NATIONAL INSTITUTE FOR HEALTH AND
CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1. Quality standard title

Community pharmacies: promoting health and wellbeing

Date of quality standards advisory committee post-consultation meeting:
10 March 2020.

1. Introduction

The draft quality standard for community pharmacies: promoting health and wellbeing was made available on the NICE website for a 4-week public consultation period between 17 January and 14 February 2020. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 32 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the quality standards advisory committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the committee as part of the final meeting where the committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the committee should read this summary alongside the full set of consultation comments, which are provided in appendices 1 to 2.

1. Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be to be for these to be put in place?

3. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

4. Do you have an example from practice of implementing the NICE guideline that underpins this quality standard? If so, please provide details on the comments form.

1. General comments

The following is a summary of general (non-statement-specific) comments on the quality standard:

* Most stakeholders agreed that the draft quality standard reflects key areas for quality improvement.
* Strong support for a quality standard that recognises expertise within community pharmacy.
* Statements seen as ambitious but achievable.
* Suggestion that implementation of quality statements should be gradual.
* Focusing the quality standard on local service commissioning is seen as a limitation considering that community pharmacy core and advanced services are written nationally.
* Suggestion that the perception of pharmacists as healthcare professionals needs to be addressed - criticism of pharmacists undertaking the roles and activities suggested within the quality standard.
* Suggestion that there should be more clarity on roles and responsibilities among healthcare professionals and within collaborations the document refers to.
* Suggestion that the quality standard should refer to registered healthcare professionals, such as pharmacists and/or pharmacy technicians rather than “community pharmacies”.
* Concern that quality standard does not cover training, supervision or resources required to do this work. Clarity of professional limits is needed to protect pharmacists and the public.
* Concern that the quality standard misses an opportunity to express an explicit commitment to vulnerable groups, disproportionately affected by health inequalities such as Blood Born Viruses (BBVs) and Hepatitis C (Hep C).
* Suggestion that sexual and reproductive healthcare services should be specifically mentioned.

### Consultation comments on data collection

Mixed response from the stakeholders:

* There are some local systems and structures in place to collect data for the proposed quality measures, however in some cases these may be quite ad hoc or informal. It should be feasible to formalise these to provide more consistent measures.
* Much of the data sources are heavily reliant on the new NHS structures proposed in the NHS long-term plan. These include but are not limited to PCNs, where discussions pertaining to scope and funding are still to be finalised.
* Local systems and structures are not in place as NHS organisations are undergoing radical re-organisation through the forming of Primary Care Networks (PCNs) and Integrated Care Systems (ICSs).
* There is currently neither the system nor the structure in place to collect data for the proposed quality measures
* Concern about the burden of data collection in the context of capacity issues within community pharmacy.
* Data from local Healthwatch suggested as the source of information on patient experience throughout the quality standard.

### Consultation comments on resource impact

* Concerns that a lot of the public health services that were commissioned from community pharmacy have recently been cut. Providing stop smoking services or sexual health services is no longer commissioned consistently across the country.
* Concerns about funding and staffing issues - existing workload pressures and cuts to commissioned services are having a negative impact on the ability of community pharmacy teams to take on more responsibilities.
* To be able to deliver the quality standard, the pharmacy workforce must be trained, competent and confident providing these services.
* Training pharmacists to deliver comprehensive advice requires funding.
1. Summary of consultation feedback by draft statement
	1. Draft statement 1

Community pharmacies and local commissioners work together to integrate community pharmacy services into existing care and referral pathways.

### Consultation comments on quality statement

Stakeholders made the following comments in relation to draft statement 1:

* Better integration and better interoperability will bring workflow efficiencies.
* There is a role for national commissioning to enhance community pharmacy integration, as well as commissioning at a local level. The Community Pharmacist Consultation Service (CPCS) is an example of a nationally commissioned service which integrates community pharmacy into local referral pathways.
* Better collaboration and joint working could be further incentivised through alignment of the Community Pharmacy Contractual Framework (CPCF) and the General Medical Services contract agreement.
* The pathways need to be clearly defined to make the experience seamless for patients. Referrals from community pharmacist to another provider should be actioned as priority referrals, not putting the person to the back of the queue.
* Any referral arrangements would need to consider implications for anticompetitive behaviour.
* ‘Buy in’ from all health care settings involved is necessary to ensure that referral pathways deliver the best possible patient outcomes. This may involve educating healthcare professionals about the services provided and ensuring that other healthcare professionals are confident in referring patients to community pharmacies.
* There should be a clear agreement on what is within the scope of community pharmacists’ practice.
* Integration of community pharmacy into the wider referral pathways has to be done in a structured, auditable and properly resourced manner.
* Statement should not refer to existing referral pathways - new referral pathways may be established to enhance pharmacy’s integration into primary care.
* Statement is unclear and implies that referral pathways should be established between community pharmacies. It would be helpful to give examples of when referral between pharmacies is appropriate.
* Information should only be accessed based on clinical need and to improve delivery of patient care.

### Consultation comments on suggested measures

* This statement is hard to measure - there are several pathways that could be pursued. Does the organisation meet the standard if only one pathway or 2 pathways are integrated?
* Local systems and structures are not in place to collect data for the proposed ‘structure’ quality measures, but it would be possible for pharmacy contractors to provide evidence of whether and how they have met the measures.
* The new CPCF includes standard metrics on the mandatory health campaigns which should be gathered through existing IT systems, assimilated nationally but monitored locally through the Community Pharmacy Assurance Framework (CPAF).
* The NHS Digital and Professional Record Standards Body Pharmacy Information Flows project provides a basis for data collection required for monitoring this quality standard.
* This statement can be measured by auditing local care and referral pathways particularly those relating to long-term conditions.
* Structure measure b:
* This data may be difficult to accurately collate.
* Local collaborative relationships between community pharmacies and other health settings including community and voluntary organisations can facilitate effective referrals and sign posting but this may not always be captured.
* Structure measure d:
* Enhanced information sharing between healthcare settings will bring benefits for patients - more seamless care and potentially improved patient safety.
* This may be a challenge to measure - potentially large number and variety of social care providers within a PCN boundary, data sets not matching up, local willingness to share data within the rules.
* Access to a read/write facility is outside the remit of local commissioning arrangements – this should be left as a national framework objective.
* Data collection for Pharmacy Quality Scheme (PQS) is done nationally, not locally.
* As Local Health and Care records (LHCR) develop, community pharmacies should have both read and write access to these.
* Outcome measure a:
* It is not possible to quantify all referrals and signposting from community pharmacies - this information will not always be captured
* Referral information and data is not yet part of the PQS - related criteria would need to be incorporated.
* Measuring number of referrals does not provide information about the appropriateness, quality or effectiveness of the referral - need to embed an element of quality within the referral process.
* It is output rather than outcome
* It should be amended to numbers of direct referrals into and from community pharmacies to other health and social care services
* Referrals should be fast-tracked if the pharmacist thinks that this is necessary - outcome could be measured in terms of routine and fast-tracked referrals.
* PharmOutcomes and Sonar are not universally used or funded, so may not be a good data source.
* Outcome measure b:
* Numerator and denominator are very difficult to define and measure; patient survey wouldn’t reflect this data as it only captures those who respond; are users of the service those who go to the pharmacy, or anyone who gets a script?
* A more measurable denominator would only include people who visited the pharmacy with a health condition or service that was being commissioned.
* Data sources should include both quantitative data (such as those from surveys) and qualitative data (feedback and experiences) – this could be feedback collected throughout the year including complaints data and any learning implemented.

