Health Promotion in Community Pharmacy

Country Report – United Kingdom

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Barnet High Street Health Scheme

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Information on institution commissioning the project:
Local Health authority

If additional resources are used for the project, where do they come from?
- (additional) public funding
- private sponsorship/donations
- pharmaceutical industry

Information on institution co-ordinating the project:
Barnet Health Authority

Status of project:
integral part of everyday practice

Running Time:
since December 1991
Short abstract of the project:

What are the goals, aims and targets?
- to investigate the effect of HSHS on participating pharmacists;
- to explore customer and patient impressions of the pharmacists’ role in health promotion;
- to measure the extent of pharmacy health promotion activity in English FHSAs and the influence of HSHS on that activity;
- to build a picture of pharmacists’ role in health promotion;
- to examine the opportunities, strengths, and constraints on that role and to propose a model for the development of health promotion in community pharmacy.

What are the main activities, strategies and measures applied?
The Barnet High Street Health Scheme was launched in 1991; it involves seven days of accredited training in health promotion knowledge and skills together with ongoing support for the health promotion role. The scheme was evaluated in a number of ways including in-depth interviews, customer surveys audit, and covert participant research. The main findings were that the scheme had changed those pharmacists who were interviewed and those who were surveyed in the covert research. The in-depth interviews indicated that the pharmacists had changed both their attitude and their behaviour. They were more likely to: be involved in health promotion than they were before the scheme; make interventions that are informal and opportunistic, linked to sale or supply of medicines; be involved in health promotion in the areas of diet, smoking cessation and asthma; have moved away from a product orientated role to a more patient orientated one; be spending less time dispensing medicines and more time talking to and advising patients who expected them to give health promotion advice; to give social and psychological care to their patients; and to use health promotion leaflets appropriately. Lack of remuneration was the largest barrier to involvement in health promotion perceived by the Barnet pharmacists, whereas prior to training, time and lack of training were the largest barriers perceived by both Barnet pharmacists and controls.

Selected references:

What is the scope of the project?
local project but similar projects in other areas of UK. Following the Barnet scheme a number of health authorities provided pharmacist training; over half of English health authorities being influenced by the Barnet scheme.
Which evaluation strategies are being applied/planned?
An MSc and a PhD project

Results of evaluation:
See above

Which issue(s) does the project address?
- diabetes
- tobacco
- cancer
- drug abuse
- asthma
- nutrition
- blood pressure
- physical exercise
- cardiovascular disease
- travel health
- use of medication
- psychosocial/ mental health
- dental health
- general health
- sexual health, AIDS/ HIV

Which target group does the project mainly address?
unselected population (e.g. patient list, clients served)

Which type of intervention is mainly used in the project?
patient information (e.g. on handling of medical devices/ appliances in self-medication; self-monitoring)
use of specific instruction backup: provision of support material (e.g. video, leaflets, handbooks, brochures)
- group health education and counselling (including patient and general health education): schools and community groups
- individual health education and counselling (including patient and general health education):
  - self-care/ self-management education
  - pharmaceutical care
  - lifestyle (e.g. diet/ nutrition; smoking cessation)
- screening and case-finding
Which health professional is mainly involved in project activities?
- community pharmacist
- primary care team at premises (e.g. practice nurse, receptionist, pharmacy assistant)

Extended partners of the project?
- health promotion agencies
- universities

Which were the most important factors supporting development and implementation of the project?
- An ongoing training scheme workshops and now distance learning courses – initial training 7 days plus 3 evenings – on going training
- initially a practice facilitator, ongoing support and recognition by health authority

Which were the most important barriers concerning development and implementation of the project?
Pharmacists are not paid for health promotion activities, therefore do not always give it enough time.

Which specific aspect would you consider especially well developed or otherwise instructive and thus relevant for transfer?
The training scheme and sustainability of the project

Which further information on the project is available?
- journals (English)
- reports (English)
Improving the care of community based patients with ischaemic heart disease: a study of GP-pharmacist collaboration

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Information on institution commissioning the project:
Health Authority

Information on institution co-ordinating the project:
University of Manchester Drug Usage and pharmacy Practice Group at School of Pharmacy and Pharmaceutical Sciences

Status of project:
finished

Running Time:
April 1997-June 1998

Short abstract of the project:

What are the goals, aims and targets?
- To explore and describe changes in patient management resulting from the delivery of six evidence based interventions (cessation of smoking, dietary advice, exercise, aspirin, beta blockers and statins)
- To determine the impact of the pharmacist –run review clinics on the quality of life of patients with angina
- To explore the pharmacist, GPs and patient’s perceptions relating to the review clinics

