacy in the first instance is not solely due to a lack of awareness, but also relates to the restricted capabilities of pharmacy teams. As the table on the next page indicates, of particular concern is the inability of pharmacy teams to provide a full examination, to refer directly into other services and access medical records.

Table five: opinion polling – you mentioned that you would be most likely to access advice about minor ailments or common conditions (e.g. coughs, aches, minor skin conditions, infections etc) from your local GP surgery. Why would you be more likely to access this advice from your local GP surgery rather than your local pharmacy?

Reason	Percentage of participants
Professionals in a GP surgery can provide a full examination if necessary	50%
Professionals in a GP surgery can directly refer to other healthcare services	44%
Pharmacy teams do not have access to my medical records	39%
Pharmacy teams may not have the same level of expertise and skill as the professionals in a GP surgery	37%
I am unsure if my particular local pharmacy/ies could provide this advice/service	27%
Concerns about issues of privacy in the pharmacy	27%
Concerns about confidentiality in the pharmacy	22%
Possibility of a longer consultation time in a GP surgery	17%

Conclusion and recommendations

Over recent years, there has been a growing focus on the potential of community pharmacy teams to promote healthy lifestyles, deliver public health services and ultimately, relieve the burden on over-stretched health services.

This focus has led to a rapid expansion in the number of pharmacies undertaking public health work, with a growing number of studies demonstrating the effectiveness of this approach. Alongside this however, some have raised concerns that pharmacy is not being utilised to its full potential.

The role of pharmacy in promoting the public's health has never been more important; through this joint report, the RSPH and PHE have sought to explore both the opportunities and challenges faced by community pharmacy.

This report provides an insight into the views of pharmacy teams, LPC chief officers and commissioners, uncovering a number of key themes; namely the ongoing capacity issues of pharmacy teams – relating to both insufficient staff numbers and training, the comparative exclusion of pharmacy from the commissioning landscape and the enduring lack of awareness amongst the public, commissioners and other healthcare professionals of the services provided by pharmacy.

To ensure that pharmacy realises its potential as a community hub for healthy lifestyles, these findings highlight several recommendations for the future of pharmacy in public health:

1. Commissioners to recognise pharmacy as a local health asset, enhancing their understanding of the profession through increased pharmacy visits and greater engagement with the local pharmacy leadership.
2. Local authority directors of public health and commissioners to consider the contribution of Healthy Living Pharmacies to promoting health and wellbeing and seek to increase the number of community pharmacies seeking accreditation.
3. For every community pharmacy to have at least one health champion and where lack of staff or affordability is an issue, for pharmacies to consider alternative training options like train the trainer, joint training sessions between local pharmacies or e-learning options.
4. Greater joint working between community pharmacy teams and GPs, including improved communication channels, joint meetings and increased integration between the two professions
5. Improved leadership from LPCs by ensuring their presence at relevant meetings and greater engagement with local commissioners, other stakeholders, including directors of public health, councillors and other local authority officials and individual local pharmacies.
6. Pharmacy leaders providing system leadership to ensure pharmacy makes a contribution to the Five Year Forward View.

Online Appendix survey

1. Are you a commissioner, member of the pharmacy team or LPC chief officer?
 - a. Member of a pharmacy team
 - b. Commissioner
 - c. LPC chief officer