### Consultation comments on audience descriptors

* Only community pharmacists should be able to make or receive referrals rather than community pharmacy teams.

### Equality and diversity considerations

* People in rural communities find it difficult to access some of the services due to lack of transport support. Whilst a referral may be made to health and wellbeing support, it’s important to be realistic in regards to the person’s location and transport availability. Integration of pharmacies working with local community support groups, luncheon clubs, social activities in rural areas would be great and a much needed priority.
	1. Draft statement 2

Community pharmacies and local commissioners promote healthcare services and support available from community pharmacies.

### Consultation comments on quality statement

Stakeholders made the following comments in relation to draft statement 2:

* This is a useful aim but not a quality standard.
* Relative organisational immaturity of Primary Care Networks (PCN) may mean that supporting the achievement of this quality statement should be best recognised as a longer-term objective.
* Communication at a national level is required for the initiatives to result in increased awareness of pharmacy teams’ skills and a significant shift in workload from GP practices and other providers to community pharmacy.
* The statement should be more explicit about the need to increase public confidence in pharmacy teams. This would support the overall outcome of uptake of pharmacy services.
* The availability of a highly qualified pharmacist at all times on a walk-in basis should be at the heart of any campaign to promote the extent of services and skills available via community pharmacy.
* Concern that encouraging patients to seek help from community pharmacists who had no training in minor illness or local referral processes may increase the workload for other services, particularly primary care.
* Suggestion to include “other health and care providers” in the statement.
* Suggestion to amend “healthcare services” to “health and wellbeing services”.

### Consultation comments on suggested measures

* Local systems and structures are not in place to collect data for the proposed quality measures, but it would be possible for pharmacy contractors to provide evidence of whether and how they have met the measures. However, such data collection at contractor level may not be a good use of constrained resources.
* Pharmaceutical needs assessment published by local authorities could be used as data source.
* It would be useful to look at measures that monitor how much work is being moved ‘upstream’.
* Structure measures:
* Counting the number of initiatives is potentially misleading as it is the effectiveness of initiatives that is important.
* Outcome measure a:
* Difficult to measure the uptake - if the quality standard is successful patients will self-present / self-refer but this is not measurable.
* Outcome measure b:
* this will not measure public awareness of those who do not currently access GP services; surveys need to be carried out with other community services used by underserved groups.

### Consultation comments on audience descriptors

* The description should refer to a pharmacist rather than pharmacy teams - a responsible pharmacist is accountable by law for all the activities that occur within a pharmacy setting.
* Suggestion that promotional activities should be more targeted to reach those who will benefit from the services most.

### Equality and diversity considerations

* Include social care workers in supporting people who are homebound, as relevant for domiciliary and supported living services for people who may not have friends/family involved.
	1. Draft statement 3

Community pharmacies work with local commissioners to establish population needs, identify gaps in services and agree actions to address health inequalities.

### Consultation comments on quality statement

Stakeholders made the following comments in relation to draft statement 3:

* Health inequalities is a broad definition so needs to be more clearly defined in the context of this statement.
* The role of pharmacies in service design and commissioning should be clarified. Pharmacy teams have frequent contact with people and may be able to identify where increased support could be provided and signal to a commissioner that their patients are requesting support they are not commissioned to provide. It would be difficult for individual community pharmacies to be able to ‘agree actions to address health inequalities’. Local Pharmaceutical Committees (LPCs) and Primary Care Networks (PCNs) can engage with local commissioners on behalf of all pharmacy contractors in the area, thus ensuring that local population needs are met.
* Community pharmacies do not have access to data sources or the required background skills to undertake this sort of analysis. It is the responsibility of the NHS and Public health institutions to undertake population needs analysis, to identify unmet needs and to commission services to meet these needs.
* Quality statement should include local public health teams and The Local Pharmaceutical Committee Chief Officer with the District Prescribing Committee (DPC).
* Community Pharmacies are in a position to support the proposed PCN Health Inequalities DES but this will need to be recognised and funded through the Community Pharmacy Contractual Framework (CPCF) and/or local service commissioning.
* Healthy Living Pharmacy (HLP) quality criteria already requires community pharmacies to understand local health needs and inequalities (Joint Strategic Needs Assessment (JSNA), Health Profiles etc.)

### Consultation comments on suggested measures

* Pharmaceutical Needs Assessments (PNAs) should be included in data sources alongside the JSNAs as they are often co-dependent documents.
* Structure measure a)
* Public health teams in localities already undertake significant data collection and analysis of population health needs using nationally agreed datasets. It would be inappropriate to base commissioning decisions on this information. However, LPCs and PCN Leads could inform decisions on how services are delivered and what opportunities are available.
* “intelligence from community pharmacies” – it is equally important for community pharmacies to use intelligence from a variety of sources; it may be more useful to present this as an iterative cycle rather than a linear process.
* Outcome measure:
* Data collection would be challenging. Pharmacy systems do not record any significant demographic information. It may be possible to identify pharmacies in areas with higher populations of people from underserved groups. The service uptake in these areas could then be monitored and used as an indicator for service use among underserved groups.
* Underserved groups should be defined.
* Additional measures suggested:
* experience of people in underserved groups
* qualitative measure to ensure that all underserved groups are treated equitably.

### Consultation comments on audience descriptors

* Further clarity is needed on how this engagement would be delivered.
* To develop an understanding of the extent of local health inequalities, different health providers must share intelligence to build a full picture of health outcomes and gaps in service provision. Local Pharmaceutical Committees (LPCs) can engage with local commissioners on behalf of all pharmacy contractors in their area and share information with commissioners, thus ensuring that local population needs are met. In this way, community pharmacies can collectively share data to enable the development of an understanding of local inequalities.
	1. Draft statement 4

People who have a long-term health condition or need support to adopt a healthier lifestyle are offered health and wellbeing advice and education when they use community pharmacy services.

### Consultation comments on quality statement

Stakeholders made the following comments in relation to draft statement 4:

* Suggestion to remove “have a long-term health condition” from the statement as other groups would also benefit from this advice. The payback to the NHS of having a younger person adopt a healthier lifestyle is likely to be greater than an older person with a long-term condition who could, apart from their condition, be leading a very healthy lifestyle.
* Suggestion to focus on smoking and weight management services - more targeted support commissioned by local CCGs would enable pharmacies to deliver support leading to better health outcomes.
* Suggestion to add people with a learning disability and/or autism to the statement.
* Brief advice and resources such as leaflets may raise awareness about living a healthier lifestyle but tailored and ongoing support is often needed to successfully make lifestyle changes and improve person’s health.
* The quality statement should make it more explicit that the advice and education could cover both the prevention agenda and help with managing existing conditions.
* As well as supporting patients to make lifestyle changes to improve their health and wellbeing, community pharmacy teams are well placed to identify ongoing symptoms which may require signposting to another healthcare professional.
* Suggestion to use “healthier behaviours” rather than “healthier lifestyles”.
* Community pharmacy teams may have the skills and desire to provide more health and wellbeing advice to people, but they may not have the time or financial capacity to undertake this work.
* For consistent delivery of any given service that standardised training should be provided by commissioners.
* Pharmacists should offer people the opportunity to talk in private about their health and wellbeing, in their consultation rooms and should have protected time to deliver this service.