What are the main activities, strategies and measures applied?
convenience sample of GPs and CPs were paired. All CPs had previously worked on a GP prescribing initiative, CPs trained in clinical and HP aspects of IHD and the management of change. A generic study protocol was developed. Pts aged 45-75 years with stable angina and receiving 4 or fewer prescribed medicines were eligible - a convenience sample was selected. 5 CPs conducted reviews in 8 general practices. The stages of change model was used to support the delivery of lifestyle interventions. Two telephone follow up interviews

What is the scope of the project?
local
Which evaluation strategies are being applied/planned?
- quantitative patient management data
- qualitative interviews with stakeholders

Results of evaluation:
Out of 327 invited, 236 patients attended clinics and 208 remained until completion.

Improvements were seen across all therapeutic and lifestyle interventions significant improvements in relation to the positive modification of diet and the prescribing of statins were seen. In relation to the prescribing of beta blockers and the reduction of obesity achievements were negligible. The outcome was improved patient management and quality of life.

The pharmacists considered the general practice to be an appropriate place to undertake reviews and showed high levels of satisfaction with their achievements. Most of them described a closer, more constructive and professionally satisfying relationship with the GPs. The main them that emerged in the GP interviews was a high level of satisfaction with both the conduct and the outcome of the pharmacist –run angina review clinics. Some GPs indicated that they had changed their approach to the management of angina. Most patients were highly satisfied with the view clinics and believed that the pharmacists had offered a holistic model of care. They perceived the pharmacists as less threatening than the GPS which was said to foster more constructive attitudes towards the declaration and modification of lifestyle risk factors.

Which issue(s) does the project address?
- tobacco
- nutrition
- physical exercise
- cardiovascular disease
- use of medication

Which target group does the project mainly address?
- at risk population
- adults 45-75 with angina

Which type of intervention is mainly used in the project?
individual health education and counselling (including patient and general health education):
- self-care/ self-management education
- pharmaceutical care
- lifestyle (e.g. diet/ nutrition; smoking cessation)
Which health professional is mainly involved in project activities?
- general practitioner
- community pharmacist
- primary care team at premises (e.g. practice nurse, receptionist, pharmacy assistant)

Which were the most important factors supporting development and implementation of the project?
- specific professional educational development measures for competence and skills building (e.g. tutorials, workshops, group or self-directed learning, courses)
- support by specific professionally developed instruments (e.g. guidelines, protocols, manuals, consensus conferences)

Which specific aspect would you consider especially well developed or otherwise instructive and thus relevant for transfer?
The protocol and working methods

Which further information on the project is available?
- reports (english)
Pharmacy Health Care Scheme

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Information on institution commissioning the project:
Department of Health, England

If additional resources are used for the project, where do they come from?
private sponsorship/donations

Information on institution co-ordinating the project:
Pharmacy Healthcare

Status of project:
integral part of everyday practice

Running Time:
ongoing

Short abstract of the project:

What are the goals, aims and targets?
TO DEVELOP THE PUBLIC HEALTH POTENTIAL OF PHARMACY BY:
- SUPPORTING PHARMACISTS TO DELIVER TARGETED HEALTH PROMOTION CAMPAIGNS
- RAISING PUBLIC AWARENESS OF HEALTH ISSUES
- EMPOWERING PEOPLE TO LOOK AFTER THEIR OWN HEALTH

What are the main activities, strategies and measures applied?
TWO MAIN STRANDS TO ACTIVITIES:
- RUNNING CAMPAIGNS – TO PLAN PUBLIC HEALTH INFORMATION CAMPAIGNS IN CONJUNCTION WITH THE PUBLIC HEALTH PRIORITIES OF THE DEPARTMENT OF HEALTH AND PROVIDE PHARMACIES WITH THE INFORMATION AND RESOURCES NECESSARY TO SUPPORT NATIONAL CAMPAIGNS
- TRAINING AND DEVELOPMENT – TO IDENTIFY PHARMACIES’ TRAINING NEEDS IN SUPPORTING AND DEVELOPING PUBLIC HEALTH INFORMATION CAMPAIGNS AND ACTIVITIES. TO COMMISSION OR PROVIDE APPROPRIATE TRAINING OPPORTUNITIES TO THEM.
What is the scope of the project?
COVERS ENGLAND WALES AND NORTHERN IRELAND

Which evaluation strategies are being applied/planned?
NO SYSTEMATIC EVALUATION IN PLACE AT PRESENT ALTHOUGH REPEATED CONSUMER AND PHARMACY SURVEYS HAVE BEEN CARRIED OUT AT VARIOUS INTERVALS. THE SCHEME IS CURRENTLY REVIEWING THE EVIDENCE BASE FOR HEALTH PROMOTION AND PUBLIC HEALTH ACTIVITY IN PHARMACY AND WILL UTILISE THESE FINDINGS TO PLAN FUTURE ACTIVITY.