Community pharmacists

1. Where in England is your community pharmacy based?
 - a. North West
 - b. North East
 - c. Yorkshire and the Humber
 - d. East Midlands
 - e. East of England
 - f. South East
 - g. South West
 - h. West Midlands
 - i. London
2. What type of community pharmacy do you work in?
 - a. Large pharmacy multiple chain (over 200 branches)
 - b. Medium / regional multiple chain (between 50 and 200 branches)
 - c. Small pharmacy chain (between 6 and 49 branches)
 - d. Independent pharmacy (Fewer than 5 branches)
3. Which of the following statements best describes your community pharmacy?
 - a. It is already a Healthy Living Pharmacy
 - b. It is not a Healthy Living Pharmacy, but is working towards becoming one
 - c. It is not a Healthy Living Pharmacy and is not working towards becoming one
 - d. Don't know
4. What is your role within the pharmacy?
 - a. Pharmacist Manager
 - b. Employee Pharmacist
 - c. Locum Pharmacist
 - d. Pre-registration Trainee Pharmacist
 - e. Non-pharmacist Manager
 - f. Registered Pharmacy Technician
 - g. Registered Accuracy Checking Pharmacy Technician
 - h. Non-registered Accuracy Checker / Accuracy Checking Technician
 - i. Pharmacy Assistant
 - j. Medicines Counter Assistant
 - k. Other (please specify)
5. Have you taken the Level 2 RSPH Award in Understanding Health Improvement?
 - a. Yes
 - b. No
 - c. Don't Know
6. In what setting does your community pharmacy primarily operate?
 - a. Within a general practice building
 - b. Within a hospital
 - c. Community setting (including high streets)
 - d. Supermarket
 - e. Other (please specify)

7. Is your community pharmacy in a rural setting?
- Yes
 - No
 - Don't know
8. Which of the following public health services does your community pharmacy provide? (NHS/Private/Both/Do not provide/Don't Know)
- Weight management service
 - Minor ailments Service
 - Substance misuse service
 - Alcohol intervention and brief advice service
 - Flu vaccination service
 - Other immunisation service
 - Chlamydia screening and treatment
 - Emergency hormonal contraception
 - Falls prevention service
 - NHS Health Checks
 - Stop smoking service
 - Other (please specify)
9. In addition to your primary pharmacy location, where else do you provide public health services? (Select all that apply)
- Care homes
 - Supermarkets
 - High streets
 - Youth clubs
 - GP building
 - Hospitals
 - Universities
 - Community centres
 - Colleges
 - Schools
 - Workplaces
 - In people's homes
 - None, all public health services are provided within the pharmacy
 - Other (please specify)
10. Who do you feel locally champions your interests as a community pharmacy? (Select all that apply)
- Local pharmaceutical committee
 - Local professional network
 - Director of public health
 - Local medical committee
 - Clinical commissioning group
 - Local Healthwatch
 - NHS England local team
 - Health and wellbeing board
 - My pharmacy
 - Other local pharmacies
 - GPs
 - Local councillors/elected officials
 - No-one
 - Other (please specify)
 - Don't Know

11. Do you feel that your pharmacy is being fully utilised to provide public health services?
- Yes
 - No
 - Don't Know
12. If no, what is the main reason that your pharmacy may be being under-utilised?
(Select all that apply)
- Lack of physical space in pharmacy
 - Insufficient staff numbers
 - Lack of appropriate facilities
 - Staff yet to be trained
 - Training not available
 - High staff turnover
 - Insufficient evidence of outcomes
 - Other (Please specify)
13. In your opinion, do you feel that the following individuals/organisations view community pharmacy as being capable in providing public health services? (1-5: Completely incapable, somewhat incapable, neither, somewhat capable, completely capable, don't know)
- Clinical commissioning group commissioners
 - Director of public health
 - Local authority commissioners
 - Members of the public
 - Local medical committee
 - Health and wellbeing board
 - Local elected officials
 - GPs
 - NHS England local team
14. To what extent do you agree or disagree that the following individuals/organisations may be a barrier to your pharmacy being commissioned to provide public health services? (Strongly Agree, Agree, neither agree nor disagree, disagree, strongly disagree, don't know)
- Local medical committees
 - Local authority commissioners
 - Clinical commissioning groups
 - Directors of public health
 - Locally elected officials
 - GPs
 - NHS England local teams
 - Health and wellbeing boards
 - None (There are no barriers within the commissioning structure)
 - Other (please specify)
15. Have you ever turned down the opportunity to submit a tender application?
- Yes
 - No
 - Dealt with by head office
 - Don't Know

16. If yes, why did your pharmacy turn down the opportunity to submit a tender application?

(Select all that apply)