### Consultation comments on suggested measures

* Community pharmacy teams have many health and wellbeing conversations with people but the interactions that are usually recorded are those associated with delivery of commissioned services.
* Considering the freeze in funding over a number of years, the measures should focus on commissioned services and training undertaken by community pharmacy teams to meet the service requirements.
* Suggestion that quantitative datasets may not provide the desired information and sources such as longitudinal studies and/or service evaluations should also be considered.
* Accurately quantifying the ‘number of interventions and advice delivered by local pharmacies’ is not feasible.
* The pharmacy may not be able to record advice given - there is no requirement for the patient to give their personal details to obtain advice. Unless the pharmacy dispenses medicines to the patient, they do not have a patient record against which they could record the advice given.
* Structure measure b:
* Considering the large locum workforce in the community pharmacy sector, it may be difficult to collect this information.
* Given that the latest Community Pharmacy Contractual Framework requires all community pharmacies to be level 1 accredited HLPs from April 2020, all community pharmacy teams will be adequately trained to provide health and wellbeing advice and education.
* Outcome measure a:
* All pharmacies are required to undertake an approved patient satisfaction survey annually.
* Outcome measure b:
* The number of brief interventions will not say anything about the impact, the quality or the appropriateness of the intervention.
* Suggestion to add greater commissioning of health improvement services as an outcome measure.

### Consultation comments on audience descriptors

* Suggestion to replace ‘community pharmacist’ with ‘a member of the community pharmacy team’, as it is often the team members that communicate with people and in different languages.
* Promotion of healthier lifestyles by pharmacist should extend to:
* sun safety and skin surveillance
* contraception
* substance misuse
1. Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

* Implementation of reasonable adjustments within the community pharmacies.
* Frailty and multi-morbidity as an opportunity for community pharmacy to reduce polypharmacy.
* Inhaler technique checking and optimisation.
* Medicine compliance - development of robust referral/escalation processes to communicate the outcomes of reviews, particularly when suboptimal medicines use is identified.

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# Appendix 1: Quality standard consultation comments table – registered stakeholders