Results of evaluation:

Which issue(s) does the project address?
- alcohol
- diabetes
- tobacco
- cancer
- drug abuse
- asthma
- nutrition
- blood pressure
- physical exercise
- cardiovascular disease
- travel health
- use of medication
- psychosocial/mental health
- dental health
- (domestic) violence
- general health
- sexual health, AIDS/ HIV
- accident prevention
- child birth and antenatal care
- immunisation
ANY OF THE ABOVE – DEPENDING ON GOVERNMENT PRIORITIES

Which target group does the project mainly address?
GROUPS WHICH ACCESS THE PHARMACY FOR ADVICE ON HEALTH AND HEALTH CARE ISSUES
Which type of intervention is mainly used in the project?
Individual Advice and Counselling and ‘Signposting’ to other Services and Sources of Help

Which health professional is mainly involved in project activities?
- community pharmacist
- AND MEMBERS OF THE PHARMACY TEAM IF APPROPRIATELY TRAINED

Extended partners of the project?
- local/regional government
- health promotion agencies schools
- universities
- other public agencies
- VOLUNTARY SECTOR, E.G. FAMILY PLANNING ASSOCIATION

Which were the most important factors supporting development and implementation of the project?
- HAD SUPPORT FROM NATIONAL PHARMACY POST-GRADUATE EDUCATION BODY
- HAVE ACCESS TO AND USE SYSTEMATIC REVIEWS OF EVIDENCE FOR HEALTH PROMOTION AND OTHER RESEARCH FINDINGS WHEN AVAILABLE AND APPROPRIATE
- HAVE HAD SUPPORT FROM ENGLISH GOVERNMENT FOR THE PROJECT – MAIN FUNDER
- IS SUPPORTED BY A NUMBER OF NATIONAL AGENCIES WITH A SPECIFIC REMIT FOR HEALTH AND/ OR PHARMACY ISSUES
- HAVE FACILITIES PROVIDED BY THE ROYAL PHARMACEUTICAL SOCIETY
- USE MARKET RESEARCH FINDINGS AND OTHER RESEARCH TO TAILOR ACTIVITIES

Which were the most important barriers concerning development and implementation of the project?
- GAINING SUPPORT FOR THE PROJECT IN THE FIRST INSTANCE AND MAINTAINING SUPPORT (PARTICULARLY FINANCIAL) YEAR ON YEAR
- AGREEING DIFFERENT ROLES AND INPUT FROM ALL INTERESTED PARTIES

Which specific aspect would you consider especially well developed or otherwise instructive and thus relevant for transfer?
Multi-Agency Support and Reference to the Evidence-base for Deciding Activities Supporting the National Public Health Agenda

Which further information on the project is available?
- reports (english)
- leaflets (english)
- other material (english)
Part A II: National Guidelines/ Guidance Documents

Pharmacists – Can you do more to help smokers stop?

Date of publication:
MARCH 2000

Actors mainly involved in its development:
PHARMACY HEALTHCARE SCHEME, THE DEPARTMENT OF HEALTH, INDEPENDENT EXPERTS ON SMOKING CESSATION

Who has been commissioning its development?
PHARMACY HEALTHCARE SCHEME

Knowledge about utilisation of the guidelines:
HAS BEEN DISSEMINATED TO ALL REGISTERED PHARMACIES IN ENGLAND, WALES AND NORTHERN IRELAND.
RECEIVED A LARGE NUMBER OF TELEPHONE CALLS (APPROX 50) ASKING ABOUT ITS DEVELOPMENT AND GENERAL QUESTIONS RELATING TO SMOKING CESSATION
MANY ORDERS FOR FURTHER COPIES OF THE DOCUMENT (OVER 1000) HAVE BEEN MADE

Guidance for the development of health promotion by community pharmacists

Date of publication:
September 1998

Actors mainly involved in its development:
Dr Claire Anderson, King’s College London (now at University of Nottingham) plus an expert group of key stakeholders and informants.