- a. Application process was too complex
- b. Penalties that would apply to the contract
- c. Costs outweighed the benefits
- d. Belief that the application was likely to be unsuccessful
- e. Too time consuming to complete
- f. Insufficient capacity to deliver the tender
- g. Staff capacity
- h. Other (Please specify)

17. Have you ever turned down an opportunity to provide a service under a contract?

- a. Yes
- b. No
- c. Dealt with by head office
- d. Don't Know

18. If yes, why was the opportunity to provide a service under contract turned down?

(Select all that apply)

- a. Too complex
- b. Penalties that would apply to the contract
- c. Costs outweighed the benefits
- d. Insufficient capacity to deliver the service
- e. Other (Please specify)

19. Overall, which of the following statements best reflects your relationship with local general practices?

- a. Overall we have a good working relationship with local GP surgeries
- b. Overall we have a practical/neutral relationship with local GP surgeries
- c. We have a mixed relationship with local GP surgeries; some are good, whilst others are poor or neutral
- d. Overall we have a poor relationship with local GP surgeries
- e. We have no established relationships with any of the local GP surgeries
- f. I am uncertain of the relationship between our pharmacy and local GP surgeries

20. Overall, which of the following statements best reflects your relationship with your NHS England local team?

- a. Overall, we have a good working relationship with our NHS England local team
- b. Overall, we have a practical/neutral relationship with our NHS England local team
- c. Overall, we have a poor relationship with our NHS England local team
- d. We have no established relationships with any NHS England local team
- e. I am uncertain of the relationship between our pharmacy and NHS England local team

21. Overall, which of the following statements best reflects your relationship with your local CCG?

- a. Overall, we have good working relationships with our local CCG
- b. Overall, we have a practical/neutral relationship with our local CCG
- c. Overall, we have poor relationships with our local CCG
- d. We have no established relationships with our local CCG
- e. I am uncertain of the relationship between our pharmacy and local CCG

22. Overall, which of the following statements best reflects your relationship with your local authority?
- a. Overall, we have a good working relationship with the local authority
 - b. Overall, we have a practical/neutral relationship with the local authority
 - c. Overall, we have a poor relationship with the local authority
 - d. Overall, we have no established relationships with the local authority
 - e. I am uncertain of the relationship between our pharmacy and the local authority
23. Overall, which of the following statements best reflects your relationship with the director of public health?
- a. Overall, we have a good working relationship with the director of public health
 - b. Overall, we have a practical/neutral relationship with the director of public health
 - c. Overall, we have a poor relationship with the director of public health
 - d. We have no established relationships with the director of public health
 - e. I am uncertain of the relationship between our pharmacy and the director of public health
24. Has your pharmacy experienced any “push-back” (in terms of negativity or attempts to stop commissioning) from GPs in relation to the commissioning of public health services?
- a. Yes
 - b. No
 - c. Don't know
25. If yes, the commissioning of which services has brought about “push-back” from GPs?
(Select all that apply)
- a. Weight management service
 - b. Minor ailments Service
 - c. Substance misuse service
 - d. Alcohol intervention and brief advice service
 - e. Flu vaccination service
 - f. Other immunisations service
 - g. Chlamydia screening and treatment
 - h. Emergency hormonal contraception
 - i. Falls prevention service
 - j. NHS Health Checks
 - k. Stop smoking service
26. What are the practical examples of what you think could make a positive difference to building positive relationships between pharmacy and general practice?
- a. Open textbox
27. What are the practical examples of what you think could make a positive difference to building positive relationships between pharmacy and commissioners of public health services?
- a. Open textbox
28. In your opinion, how would you rate the cooperation and support of the following individuals/ organisations/bodies, in the commissioning of public health services in pharmacies?
(-5 = fully uncooperative 5= Fully cooperative)
- a. Local pharmaceutical committee
 - b. Local professional network
 - c. Director of public health
 - d. Local authority commissioners
 - e. Local medical committee
 - f. Clinical commissioning group commissioners
 - g. NHS England local team
 - h. Local Healthwatch
 - i. Health and wellbeing board
 - j. GPs
 - k. Other (please specify)