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| --- | --- | --- | --- |
| **ID** | **Stakeholder** | **Section** | **Comments** |
| 1 | Action on Smoking and Health (ASH) | General | Smoking cessation should be an essential part of the health and wellbeing offer from community pharmacies and this is rightly identified in the quality standard as an issue for community pharmacies to address. Whilst across England community pharmacists are already engaged in supporting clients with smoking cessation, with 63% of local authorities in England commissioning professionals in primary care, including pharmacies, to provide such support, this practice is not widespread and is variable where it does take place. Multiple systematic reviews, including a recent Cochrane Review, clearly demonstrate that smoking cessation interventions delivered in community pharmacies are clinically effective. As one review and another study note,2, the sheer volume of patients and smokers reached by community pharmacies provides very good reason for them to be delivering brief opportunistic interventions on smoking cessation, such as Very Brief Advice (VBA), which if delivered on such scale would have substantial public health benefits. VBA and full interventions for smoking cessation should, therefore, be delivered through community pharmacies and community pharmacies should also be fully integrated into local smoking cessation pathways.To summarise:• ASH welcomes the four statements outlined in the draft quality standard which, in relation to smoking cessation, would be clinically and cost-effective;• Implementing the draft statements, in relation to smoking cessation, should not require new mechanisms to collect the data proposed by the quality standard – much of this could be achieved by community pharmacy teams feeding into existing networks such as Local Tobacco Control Alliances and Health and Wellbeing Boards and their respective strategies;• Achieving the draft statements, in relation to smoking cessation, is feasible with resources available and the most significant costs implied would be in the training of pharmacy staff to deliver smoking cessation interventions however, support as well as free materials are available from organisations such as the NCSCT and could be co-ordinated by local public health teams;• Achieving the draft statements would be highly-cost effective and would deliver net savings to the NHS, local health and care providers and wider society. |
| 2 | British Thoracic Society | General | The British Thoracic Society welcomes the fact that community pharmacists are gaining more recognition for their unique expertise and are named specifically in the NHSE Long Term Plan/NHS People Plan. We welcome the development of the quality standard document to support such services. |
| 3 | British Thoracic Society | General | The British Thoracic Society is concerned that throughout the QS and Briefing paper it states “Community Pharmacies” rather than referring to professional personal. We suggest that this term is changed and that the reference should be to registered healthcare professionals, such as pharmacists and/or pharmacy technicians rather than using a term implying a building or heath care centre. Just to illustrate the point, “Evidence of community pharmacies and local commissioners working together to integrate community pharmacy services into existing care and referral pathways” – this should say community pharmacists. Furthermore, the term community pharmacy teams is utilised throughout the document, which is supported as it is inclusive of the team but we would promote that the statement “community pharmacist and the team”. |
| 4 | Company Chemists’ Association  | General | We agree with the expected outcomes of this draft quality standard. However, the expectation that there will be improvements in the ‘referral pathways within the Primary Care Networks’ should be broadened e.g. ‘referrals pathways across the health system’. PCNs are being established to improve collaboration and integration between primary care providers, however this quality standard has the potential to improve referral pathways between community pharmacies and organisations beyond PCNs, such as secondary care. For example, as part of a pilot detailed in the Community Pharmacy Contractual Framework, patients will be referred from secondary care into community pharmacy to complete a smoking cessation programme. Furthermore, this intended outcome may infer that referral pathways can only be established within one PCN and there may be opportunities for integration between multiple PCNs. Enhanced referral pathways to and from community pharmacy will be supported by improved access to medical records in pharmacies.  |
| 5 | Faculty of Sexual and Reproductive Healthcare (FSRH) | General | FSRH supports the integration of community pharmacies into existing healthcare services. We also agree that community pharmacies can play an integral role in reducing health inequalities, particularly in areas of deprivation. To achieve these goals, we believe that sexual and reproductive healthcare services, as provided through community pharmacies, must be included in this quality standard. Sexual and reproductive healthcare services are public health services and should be included in quality standards related to public health. Community pharmacies offer a local, confidential, accessible setting for individuals seeking advice. These factors are essential for individuals seeking advice and care for services such as contraception. For some individuals, particularly in deprived areas, community pharmacies are their only contact with healthcare professionals. It is imperative that these individuals can access consistent, high quality care at their community pharmacy. The fragmented commissioning of services in England has particularly affected sexual and reproductive healthcare services. Community pharmacies have the potential to improve sexual and reproductive healthcare education and provision, and to alleviate the pressures on existing healthcare services. Community pharmacies can promote sexual and reproductive healthcare and wellbeing, but these services are not consistently provided across the country. The integration of community pharmacies into existing services provides the opportunity to develop a consistent approach to the provision of sexual and reproductive healthcare within the community pharmacy setting (see The Pharmacy Offer for Sexual Health, Reproductive Health and HIV, published by Public Health England). |
| 6 | Faculty of Sexual and Reproductive Healthcare (FSRH) | General | Links to ‘Other quality standards that should be considered’ should also include links to standards for Sexual Health (QS178) and standards for Contraception (QS129).  |
| 7 | Healthwatch Birmingham | General | Healthwatch Birmingham asks that patient and public involvement be built-in into the standard and should go beyond using survey data. It is important that this includes patient experiences, feedback, complaints or compliments data and any learning from these. We ask that the use of patients, service users and carer’s insight and experience is used to identify, understand and address health inequality issues that impact service user access to services and the quality of services. This will help pharmacies understand the experiences of people who use their service and use this insight to inform service improvement or other decision-making processes. It is our view that the proposed standard would be strengthened by including the need for pharmacies to engage that is based on a clear link between the two public sector legislative duties that require public sector organisations to: • Engage/involve the public and patients; and• Reduce health inequality and improve health outcomes. |
| 8 | Managing Adult Malnutrition in the Community | General | We would recommend that reference is included to NICE QS24 ‘Nutrition support in adults’ Rationale : to acknowledge that at any point in time more than 3 million people in the UK are malnourished and most (93%) live in the community. Community pharmacists are ideally placed to assist in the identification of those who are undernourished as well as those who are overweight. The estimated health and social care associated with malnutrition are considerable. Data from Elia and the NIHR (2015) illustrate the cost impact in failing to identify and treat malnutrition. Additional health and social care costs were estimated as follows: £7,408 to manage a malnourished patient compared with £2,155 for a non-malnourished patient. NICE has previously demonstrated through cost impact analysis that costs could be reduced if those at risk can be identified early these costs could be reduced. Community pharmacists could assist in implementing NICE CG32/QS24 and it may be of merit to incorporate this recommendation into this proposed guidance. Elia M, on behalf of the Malnutrition Action Group (BAPEN) and the National Institute for Health Research Southampton Biomedical Research Centre. The cost of malnutrition in England and potential cost savings from nutritional interventions (full report). 2015. http://www.bapen.org.uk/pdfs/economic-report-full.pdf  |
| 9 | McKesson UK | General | ‘This quality standard is expected to contribute to improvements in the following outcomes:- Awareness of services provided by community pharmacies- Uptake of interventions offered by community pharmacies- Referral pathways within the Primary Care Networks- Health outcomes among the population - Health inequalities- Pharmacy as the first-place people go with a non-urgent health issue- Minimising inappropriate use of health and social care servicesWe agree with the expected outcomes of this draft quality standard. However, the expectation that there will be improvements in the ‘referral pathways within the Primary Care Networks’ should be refined. PCNs are being established to improve collaboration and integration between primary care providers, however this quality standard has the potential to improve referral pathways between community pharmacies and organisations beyond PCNs, such as secondary care. For example, as part of a pilot detailed in the Community Pharmacy Contractual Framework, patients will be referred from secondary care into community pharmacy to complete a smoking cessation programme. Furthermore, this intended outcome may infer that referral pathways can only be established within one PCN and there may be opportunities for integration between multiple PCNs. Therefore, this outcome could be made more general to say: ‘referral pathways between community pharmacy and other health and social care providers.’ Enhanced referral pathways to and from community pharmacy will be supported by improved access to medical records in pharmacies.  |