Who has been commissioning its development?
Pharmaceutical Division, Department of Health, England
Royal Pharmaceutical Society of Great Britain

Knowledge about utilisation of the guidelines:
Used widely to inform health authorities and pharmacy chains about what other people are doing. Mentioned in a number of reports and publications regarding health promotion in community pharmacy.
The NPA Pharmacy Health Improvement Frameworks

Date of publication:
- Cancer – August 1999
- Coronary heart disease and stroke- August 1999
- Smoking cessation- September 1999
- Accidents- September 1999
- Mental health – November 1999

Actors mainly involved in its development:
Professional development Department National Pharmaceutical Association (NPA)

Who has been commissioning its development?
National Pharmaceutical Association (NPA) based on Department of Health health improvement programmes and aimed at pharmacists at a local level who have been asked to respond to health improvement programmes

Knowledge about utilisation of the guidelines:
Used widely throughout the UK.

Medicines Ethics and Practice Guide

Date of publication:
Published six monthly by Pharmaceutical press sent free to all registered pharmacists

Actors mainly involved in its development:
RPSGB

Who has been commissioning its development?
RPSGB

Knowledge about utilisation of the guidelines:
widely used as they are the professions guidelines.
Contains guidelines on health promotion, advice, health screening and so on but out of date all references only up to 1994 .
Pharmacy in a New Age (PIANA) and subsequent publications: Summary of responses, Building the Future, Over to You

Date of publication:
PIANA- 1996 subsequent accompanying publications from 1996-9

Actors mainly involved in its development:
Royal Pharmaceutical Society of Great Britain

Who has been commissioning its development?
as above

Knowledge about utilisation of the guidelines:
Widely used and implemented, an ongoing PhD project is looking at this issue (Karen Rosenbloom, University of Derby) Used by local community pharmacy development groups nationally to implement services.

Pharmacists can you do more to help smokers stop?

Date of publication:
May 2000

Actors mainly involved in its development:
Department of Health, Pharmacy Healthcare Scheme

Who has been commissioning its development?
as above

Knowledge about utilisation of the guidelines:
distributed to all community pharmacists but no knowledge re utilisation
Part B: Community Pharmacy in the UK

There are 12,000 community pharmacies in the UK, approximately half of these are independent contractors. Traditionally community pharmacies have been situated in high streets, villages, and shopping centres. Pharmacies are now also in or alongside primary care centres and in supermarkets. The pharmacist's core task remains the supply of both prescription and non-prescription medicines.

Pharmacists must complete a four year MPharm university degree (in 1999 the last people graduated from the three year BPharm). There are 16 UK schools of pharmacy providing undergraduate MPharm degrees, a further three offer postgraduate degrees. The syllabuses of all undergraduate degree courses are accredited by the Royal Pharmaceutical Society every four years. A one year, competency based pre-registration programme must be undertaken with an accredited pre-registration tutor before a graduate can enter the register. Pre-registration graduates must also pass the pre-registration examination. Pharmacists and their premises are registered with the Royal Pharmaceutical Society of Great Britain or Northern Ireland but are required to have contracts with local health authorities/health boards to provide the following national health services:

- Dispensing prescriptions
- Practice leaflet
- Keep patient medication records
- Display eight (or locally agreed number) of health promotion leaflets in Scotland set aside an area for health promotion activity

Additional services as agreed and commissioned locally examples include:

- Advice to care homes.
- Injecting equipment supply and exchange
- Supervised administration of methadone for drug users
- Health promotion
- Disposal of unwanted medicines
- Talks in schools and local community groups
- Anticoagulant monitoring

Pharmacists lead prescribing under group protocols, e.g. headlice, emergency contraception, medicines for minor ailments.

The recent National Health Services Plan proposes new ways of paying pharmacists moving away from a fee per item basis for dispensed medicines to a payment for services such as medicines management / pharmaceutical care and repeat dispensing. It is also envisaged that more medicines will be available via pharmacies whether by deregulation or pharmacist dispensing. The details of this plan will not be known until autumn 2000.
Health promotion has been defined as part of the professional role as ‘the promotion and support of healthy lifestyles—helping people protect their own health, through health screening, advice on healthy living and other services’.

In a guidance document produced for the Royal Pharmaceutical Society of Great Britain and the Department of Health in England, health promotion was defined:

“Whilst maintaining the pharmacist’s role as the expert on medicines, health promotion must become an implicit part of pharmaceutical care and indeed will most often be linked to the sale or supply of medicines. Health promotion is something that all pharmacists should do, the basic philosophy of health promotion is something that all pharmacists should have. Health promotion will occur at different levels (See below). All pharmacists can provide a basic service, whilst others can do a lot more. There will be different levels of entry, with the aim of all pharmacists eventually reaching the highest level. Pharmacists should work for health gain and not just for lifestyle changes, aiming to improve the health of the people with whom they come in to contact, helping to increase the number of years that people spend free of illness. Pharmacists see the worst off people in society and can help to tackle inequalities in health. All interactions between community pharmacists and the public should aim to be health promoting.”