29. How much influence do you feel your local pharmaceutical committee has over the outcomes of the following local assessments: (1-5: No influence, Little influence, Some influence, Strong influence, Complete influence, Don't know)
- Joint Strategic Needs Assessment (JSNA)
 - Joint Health and Wellbeing Strategy (JHWS)
 - Pharmaceutical Needs Assessment (PNA)

Commissioners

- Which commissioning organisation are you from?
 - Clinical commissioning group
 - Local authority
 - NHS England
 - Other (please specify)
- In which region do you have commissioning responsibilities? (Select all that apply)
 - North West
 - North East
 - Yorkshire and the Humber
 - East Midlands
 - East of England
 - South East
 - South West
 - West Midlands
 - London
 - National
- What do you consider to be the most important characteristics that influence your commissioning decisions related to community pharmacy and public health services? (Select all that apply)
 - Location of pharmacies
 - Accessibility
 - Anonymity (between pharmacist and client)
 - Demonstrated capability
 - Staff that reflect the demography of the local community
 - Opening hours
 - Healthy Living Pharmacy status
 - Public trust
 - Pharmacy facilities
 - Skills and training of staff
 - Other (please specify)
- Which of the following models of commissioning do you use to commission public health services from community pharmacies? (Select all that apply)
 - Individual contracts with individual pharmacies
 - Contract with a lead pharmacy which then sub-contracts
 - Contract with a non-pharmacy third party who then sub contracts
 - Contract with a pharmacy provider company who then subcontracts
 - Don't know
- Have you ever decommissioned public health services from pharmacies?
 - Yes
 - No
 - Don't know

6. If yes, why were the public health services decommissioned from pharmacy?
(Select all that apply)
 - a. Poor quality performance
 - b. Lack of resources (including human resources)
 - c. Lack of public uptake
 - d. Wrong location
 - e. Too expensive
 - f. Better alternatives
 - g. Service redesign
 - h. Other (Please specify)
7. How effectively do you feel community pharmacies provide the following public health services (if you commission the service locally)? (1-5: Completely ineffective, somewhat ineffective, neither, somewhat effective, completely effective, don't know, don't commission that service from community pharmacies)
 - a. Weight management service
 - b. Minor ailments Service
 - c. Substance misuse service
 - d. Alcohol intervention and brief advice service
 - e. Flu vaccination service
 - f. Other immunisations service
 - g. Chlamydia screening and treatment
 - h. Emergency hormonal contraception
 - i. Falls prevention service
 - j. NHS Health Checks
 - k. Stop smoking services
 - l. Other (please specify)
8. In your opinion, are the pharmacies in your local commissioning area being fully utilised in the provision of public health services?
 - a. Yes
 - b. No
 - c. Don't know
9. If no, what are the main reasons as to why pharmacies are being under-utilised?
(Select all that apply)
 - a. Lack of physical space in pharmacy
 - b. Insufficient staff numbers
 - c. Lack of appropriate facilities, such as a private consultation room.
 - d. Staff yet to be trained
 - e. Training not available
 - f. High staff turnover
 - g. Insufficient evidence of outcomes
 - h. Other (Please specify)

10. Which of the following professionals are represented on your local health and wellbeing board?
(Select all that apply)

- a. GPs
- b. Dentists
- c. Opticians
- d. Fire service
- e. Allied health professionals
- f. Housing professionals
- g. Social care
- h. Pharmacists
- i. Nurses
- j. Education professionals
- k. Don't know
- l. Other (please specify)

11. To what extent do you understand the role of the local pharmaceutical committee? (1-5: Not at all, very little, somewhat, very well, completely, don't know)

12. How regularly would you say that you engage with the local pharmaceutical committee, for discussions on the commissioning of public health services within your area? (1-5: Not at all, rarely, occasionally, regularly, all of the time, don't know)