| 10 | Mencap | General | People with a learning disability (and all disabled people) require pharmacies to make reasonable adjustments in order to make their premises and services accessible – in addition, adaptations to medication packaging, and support to understand medication can enable many individuals the chance to be in charge of their medication, or ensure an individual without support can take their medication effectively, which can directly improve their health and wellbeing. However, there can be uncertainty regarding what is expected of a community pharmacy, particularly when regards to ‘reasonable’ adjustments, leading to very different levels of accessibility, and support provided, from pharmacy to pharmacy. The Guidelines state that pharmacies should ‘take account’ of an individual’s characteristics to affect the approach taken. We recommend that a fifth Quality Statement is developed to encourage, and monitor how well pharmacies have made adjustments needed by an individual as required by either the Equality Act, Mental Capacity Act and Accessible Information Standard. Please see the Mencap pharmacy project for more information: https://www.mencap.org.uk/about-us/our-projects/disability-partnerships-pharmacy-project |
| 11 | National Pharmacy Association | General | General Statement Community pharmacy straddles health and social care, and the community pharmacist is a valued healthcare professional integral to the primary care multi-disciplinary team. The pharmacy’s accessibility and in some cases anonymity makes it the first port of call for the public, regardless of their state of health. Community pharmacy is ideally placed to offer targeted support, tailored lifestyle advice, personalised care and be a part of the healthcare workforce that addresses many of the ambitions set out in the NHS long-term plan. From April 2020, all community pharmacies in England would be required to have achieved level 1 HLP status. This means that under the leadership and supervision of the responsible pharmacist all pharmacy teams would be trained to provide healthy living advice to their local population. They will also be able to signpost patients into a number of local community services that support the health and improvement of the local population. The NPA is supportive of the NICE quality standard Community pharmacies: promoting health and wellbeing for everyone in contact with the community pharmacist and their teams. |
| 12 | NHS England and Improvement | General | Why is there only reference to local service commissioning? Community pharmacy core and advanced services are written nationally, and therefore I think many of these standards could be used by commissioners at a national level when developing service specs etc  |
| 13 | Obesity Group of the British Dietetic Association | General | We agree that staff training to support behavioural change and brief advice, allowing consistency of delivery is essential. Raising the issue of & discussing weight are sensitive subjects. Training and CPD in effective communication and behavioural approaches to support change should be mandatory, including clear guidance on working within professional limits and the importance of signposting to appropriate services and healthcare professionals as needed.  |
| 14 | Obesity Group of the British Dietetic Association | General | We are unclear how community pharmacies may use a tailored approach to issues such as weight management without specialist training in this area. We have concerns that there is a potential for inadvertent harm should incorrect or outdated information about nutrition be given out. It is our view that there needs to be absolute clarity about the professional limits of the role of community pharmacists in this regard, both to protect pharmacists and the public.  |
| 15 | Obesity Group of the British Dietetic Association | General | We agree that local providers should ensure that interventions are carried out only by staff members with the skills and competencies to do so. However we are unclear how this will actually happen in practice, specifically with regard to weight management. It is our view that there needs to be absolute clarity about the limits of what can be dealt with within the community pharmacy. It is also our view that properly managed this could be a valuable additional resource to help support weight management.  |
| 16 | Obesity Group of the British Dietetic Association | General | We support the principle of community pharmacies taking a proactive role in promoting physical activity and healthy nutrition. However the limits of community pharmacist in these areas need to be carefully defined.  |
| 17 | Obesity Group of the British Dietetic Association | General | We agree that community pharmacies are accessible and potentially very valuable in supporting healthy living initiatives and signposting individuals to specific tailored interventions. However we are unclear how community pharmacists would be able in practice to provide personalised exercise management programmes (as opposed to general activity advice) or diet, nutrition and weight management support, without the knowledge, skills and competencies to do so. The extent to which these are included in the education of pharmacists needs to be ascertained to ensure that the knowledge, skills and competencies of community pharmacists support this work.  |
| 18 | PHE | General | In October 2019 the NHS Community Pharmacist Consultation Service was launched where NHS 111 refer people to their local community pharmacy for quick same day-advice from a qualified health professional on minor ailments; relieving pressure on Accident & Emergency and general practitioner services. This can be viewed at: <https://www.england.nhs.uk/primary-care/pharmacy/community-pharmacist-consultation-service/>. The NHSE/I ‘Help us help you’ campaign highlights community pharmacy as the first port of call for minor ailments. This can be viewed at: https://campaignresources.phe.gov.uk/resources/campaigns/81-help-us-help-you/overview. |
| 19 | Royal College of General Practitioners | General | Overall this document is well received. However, in order to work effectively it is essential that the community pharmacists are adequately trained, supervised and resourced to perform this work, details of which are not covered in the quality standard. The briefing paper covers some details on this but an acknowledgement of this need would be useful within the quality standard. There is some evidence that increasing availability of healthcare drives up demand and if the availability of pharmacists means that they are consulted by patients who would otherwise depend on lay networks such as their own families and friends, and some are referred on, then it’s not at all clear that it relieves pressure and may well be adding to it. More research is required in this area to determine the cost-effectiveness of this approach. |
| 20 | Royal College of Nursing  | General | Care of Dying Adults in the last days of life NG31: in order to maintain comfort and wellbeing at end of life, people need to have appropriate medication available in a timely manner. |
| 21 | Royal College of Physicians | General | The RCP is grateful for the opportunity to respond to the above consultation. We would like to endorse the response submitted by the British Thoracic Society (BTS). |
| 22 | Royal Pharmaceutical Society | General | The RPS welcomes these quality standards as they highlight the role community pharmacists and pharmacy staff can play in supporting and promoting the health and wellbeing of patients and the public. It highlights the role of community pharmacies in promoting self-care and supporting people with long term conditions to self-manage. We believe that the statements are ambitious but achievable if healthcare providers work together to achieve the same goal. The right systems need to be in place in order to support more public health services being delivered by community pharmacies. |
| 23 | Royal Pharmaceutical Society | General | The perception of pharmacists as healthcare professionals needs to be addressed following national criticism of pharmacists undertaking the roles and activities suggested as part of this consultation. There should be more clarity on roles and who can provide what in relation to healthcare professionals and collaboration should be supported. |
| 24 | Royal Pharmaceutical Society | General | The standards, if agreed, should be implemented in a stepwise approach. If they are all implemented at once there is a risk that the system will not able to support all of the work. |
| 25 | The Hepatitis C Trust | General | The people accessing OST and NSPs are the population most at risk of having an active hepatitis C infection and passing it on. Pharmacies are key providers of both of these interventions and, as such, are uniquely placed to encourage people to get tested – both for hepatitis C and other BBVs – and to offer harm reduction advice. Currently, the ‘Community pharmacies: promoting health and wellbeing’ draft quality standard misses an opportunity to express an explicit commitment to this highly vulnerable group, disproportionately affected by health inequalities.  |
| 26 | The Pharmacists’ Defence Association | General | This QS has an underpinning development source NG102 published in August 2018. Our response to this QS proposal is partly based on the fact that NG102 is itself based on weak or non-existent evidence (as acknowledged by NICE during the development process for NG102). We welcome the acknowledgement that the Community Pharmacy setting has a vital role to play in promoting wellbeing in local populations in addition to its existing role of supplying medicines and the associated services related to that supply (for example the New Medicines Service, or the MUR service etc) Whilst we appreciate that the Guidance and this Quality Standard aims to embed commissioning of various public health related “health and well being services” from Community Pharmacy as an integral part of the wider NHS Long-Term plan we still need to ensure that any services commissioned as a result of this QS and the Guidance are properly resourced, are deliverable and the outcomes measurable. Given that this QS and NG102 may be used by the NHS and commissioners it’s important not only to understand the public health potential of Community Pharmacy but also to understand how best to facilitate the extra services that commissioners may want to provide based on local needs to address local Health Inequalities. We would also add that The PDA is a source of support for Pharmacists (in the same way as the NPA is noted as a source of support during the development of NG102). We welcome the acknowledgment during the development of NG102 on the paucity of evidence and the recommendation that further research is needed to establish sufficiently robust high-quality evidence on this subject matter. |