The guidance proposed two levels of health promotion, level one would be expected for all pharmacists and level two for those who wished to specialise.

Level one

Focuses on the pharmacists encouraging healthy behaviour. Pharmacists set aside an area for health promotion literature and information. Pharmacists and their staff use leaflets to highlight health issues. Pharmacists respond to requests for advice and actively give simple health promotion advice when giving out prescriptions, making sales and advising about treating symptoms.

Level two

In addition to level one activities, pharmacists seek opportunities to promote health. If appropriate they should identify the stage of change a person is at and offer individualised advice and ongoing support.
All Pharmacists should:
- present medicines in a way that prevents accidents in the home;
- give health promotion advice linked to sale and supply of medicines;
- give health promotion advice linked to presenting symptoms;
- utilise leaflets appropriately;
- take part in local and national health promotion events;
- give dietary advice;
- give simple advice on smoking cessation and promote the use of nicotine replacement therapy;
- give advice about contraception and safe sex, conception, pregnancy, breast feeding immunisation and health of under fives;
- give evidence based health promotion advice;
- take part in a needle exchange scheme and a supervised methadone administration scheme, if appropriate;
- take part in disposal of unwanted medicines campaigns.

Pharmacists see the most vulnerable people in society, including the elderly, mothers and their young children, those with chronic illness and those in the lower (C2DE) social classes who are less likely to be empowered for self care. The Royal Pharmaceutical Society have estimated that an “average” pharmacy might expect to serve approximately 50 diabetics, 150 asthmatics, 15 people discharged from hospital in the previous week (including day surgery patients), eight people with colostomies, 750 elderly people, including 30 over 75s and 20 in residential care, three people with coeliac disease, 20 people suffering from cancer, of which four will be receiving terminal care, one person with cystic fibrosis, up to 500 people taking antihypertensive medication, several people who are keen to stop taking tranquillisers, 600 carers (carers are high users of pharmacies, with a third of them visiting pharmacies more than once a week), a few hundred people with a disability, many who have difficulties managing their medication, at least two people who have AIDS or are HIV positive, an assortment of drug users, 300 under fives, 50 pregnant women, and a handful of people with chronic mental health problems.

In RPSGB commissioned research to examine access to and usage of community pharmacies. A sample of 517 people were interviewed in their homes across Great Britain. Only 11% had sought general health advice from pharmacists, of whom half were seeking advice about medicine usage. These 11% consisted of women mainly, people with children, those in lower social classes (C2DE) and “striving” and inner city respondents. A further 14% had received unsolicited health related advice which was defined as whether they had seen a poster, picked up a leaflet, or the pharmacist had spoken to them about a particular health-related product or issue. This advice was received on average twice in the last year and was more likely to have been received by respondents with children and heavier users of pharmacies.

A census of CP HP activity in health authorities was published in 1996. A update was published in 1998. A review of the development of HP in CP in the UK was recently published.

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Preferences and expectations

In September 1996, the RPSGB published New Horizons, a summary of the largest ever consultation on the future of the pharmacy profession. It gave a summary of the views of more than 5000 pharmacists. Health promotion was ranked second, after advice to patients, as the most important new or expanded service for patients that pharmacists should be providing. Almost every response stressed as important the structural advantages enjoyed by the pharmacist and the fact that pharmacists are probably more accessible and available than any other health care professional. The report also emphasised that pharmacists can advise both those who are well and those who are ill, and that the public are willing to seek health promotion advice from pharmacists. The barriers, the report said, are principally shortage of time and (in some cases) limited appropriate physical facilities in the pharmacy. The benefits to pharmacists are reported as greater professional satisfaction and opportunities to work more closely with other health care professionals.

The main findings from in-depth interviews with pharmacists on the Barnet High Street Health Scheme were that the scheme has changed those pharmacists who were interviewed. The pharmacists had changed both their attitude and their behaviour. They were more likely to: be involved in health promotion than they were before the scheme; make interventions that are informal and opportunistic, linked to the sale or supply of medicines; be involved in health promotion in the areas of diet, smoking cessation and asthma; have moved away from a product orientated role to a more patient orientated one; spend less time dispensing medicines and more time talking to and advising patients who expected them to give health promotion advice; to give social and psychological care to their patients; and to use health promotion leaflets appropriately. Lack of remuneration was the largest barrier to involvement in health promotion perceived by the pharmacists, whereas prior to training, time and lack of training were perceived as the largest barriers.