13. In your opinion, how would you describe the local leadership of pharmacy in your local commissioning area? (1-5: Very poor, poor, average, strong, very strong, don't know)

LPC Officer Survey

1. Where in England is your LPC based?

- a. North West
- b. North East
- c. Yorkshire and the Humber
- d. East Midlands
- e. East of England
- f. South East
- g. South West
- h. West Midlands
- i. London

2. What do you consider to be the most important characteristics that enable your local community pharmacies to be commissioned to deliver public health services? (Select all that apply)

- a. Location of your pharmacy
- b. Accessibility
- c. Anonymity (between the pharmacist and client)
- d. Demonstrated capability
- e. Staff that reflect the demography of the local community
- f. Opening hours
- g. Healthy Living Pharmacy status
- h. Pharmacy facilities
- i. Skills and training of pharmacy staff
- j. Public trust
- k. Other (please specify)

3. Beyond your LPC, who do you feel locally champions the interests of community pharmacy?
(Select all that apply)
 - a. Local professional network
 - b. Director of public health
 - c. Local medical committees
 - d. Clinical commissioning groups
 - e. Local Healthwatch
 - f. NHS England local team
 - g. Health and wellbeing board
 - h. Local pharmacies
 - i. Local councillors/elected officials
 - j. GPs
 - k. No-one
 - l. Other (please specify)
 - m. Don't Know
4. Do you feel that community pharmacy is being fully utilised to provide public health services?
 - a. Yes
 - b. No
 - c. Don't Know
5. If no, what is the main reason that community pharmacy may be being under-utilised?
(Select all that apply)
 - a. Lack of physical space in pharmacy
 - b. Insufficient staff numbers
 - c. Lack of appropriate facilities, such as lack of private consultation room
 - d. Staff yet to be trained
 - e. Training not available
 - f. High staff turnover
 - g. Insufficient evidence of outcomes
 - h. Other (Please specify)
6. In your opinion, to what extent, do you feel that the following individuals/organisations, view community pharmacy as being capable in providing public health services? (1-5: Completely incapable, somewhat incapable, neither, somewhat capable, completely capable, don't know)
 - a. Clinical commissioning group commissioners
 - b. Local medical committees
 - c. Director of public health
 - d. Local authority commissioners
 - e. Members of the public
 - f. GPs
 - g. NHS England local team
 - h. Local elected officials
 - i. Health and wellbeing board
 - j. Other (please specify)

7. In your opinion, to what extent do you agree or disagree that the following individuals/ organisations may be a barrier to community pharmacies being commissioned to provide public health services? (Strongly agree, agree, neither agree nor disagree, disagree, strongly disagree, don't know)
 - a. Local medical committees
 - b. Local authority commissioners
 - c. Clinical commissioning group commissioners
 - d. Directors of public health
 - e. Locally elected officials
 - f. GPs
 - g. Health and wellbeing boards
 - h. NHS England local teams
 - i. None (There are no barriers within the commissioning structure)
 - j. Other (please specify)
8. Overall, which of the following statements best reflects your LPCs relationship with local general practices?
 - a. Overall, we have good working relationships with local GP surgeries
 - b. Overall, we have a practical/neutral relationship with local GP surgeries
 - c. We have a mixed relationship; some are good whilst others are poor or neutral
 - d. Overall, we have a poor relationship with local GP surgeries
 - e. We have no established relationships with any of the local GP surgeries
 - f. I am uncertain of the relationship between our LPC and local GP surgeries
9. Overall, which of the following statements best reflects your LPCs relationship with local medical committees?
 - a. Overall, we have good working relationships with local medical committees
 - b. Overall, we have practical/neutral relationship with local medical committees
 - c. We have a mixed relationship; some are good whilst others are poor or neutral
 - d. Overall, we have a poor relationship with local medical committees
 - e. We have no established relationships with any of the local medical committees
 - f. I am uncertain of the relationship between our LPC and local medical committees
10. Which of the following statements best reflects your LPC's relationship with your NHS England local teams?
 - a. Overall, we have a good working relationship with our NHS England local team(s)
 - b. Overall, we have a practical/neutral relationship with our NHS England local team(s)
 - c. We have a mixed relationship; some are good whilst others are poor or neutral
 - d. Overall, we have a poor relationship with our NHS England local team(s)
 - e. We have no established relationships with any NHS England local team(s)
 - f. I am uncertain of the relationship between our LPC and NHS England local team(s)
11. Overall, which of the following statements best reflects your LPCs relationship with local CCGs?
 - a. Overall, we have good working relationship with CCGs.
 - b. Overall, we have a practical/neutral relationship with CCGs
 - c. We have a mixed relationship; some are good whilst others are poor or neutral
 - d. Overall, we have a poor relationship with CCGs
 - e. We have no established relationships with any of the CCGs
 - f. I am uncertain of the relationship between our LPC and CCGs