| 27 | The Pharmacists’ Defence Association | General | This is what NICE said during the development of NG102: “However there is a distinct move away from commissioner led training due to the wide variety of resources available. Overall, the committee agreed that general training requirements for community pharmacy staff may be sufficient for effectively delivering information, advice and education…” This is not acceptable. In fact, it is runs contrary to the delivery of a consistent standard of service. We are further concerned that NICE, as stated during the development of this QS, seems to think it acceptable that training for its recommendations should be funded by pharmacists completing training and treating this training as extra CPD in in order to deliver services commissioned by NHS commissioners. This referral to CPD (also evident in responses by NICE during the development of NG102) in lieu of formal training provided across a whole commissioning area should not be a substitute for proper structured training that is expected by the public and which is essential to deliver a consistent standard of delivery for any given service which may be commissioned. “Training standards - Do the pharmacy staff have documented attendance at training or continuing professional development (CPD) for promoting healthy lifestyles and engaging in the health campaigns.” NICE has clearly involved itself with how training should be funded (i.e. by suggesting this already exists or could be possibly be addressed via CPD) and subsequently has failed to properly cost this training time as part of the true and real cost of service delivery. Commissioners should not be encouraged to treat training as a voluntary add-on in lieu of proper structured training that provides a consistency of service delivery. |
| 28 | The Pharmacists’ Defence Association | General - briefing paper | We welcome the opportunity to respond, as a stakeholder, to this draft Quality Standard (QS). We cannot limit our comments to just the proposed QS consultation as there are a whole number of issues in the process and thinking that led to the current proposed QS. We will address these together with the proposed QS which needs to be understood in context. In particular we have a number of relevant observations about the development source for this QS, NICE Guideline NG102 (NG102). We will also refer to the associated Briefing Paper, and the Minutes to give contextual meaning to our response. |
| 29 | The Pharmacists’ Defence Association | General - briefing paper | The need for consistent clear advice is essential for delivering an effective service. “Stakeholders suggested that consistency of service delivery is essential to ensure that people have access to the best health care advice and services. They also highlighted the importance of staff training in the context of providing support for behavioural change and brief advice.” This was noted by NICE in the briefing paper and is also acknowledged in the area of further research proposed within NG102. Given the paucity of evidence on this subject matter, it should be presumed, unless evidenced otherwise, that it can only be the pharmacist (a graduate with 5 years of documented training) that can provide this type of support for this type of service. |
| 30 | The Pharmacists’ Defence Association | General - briefing paper | We noted the comments from the PAGB with concern: “The NICE Guideline on community pharmacies: promoting health and wellbeing suggests pharmacists should proactively seek opportunities to promote people’s physical and mental health and wellbeing. Advising people on nutrition and the role of food supplements in bridging dietary gaps would be a positive way of community pharmacy proactively promoting health. For example, if a woman comes into the pharmacy to buy a pregnancy test kit, the pharmacy staff should talk to her about folic acid supplements.” The way to bridge dietary gaps is not to promote food supplements, it should be based on advocating and facilitating (by way of printing healthy quick cheap NHS meals plans available on, for example, https://www.nhs.uk/change4life/recipes or from https://www.nhs.uk/live-well/eat-well etc) better dietary habits. The aim would be to imbibe inexpensive healthy eating patterns to bridge those dietary gaps, not as a mechanism to make a sale of a supplement. Increasingly, obesity is associated with a poor diet which is often associated with a poor income. To dismiss dietary gaps with the mere offer of expensive supplements rather than focus on building an enduring and sustained pattern of sensible eating is unacceptable. Advising people on taking supplements to bridge dietary gaps is definitely not a way of promoting health. In fact, we would contend that it is the very opposite. The example then used of merely taking a folic acid supplement rather than a dialogue about diet and nutrition during pregnancy would also be wholly inappropriate. There are important NHS guides about diet and nutrition (for example https://www.nhs.uk/conditions/pregnancy-and-baby/healthy-pregnancy-diet/ which are far more appropriate) then the mere discussion about supplementation with folic acid. Pharmacy staff would also need to consider whether the issue of initiating dialogue with someone purchasing a pregnancy kit about selling folic acid is appropriate. This could be especially sensitive if it were, say, a potentially inappropriate initiation of discussion with a teenager who may be apprehensive about an unplanned or unwanted pregnancy. We use these as examples of how well-meaning guidelines and Quality Standards can be commercialised and misappropriated. During the development phase of NG102 NICE acknowledged:“…however the evidence revealed that members of public who engaged with pharmacy services deemed it vital that the motivations of pharmacy staff were genuinely altruistic and that services shouldn't be promoted in a commercial way (evidence review 2).” The public, quite rightly, expect any intervention made by pharmacists and their staff to be genuinely altruistic and not motivated by commercial gain.  |
| 31 | The Pharmacists’ Defence Association | General - briefing paper | “Key area for quality improvement 1: supporting self care with advice and treatment for people with self-treatable conditions” This is a further example of how policy can be taken out of context and may have a great impact in deprived areas with the greatest health inequalities that is often referred to within this QS. Whilst the location of pharmacies may follow the inverse care law, patients and customers in these deprived communities (often pockets within even affluent towns) are often having to make choices even between basic essentials such as eating or keeping warm. To then suggest self-care within these communities is counter-intuitive and counter-productive in the longer term. These patients cannot often even afford a meal (and we can see this evidenced by the growth of food banks), let alone buy expensive branded medicines. https://www.trusselltrust.org/wp-content/uploads/sites/2/2019/06/SoH-Interim-Report-Final-2.pdf  |
| 32 | The Pharmacists’ Defence Association | General - minutes | We are concerned that the committee may not have fully considered the pressures that community pharmacists are working under. It is factually incorrect to state, as done so in the minutes, that community pharmacies are underutilised when many pharmacies are working at near full capacity with little to no headroom to take on extra workload. “The committee acknowledged that community pharmacies are underutilised but queried how any increased use could be measured.” Pharmacists may not be currently utilised to provide the interventions discussed and proposed by NICE, but NICE provides no evidence to support the assumption that the presumed benefits of Public Health interventions outweigh the benefits of the services currently provided by Pharmacists (for example free Health Checks, or free Blood Pressure monitoring or free training in inhaler use). Indeed there needs to be a proper recognition of the value that pharmacists routinely provide as part of Community Pharmacies Contractual Framework (CPCF) and the overall medicines supply service (counselling on how to take the medicines - especially newly added ones, side effects, training in the use of inhalers and subsequent checks etc). Whilst these may not be documented, they happen as a matter of routine and are valued by the public. During the development work for the underpinning NG102, the evidence reviews commissioned by NICE discovered that there was a paucity of high-quality evidence to support some of the recommendations that are now contained within this QS. Further, the underlying premise for the QS fails to reflect the actual resource availability within Community Pharmacies (as observed by most stakeholders who responded to NG102) and thus most of its recommendations will not reach fruition unless commissioners recognise the true cost implications of the extra workload. When pharmacies are operating at near full capacity any extra service provisions need to be properly funded and these funds directly and measurably utilised for any proposed new commissioned services. The PDA recommends that to fully benefit from the recommendations within this QS, a second pharmacist must always be available for these interventions so as not to compromise the existing services provided by pharmacists. |
| 33 | The Pharmacists’ Defence Association | General - minutes | We are concerned that the committee noted, as stated in the minutes, that they had no specific resource concerns. “The committee considered the resource impact of the quality standard. There were no specific concerns raised by the committee.” We cannot see how this conclusion was arrived at given the concerns expressed (by respondents) at various stages during the development process of NG102 and this proposed QS. Only one costing was carried out by NICE and that related only to weight-management interventions, however this costing excluded any training time for staff. There was also no consideration of opportunity cost, i.e. if the staff were doing this then there would be opportunity cost of not doing something else and what the loss was for reallocating that staff resource from that “something else”. There is no justification for the underlying assumption that staff providing that intervention were doing nothing and thus no opportunity cost needed to be considered. |