Other studies have concluded that the main constraints to pharmacist involvement in health promotion are lack of time, space, finance, training and a perceived conflict between the professional and commercial roles of the pharmacist. Anderson and Alexander conducted a telephone survey of 40 pharmacists using semi-structured questionnaires, before and after attendance on a health promotion course in Wiltshire. Training led to changes in knowledge, and perceived changes in attitude and practice. The value of the increased knowledge was recognised by participants, in particular when talking to patients and other health professionals. The change in attitude, towards a more holistic view of health, was seen by the authors as a positive benefit of training, as it may be of value to the pharmacists. Changes in practice were evident despite recognised constraints.

Consumers

The published work to date suggests that consumers in the UK are broadly sympathetic to the idea of pharmacists providing health advice. However, few would take the initiative in approaching the pharmacist and asking for advice. McElney et al. said that face to face advice is preferable, while in the Aston study consumers wanted tailored advice. Leaflets were acceptable to some. However, in the Aston study only half of the general population had noticed leaflets. In the Barnet study those with prescriptions were more likely
than others to regard the pharmacist as someone to go to for advice about staying healthy. Those Barnet consumers who had taken health promotion leaflets were significantly more likely to be those who had asked the pharmacist about general health and those who thought it was the usual job of the pharmacist to give health advice. The consumers who were aware that leaflets were displayed in pharmacies were also those who were more likely to think that the media was the most convenient place to get advice about staying healthy. Many of the consumers interviewed in Barnet did not perceive that there was a role for community pharmacists in health promotion.

Laws, rules and regulations

Pharmacists are restricted by the law on supervision, this states that they must always be present in the pharmacy to supervise dispensing and sale of the Pharmacy medicines (There are three legal categories of medicines, Prescription only medicines (POM), Pharmacy (P), General Sales List (GSL). Pharmacists currently receive the bulk of the National Health Services payment on a fee per item basis for dispensing prescriptions this means that they are reluctant to provide new, services without additional remuneration.

Mandatory education is not a requirement. However, there is a professional requirement to do 30 hours of continuing professional development. Some health authorities will provide accreditation to pharmacists who have fulfilled certain training requirements. This acts as an incentive.

Health authorities/boards have provided incentives to take part in health promotion initiatives.

Barnet high street Health Scheme (1991- present)
The first to provide full locum expenses to enable pharmacists to attend daytime training.

South Staffordshire (1998-1999)
Paid 13 pharmacists for health promotion counselling services. Pharmacists were trained to provide structured plans to help patients change behaviour which is likely to result in ill health. The areas to be covered in the first year are dental health, increasing physical exercise, improving diet and smoking cessation. The pharmacists received thirty pounds per patient interview.

North West Anglia
Accreditation scheme. Pharmacists must complete 5 Centre for Pharmacy postgraduate Education evening workshops on health promotion (2 evenings), dental health, coronary heart disease, and working with GPs. Counter assistants must also be trained. Pharmacists are paid 45 pounds for attending each training evening and if they take part in ongoing health promotion campaigns, for example folic acid, avoiding going to the doctor, dealing with flu, they will be paid a further six hundred pounds per year.
St Helen’s and Knowsley (1997)

have trained pharmacists in advising patients about cardiology medicines and healthy living and pay six pharmacists 16 pounds per hour to advise patients in special clinics in the GP surgeries.

Kensington, Chelsea and Westminster (1995) ¹

113,000 pounds for pharmacy improvements which was awarded to 28 pharmacies to install either a health promotion area, a waiting area or access for the disabled. The maximum grant per pharmacy was 15,000 pounds. All applicants underwent health promotion training and displayed health promotion leaflets.

Gwent (1994) ¹

One thousand pounds per pharmacy for project to determine the frequency and nature of community pharmacy involvement in the provision of HP advice, evaluate public perception of worth of HP advice, produce a strategy for future involvement of community pharmacists in HP.

Croydon (1998) ¹

300 pounds quarterly per pharmacy for the provision of in-store information displays and leaflets on LA health related topics and the active promotion of messages tackling inequalities in health

East Riding (1998) ¹

6000 pounds for training courses for pharmacists and counter assistants to promote the health promotion theme ‘Helping People Change’ including smoking cessation, physical activity, healthy eating and alcohol.

N&E Devon (1998) ¹

1) PEACH (Pharmacists Educating All in Community Health) was a three month rolling programme of health promotion based on ‘Our Healthier Nation’ topics which was remunerated at five pounds per contractor
2) Information advice and training to include health promotion given by community pharmacists to carers and funded by HA health Promotion at 100 pounds per pharmacy involved.

North Staffs (1998) ¹

Smoking cessation programme with support remunerated at 75 pounds per patient.