12. Overall, which of the following statements best reflects your LPCs relationship with the local authority/local authorities?
- a. Overall, we have a good working relationship with local authorities
 - b. Overall, we have a practical/neutral relationship with local authorities
 - c. We have a mixed relationship; some are good whilst others are poor or neutral
 - d. Overall, we have a poor relationship with the local authorities
 - e. We have no established relationships with the local authorities
 - f. I am uncertain of the relationship between our LPC and the local authorities
13. Overall, which of the following statements best reflects your relationship with the director(s) of public health?
- a. Overall, we have a good working relationship with the director(s) of public health
 - b. Overall, we have a practical/neutral relationship with the director(s) of public health
 - c. We have a mixed relationship; some are good whilst others are poor or neutral
 - d. Overall, we have a poor relationship with the director(s) of public health
 - e. We have no established relationships with the director(s) of public health
 - f. I am uncertain of the relationship between our LPC and the director(s) of public health
14. Has your LPC experienced any “push-back” (in terms of negativity or attempts to stop commissioning) from GPs in relation to the commissioning of public health services?
- a. Yes
 - b. No
 - c. Don't know
15. If yes, the commissioning of which services has brought about “push-back”?
(Select all that apply)
- a. Weight management service
 - b. Minor Ailments Service
 - c. Substance misuse service
 - d. Alcohol intervention and brief advice service
 - e. Flu vaccination service
 - f. Other immunisation service
 - g. Falls prevention service
 - h. Chlamydia screening and treatment
 - i. Emergency hormonal contraception
 - j. NHS Health Checks
 - k. Stop smoking service
 - l. Other (please specify)
16. In your opinion, what are the critical success factors that can, and do, engender better working relationships between commissioners of public health services and community pharmacy?
- a. Open textbox
17. In your opinion, what are the critical success factors that can, and do, engender better working relationships between general practice and community pharmacy?
- a. Open textbox
18. How much influence do you feel your local pharmaceutical committee has over the outcomes of the following local assessments: (1-5: No influence, Little influence, Some influence, Strong influence, Complete influence, Don't know)
- a. Joint Strategic Needs Assessment (JSNA)
 - b. Joint Health and Wellbeing Strategy (JHWS)
 - c. Pharmaceutical Needs Assessment (PNA)

19. In your opinion, how would you rate the cooperation and support of the following individuals/ organisations, in the commissioning of public health services from community pharmacies in your LPC area? (-5 = fully uncooperative 5= Fully cooperative)

- a. Local professional network
- b. Director of public health
- c. Local authority commissioners
- d. Local medical committees
- e. Clinical commissioning groups
- f. Local Healthwatch
- g. Health and wellbeing boards
- h. NHS England
- i. GPs
- j. Other (please specify)

All

20. Would you be interested in taking part in a semi-structured interview?

- a. Yes
- b. No

21. Would you be interested in taking part in a focus group?

- a. Yes
- b. No

22. If you answered yes to either of the above, please provide your email address:

- a. Open text box

23. Any other comments.

- a. Open text box

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