| 34 | British Thoracic Society | Question 1 | Yes it is a very good list of quality improvement for community pharmacists and their teams. However, there are a number of areas that could also be considered: - frailty and multi-morbidity should be highlighted as these also overlap with the long term conditions mentioned and de-prescribing awareness through community pharmacist expertise would be something to consider to reduce polypharmacy. - encourage inhaler technique checking and optimisation by the community pharmacy team. The Long Term Plan recommends the consideration of climate friendly green inhalers – particularly the switch from aerosols (metered-dose inhalers (MDIs)) to dry powder inhalers. This is an important aim and one that community pharmacists could support by ensuring the such a switch is patient focused and therefore the preferred option for that individual patient.- identification of patients collecting repeated prescriptions for oral prednisolone courses and under using preventer inhalers (inhaled corticosteroid (ICS) containing inhalers in asthma and long acting bronchodilator(s) in COPD)- development of robust referral/escalation processes to communicate the outcomes of these reviews, particularly when suboptimal medicines use (eg poor inhaler technique, excessive prednisolone or inadequate preventer) is identified  |
| 35 | Action on Smoking and Health (ASH) | Question 1 | ASH welcomes all four of the statements included in the quality standard and agrees, in response to question 1 in the consultation, that these statements accurately reflect the key areas for quality improvement with regard to promoting health and wellbeing in community pharmacies. |
| 36 | Community Pharmacy NI  | Question 1 | This draft quality standard does reflect the key areas for quality improvement. |
| 37 | NHS West Hampshire CCG | Question 1 | Yes |
| 38 | Pharmaceutical Services Negotiating Committee | Question 1 | We believe this draft quality standard, via the four quality statements, does cover key areas where quality improvement would drive the creation of additional benefits for the population and the NHS. There are other related areas in which quality improvement would be of value, for example in enhancing record keeping and audit in relation to health behaviour change interventions provided by community pharmacy teams, but the proposed draft quality standards provide a good starting point for quality improvement.  |
| 39 | Royal College of Nursing  | Question 1 | Yes |
| 40 | The Pharmacists’ Defence Association | Question 1 | We agree that the QS identifies certain areas that need quality improvement. Given that during the scoping exercise for NG102 (the underpinning document for this QS) NICE decided to exclude areas which may have benefited from quality improvement and which may have provided better public health outcomes our response is:NO, the draft QS does not accurately reflect the key areas for quality improvement to help improve “health and wellbeing” delivered from the pharmacy setting. |
| 41 | Action on Smoking and Health (ASH) | Question 2 | In response to question 2 in the consultation, in relation to smoking cessation, evidence of arrangements having been made between community pharmacies and local commissioners will involve feeding into existing networks such as Local Authority Tobacco Control Alliances and Health and Wellbeing Boards which could incorporate the statements’ requirements into their respective strategies and action plans. These strategies and action plans are easily reviewed at a local level and could be reported against to ensure compliance with the quality statements. Evidencing the number of interventions delivered and referrals to wider support services made by community pharmacies may require further systems capacity to record such data.  |
| 42 | British Thoracic Society | Question 2 | The British Thoracic Society’s view is that currently there is neither the system nor the structure in place to collect the outcomes from the quality measures. There needs to be greater investment and support within the networks and IT infrastructure across the Primary Care Networks (PCNs) and between healthcare providers in a location to improve communication and for data to be accurately collected. This varies nationally and standardised resources to support data collection will need to be provided. Consideration regarding the workforce resource needed to collate the data is required, especially around patient experience. Much of the data collection could be carried out by administration staff or pre-registration/rotational pharmacists but processes would need to be put into place to facilitate this in order to support the QS. It is mentioned that PCNs will help provide data but the document overall puts a lot of emphasis (and pressure) on community pharmacies to deliver all of the listed standards. Perhaps the approach needs to be staggered and to be delivered similar to a CQUIN approach so that a consistent minimum standard is achieved throughout each quarter of the financial year, rather than a mad dash towards the end to ‘hit the targets’ so that it does remain very much quality focused. The PCNs may include a very large number of community pharmacies e.g. Islington has 18 pharmacists in their PCN. To encourage pharmacists’ collaborative working across a PCN would a PCN QS be an option. It is essential that processes are in place to ensure that any data collection is not just a tick box exercise for financial gain. We have seen this for previous primary care services. Data collection need to be linked to demonstrate quality of care in outcomes measured. One of the outcomes mentioned for QS1 is the number of referrals from community pharmacies to health/social care – all this will tell us is how many referrals were made but not if they were appropriate or have resulted in any action to close the loop. |
| 43 | Community Pharmacy NI  | Question 2 | There are some local systems and structures in place to collect data for the proposed quality measures, however in some cases these may be quite ad hoc or informal. It should be feasible to formalise these to provide more consistent measures. |
| 44 | NHS West Hampshire CCG | Question 2 | No |
| 45 | Royal College of Nursing  | Question 2 | We feel this would be complex to collate data and measure. Would we be asking pharmacists to self-report their activity? How would we quality assure this data and ensure it is consistently collected and measurable? |
| 46 | Royal Pharmaceutical Society | Question 2 | The draft document doesn’t specify how to achieve the targets, so it is difficult to comment if it is feasible. Time expectations are also not included. |
| 47 | The Pharmacists’ Defence Association | Question 2 | Local systems and structures are not in place currently as NHS organisations are currently undergoing radical re-organisation through the forming of PCN and ICS networks. It would be inappropriate to comment on the feasibility of putting in place the required structures until these newly created structures (which may be responsible for some of the commissioning) have had time to establish themselves. |
| 48 | Action on Smoking and Health (ASH) | Question 3 | In response to question 3 in the consultation, delivering all of the statements in relation to smoking cessation would be achievable by local services. Training on VBA, a NICE endorsed intervention for smoking cessation, is freely available via the National Centre for Smoking Cessation and Training who provide, among many resources, a free online module on VBA which can be completed in 30 minutes – all community pharmacy staff should complete this training. Beyond this, a smaller number of staff can be trained in delivering more intensive interventions for smoking cessation which could be co-ordinated by local authority public health teams which are already responsible for commissioning smoking cessation support in the area. Training could therefore feasibly be carried out in tandem or as a part of ongoing training for local authority commissioned smoking cessation advisers. Whilst there would be a cost implication for such training, providing or co-ordinating such training would be in the local authorities’ interest given the health benefits and cost-savings (detailed below) of smoking cessation. Furthermore, in response to question 3, any implied costs are likely to be overshadowed by the cost savings to local health and care systems from delivering smoking cessation interventions through community pharmacies. As is demonstrated by several studies, delivering smoking cessation interventions in community pharmacies is cost-effective. , , , ,4 One UK study which compared smoking cessation services provided by general dental practice, general medical practice and pharmacies against specialist stop smoking services (the ‘usual care’ control) found that “from the perspective of the service provider and the NHS, the service considered to be ‘cost-effective’ when compared with ‘usual care’ was pharmacy services.”11 Another UK study estimated the cost per QALY of smoking cessation support delivered via community pharmacies to be £2,600, substantially less than the £4,800 cost per QALY for standard group behavioural support for smoking cessation.9 |
| 49 | British Thoracic Society | Question 3 | We believe the QS are deliverable within functioning PCNs and therefore the QS should support delivery of best care, pharmacy metrics and QOF targets. However, there is currently vast variation nationally in the way that services are provided e.g. smoking cessation services – many stop smoking services delivered through community pharmacists have been decommissioned. We would support a standardised approach/delivery of service for each STP supporting pharmacists to provide the quality services. There does not seem to be financial resource to support the proposed quality changes in the LTP and any potential cost saving resource that may come through from NHSE will not be until 2021 and this is likely to be limited. Additional training should be provided to pharmacists, for example motivational interviewing, upskilling on consultation skills, competency-based inhaler technique training and general respiratory disease. Any pharmacist or pharmacy technician who is instructing a patient on how to use an inhaler device, should have received training and be deemed as being competent. It is essential that the pharmacist can detect, understand and tackle non-adherence by co-creating care with patients directly. To be able to deliver the QS the pharmacy workforce must be trained and competent and confident to provide the services. We suggest that Health Education England should be invited to comment on this as it will be important to ensure they are preparing the next set of future pharmacists and take into account succession planning. |