¹ Information provided by Pharmaceutical Services Negotiating Committee (PSNC)
Methadone Supervision

The average rate of remuneration per supervision of methadone consumption is one pound to one pound and fifty pence, with the highest recorded at three pounds. Most schemes are paid on a per dose basis but two areas now have variable fees based on activity i.e. number of clients. Additional funding may also be available as a start-up fee, additional recording for audit purposes and booths/areas for consumption.

Needle Exchange Schemes

Originally the Pharmaceutical Services Negotiating Committee recommended an annual retention fee with an additional payment per pack issued in excess of 50 packs per quarter. This method of payment is still the most widely used, but variations include a flat annual fee only (average 650 pounds), variable fee on a sliding scale according to activity (4000 pounds pa highest for very high activity) or payment per exchange only (average one pound per exchange). The original combination scheme averages an annual fee of 300 pounds with an exchange fee of one pound. (highest two pounds). Most schemes are within the range of 500 to 750 pounds and submit claims quarterly. Although the contents of the packs vary, they usually contain needles, syringes, medicated swabs, cotton wool, condoms and health promotion leaflets.

Education and Training

Integrated into university based undergraduate, postgraduate (e.g. postgraduate certificates, diplomas and MScs in Community Pharmacy) and continuing professional development programme (Four national centres for pharmacy postgraduate education in England, Wales, Scotland and Northern Ireland) funded by Departments of Health. The National Pharmaceutical Association (NPA) and College of Pharmacy Practice (CPP) also provide continuing education programmes. These are all well accepted.

Undergraduate curriculum: communication skills, patient counselling, social science including health policy, epidemiology, health promotion,

Postgraduate curriculum: - no set curriculum but many courses include health promotion modules e.g. Nottingham University includes health promotion, sociology for pharmacists and health policy.

Continuing Professional development: - Face to face and distance learning courses available from national centres for pharmacy postgraduate education and NPA, e.g. Health promotion, counselling, dealing with drug users, smoking cessation, men’s health, women's health, pregnancy and conception, child health, Pharmacists can become a member of the College of Pharmacy Practice or receive an advanced award by examination or by submission of a reflective portfolio. Health promotion is included as an examination subject for both membership and advanced award.

Many health authorities have provided or commissioned training in health promotion for local pharmacists. Health authorities often purchase courses from the national centres for pharmacy postgraduate education.
Specific Policies, programmes and projects for HP in CP

Pharmacy and Policy Documents concerning health

During the 1990s, the health promotion role of the pharmacist was increasingly reported, researched and accepted by both the profession and policy makers.

In 1985, The Nuffield Committee proposed an extended role, besides dispensing for the profession. Regarding health promotion, the report stated, “There is a role for community pharmacists in health education in co-operation with other health professionals”. It acknowledged that many pharmacies are only financially viable because of non-pharmaceutical business and called for a review of remuneration, considering the increasing professional role. Promoting Better Health supported the findings of the Nuffield report and stated that the health education role of the pharmacist should be extended.

In 1990, a joint working party was set up between the Department of Health (DH) and the pharmaceutical profession that culminated in the publication of the Pharmaceutical Care Report in March 1992. The report made three recommendations about health promotion: pharmacists should be encouraged to set aside areas for displaying material and providing advice and counselling; pharmacists should be encouraged to participate more widely in health promotion activities and campaigns through Family Health Service Authorities; and that pharmacists should contribute to health promotion by offering diagnostic testing and screening.

Primary Care: the Future listed health promotion in pharmacy as an area where innovative local practices exist and stated that these innovations should be developed nationally. It proposed that pharmacists should be the first port of call for provision of advice and over the counter (OTC) medicines for treatment of common ailments. If this occurred, it said, it would increase pharmacists’ health promotion role. The report also said that pharmacists should be actively promoting the health of people; contributing to the local achievement of Health of the Nation targets; and encouraging the principle of self care and individual responsibility for health. It included this quote: “People are unwilling to take responsibility for their own health. Educate people to use the pharmacist as professional adviser and pharmacists to become more than shopkeepers.” The report acknowledged that there should be changes in remuneration away from perverse incentives, increased working with the primary care team and that there is currently a major constraint due to the pharmacist having to be constantly on the premises for supervision. It also called for improvements in pharmacy premises, to create a more professional atmosphere and to provide private counselling areas or space for more health promotion material.

The white paper The New NHS: Modern, Dependable emphasised the need for the NHS to work locally to reduce inequalities in health and to improve health. It highlighted the need for health promotion and introduced the idea of Health Improvement Programmes, which are joint plans to improve health and healthcare locally. The paper acknowledged that “most people look to their family doctor or local pharmacist for advice on health.
matters”. Quality is important and national indicators of quality are being developed. Primary care groups/trusts have been set up, many involve pharmacists in the planning and provision of services. Health Action Zones have been formed, targeting areas where greatest inequalities in health exist. Pharmacists in these areas have the opportunity to develop healthy living centres as well as developing their expertise in medicines management and health promotion in areas such as smoking cessation, emergency contraception and coronary heart disease. The white paper, Saving Lives, Our Healthier Nation 27 focused on improving the health of the population as a whole by increasing the length of peoples’ lives and the number of years people spend free from illness. It sought to improve the health of the worst off in society and to narrow the health gap. Four major target areas were included, namely coronary heart disease and stroke, cancer, mental health and accidents. The paper called for local areas to develop health improvement plans and to develop services to effectively deliver appropriate health care. Health care providers, including pharmacists, are held responsible for their contribution in making people healthier.

The Scottish green paper Working Together for a Healthier Scotland 28 explicitly mentioned pharmacy:

‘Pharmacists provide a range of services to the public and have a direct impact on public health. Community pharmacists see most adults and many children regularly - a recent survey concluded that 94% of the population visited a pharmacy at least once a year ( compared with 67% of their registered patients for GPs) The wide distribution of pharmacies means that professional information and advice are available in diverse communities on UK and local health initiatives, the avoidance of further illness, safer sexual practices, drug and medicine safety, smoking cessation, healthy eating, exercise, sun safety, the management of chronic conditions and alcohol consumption. Community pharmacists also contribute to local groups tackling the misuse of drugs’

In September 1996, the RPSGB published New Horizons 2, a summary of the largest ever consultation on the future of the pharmacy profession. It gave a summary of the views of more than 5000 pharmacists. Health promotion was ranked second, after advice to patients, as the most important new or expanded service for patients that pharmacists should be providing. Building the future 29, the RPSGB’s response to New Horizons stated that pharmacists help people to maintain good health by providing health screening, advice on healthy living and other services. It acknowledged that both ill and well people visit pharmacies and that pharmacists are thus uniquely placed to offer health information and advice. It also recognised the major role played by the Pharmacy Healthcare Scheme. However, it also acknowledged that the role of pharmacists within health promotion could generally be better integrated with other national and local activities and could be specifically supported by the NHS. The report suggested that in future pharmacists will be in demand by other healthcare professionals as centres for health advice sessions and that pharmacists will also provide advice sessions in other settings. Pharmacists, it said, will also be involved in interpreting the increasing amount of health related information available, for example, on the Internet.
Actors

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| National Departments of Health (England, Wales, Scotland and Northern Ireland) all have a pharmaceutical division headed by chief pharmacist. | Producing policy documents and white papers  
Commissioning education and training  
Developing guidance  
Funds Pharmacy Healthcare Scheme |
| Health Development Agency (HDA) (formerly Health Education Authority (HEA)) | HEA worked with pharmacy on a number of projects. HAD is new and still developing its activities- no pharmacy activity at present. |
| Local health authorities/boards                                      | Commissioning local health promotion services and associated training.   |
| Primary care groups/trusts and equivalents                           | Commissioning local health promotion services and associated training.   |
| Royal Pharmaceutical Society of Great Britain, Pharmaceutical Society of Northern Ireland | Supporting developments, providing guidance, curriculum development.      |
| National Pharmaceutical Association                                  | Supporting developments with practical guidelines and regional community pharmacy facilitators.  
Producing educational materials, developing HP projects with health authorities and other agencies. |
| Pharmacy practice research and development groups in universities    | Evaluating ad developing HP projects with local health authorities and primary care groups.  
Dissemination of findings.                                             |
| Pharmaceutical Industry                                             | Support of projects, development of training materials, e.g. smoking cessation linked to NRT.  
Lobbying                                                               |

HP in CP is supported by discussion at conferences (e.g. British Pharmaceutical Conference, Health Services Research and Pharmacy Practice Conference). In professional journals (Chemist and Druggist, Pharmaceutical Journal as well as in peer reviewed journals), in newsletters from NPA and Pharmacy Healthcare Scheme. Pharmacists have successfully been involved in lobbying, for example, to make nicotine replacement therapy more widely available and prescribable on the NHS (Novartis foundation (1998), Action on Smoking and Health (ASH) 2000).

Government and professional information campaigns support the pharmacists role in HP examples include a Department of Health leaflet about ‘flu in winter 1999-2000, the NPA’s ask your pharmacist campaign and associated roadshows, Pharmacy Healthcare Scheme leaflets and information. Many Health Education Authority campaigns have mentioned pharmacy in the past.
References