| 50 | Community Pharmacy NI  | Question 3 | These statements should be achievable by local resources given the net resources needed to deliver them. We can see a resource requirement around some of the enablers that may be required such as IT developments for data collection or for materials to support a public awareness campaign. We should not underestimate the value of community pharmacy in relation to both medicines optimisation and health and wellbeing. A survey conducted by CPNI showed that over 15 million interventions take place in community pharmacies in Northern Ireland every year. https://www.communitypharmacyni.co.uk/2016/11/intervention-survey-results-revealed/  |
| 51 | Royal College of Nursing  | Question 3 | It is achievable if adequate resource is in place and is skilled appropriately . |
| 52 | The Pharmacists’ Defence Association | Question 3 | “Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.”Please see our previous comments on:Training requirement2nd pharmacist requirement  |
| 53 | Action on Smoking and Health (ASH) | Question 4 | In response to question 4 in the consultation, the Greater Manchester Health and Social Care Partnership (GMHSCP) have developed a standard specification for community pharmacies across Greater Manchester. The specification has been produced for localities to commission pharmacy brief advice services. A number of localities already have pharmacy services, but this aims to standardise the offer and the hope is that eventually all 10 GM localities will commission their pharmacy services on this specification. The specification was developed with Pharmacy colleagues within GMHSCP/NHS England and it supports the GM healthy living pharmacy framework. The specification is attached to ASH’s e-mail submission. |
| 54 | British Thoracic Society | Question 4 | Community pharmacy services (SIMPLE) for people with COPD and Asthma in Leicestershire, Leicester and Rutland to support quality services, by enhancing inhaler technique optimisation, stop smoking services and referral to pulmonary rehabilitation. |
| 55 | Community Pharmacy NI  | Question 4 | Key examples from Northern Ireland include our Living well campaigns which provide key public health messages and advice through community pharmacies which can help address risk factors which contribute significantly to the overall prevalence of disease. A campaign schedule has been developed that is aligned with public health priorities. Community pharmacists and pharmacy staff will display and provide information as well as give advice on targeted campaign topics to patients presenting prescriptions and to general pharmacy visitors. http://www.hscbusiness.hscni.net/services/3035.htm The other excellent example is Building the Community-Pharmacy Partnership Programme (BCPP). BCPP has been operational for over 15 years and supports communities and community pharmacists to work in partnership to address locally defined needs so that people make connections, listen to and understand each other better and work together to address the social determinants of health and health inequalities. https://www.cdhn.org/bcpp  |
| 56 | National Pharmacy Association | Question 4 | The NPA is aware of a number of pilot sites which include elements of the quality standard being proposed, however, is unable to provide full details owing to the short timeframe of this consultation. The NPA welcomes the opportunity to share examples from practice and to do this please contact Helga Mangion at h.mangion@npa.co.uk |
| 57 | NHS West Hampshire CCG | Question 4 | 2016 Diabetes foot care pathway, opportunistic conversations when coming in to pick up prescriptions using awareness cards (£3 per conversation). Not sustainable due to costs and volume of pharmacies across west Hampshire |
| 58 | Royal College of Nursing  | Question 4 | No |
| 59 | The Pharmacists’ Defence Association | Question 4 | We have no examples of NG102 being implemented in practice. |
| 60 | Company Chemists’ Association  | Statement 1 | As above, ‘and future’ should be added.  |
| 61 | Company Chemists’ Association  | Statement 1 | As well as community pharmacies and local commissioners working to ensure that pharmacies are integrated into existing care and referral pathways, the guidance should refer to other health and care providers who may have a greater role in referrals to and from pharmacy. To ensure that referral pathways deliver the best possible patient outcomes, there must be ‘buy in’ from all healthcare settings involved. This may involve direct engagement with other healthcare professionals about the services provided by community pharmacies, to ensure that, where appropriate, other healthcare professionals are confident in referring patients to community pharmacies. Better collaboration and joint working could be further incentivised through alignment of the Community Pharmacy Contractual Framework and the General Medical Services contract agreement. There is a role for national commissioning to enhance community pharmacy integration, as well as commissioning at a local level. The Community Pharmacist Consultation Service (CPCS) is an example of a nationally commissioned service which integrates community pharmacy into local referral pathways. CPCS involves patients being referred from NHS 111 into community pharmacy for a consultation, and treatment if necessary, for conditions including sore throats, coughs, and colds, and emergency supply of medicines. We also suggest that the statement should be amended to not only refer to existing referral pathways, as new referral pathways may be established to enhance pharmacy’s integration into primary care. We recommend that the statement should read: ‘Community pharmacies, other health and care providers, and commissioners work together to integrate community pharmacy services into existing and future care and referral pathways.’ |
| 62 | Healthwatch Birmingham | Statement 1 | We welcome that the quality statement will address issues of independence for pharmacies, within limits, thus enabling them to make referrals to the service most appropriate to the person without the need for the GP to be involved unless appropriate. Also important is that people receive the support they need from the community pharmacy team or are referred directly to relevant health and care services. We believe this will be of benefit to the many patients who access community pharmacies. Healthwatch Birmingham has heard from service users, patients and members of the public, on the importance of pharmacist’s ability to make decisions concerning referrals and prescriptions. People have told us:“I called 111 and was advised to attend the pharmacist (on the understanding that he would be able to prescribe). We attended at 3.40, he was very helpful but unable to prescribe and he escalated her case back to 111 for further assessment”.“It's the bank holiday weekend and I've been struggling to renew my prescription at my GP. I suffer with anxiety, so I was becoming quite stressed, trying to get hold of the medication that I needed, with no help from my GP surgery. The pharmacist was very empathetic to my predicament and issued me with enough medication until I can renew my prescription after the bank holiday. I found the pharmacist very friendly and supportive. She really put my anxiety at ease and helped me with my situation. A true legend!!” |
| 63 | Healthwatch Birmingham | Statement 1 | It is commendable that pharmacies have to complete a Community Pharmacy Assurance Framework (CPAF) every year that captures issues around people’s satisfaction with the service they receive from community pharmacy services. We believe that this is an insufficient data source for demonstrating this outcome. It is important that pharmacies have in place engagement policies that ensure that there is continuous listening of patient’s feedback and experiences to inform changes or improvement to services. This data source should include feedback collected throughout the year including complaints data and any learning implemented as a result of this data. It is also important that data sources include both quantitative data (such as those from surveys) and qualitative data (feedback and experiences).  |
| 64 | McKesson UK | Statement 1 | As above, the word ‘existing’ should be removed and replaced with ‘evolving’.  |
| 65 | McKesson UK | Statement 1 | ‘Community pharmacies and local commissioners work together to integrate community pharmacy services into existing care and referral pathways’. As well as community pharmacies and local commissioners working to ensure that pharmacies are integrated into existing care and referral pathways, the guidance should refer to other health and care providers who will be involved in referrals to and from pharmacy. To ensure that referral pathways deliver the best possible patient outcomes, there must be ‘buy in’ from all health care settings involved. This may involve educating other healthcare professionals about the services provided by community pharmacies, to ensure that, where appropriate, other healthcare professionals are confident in referring patients to community pharmacies. The NHS Long Term Plan identifies several prevention opportunities, including the identification of all people admitted to hospital who smoke will be offered NHS-funded treatment services. Community pharmacy could play a significant role in supporting people to quit through referrals from secondary care settings. Better collaboration and joint working are also key elements of the Community Pharmacy Contractual Framework, and the General Medical Services contract agreement. There is a role for national commissioning to enhance community pharmacy integration, as well as commissioning at a local level. The Community Pharmacist Consultation Service (CPCS) is an example of a nationally commissioned service which integrates community pharmacy into referral pathways. CPCS involves patients being referred from NHS 111 into community pharmacy for a consultation, and advice on treatment if necessary, for conditions including sore throats, coughs, and colds. We suggest that the statement should read: ‘Community pharmacies, other health and care providers, and commissioners work together to integrate community pharmacy services into evolving care and referral pathways.’ |
| 66 | McKesson UK | Statement 1 | ‘Community pharmacies and local commissioners work together to integrate community pharmacy services into existing care and referral pathways’ The word ‘existing’ should be removed from the quality statement. We suggest that ‘evolving’ could be used instead. New referral pathways may be established to enhance pharmacy’s integration into primary care. For example, the Community Pharmacist Consultation Service, which was launched nationally in October 2019, involves the referral of eligible patients calling NHS 111 into community pharmacy for treatment of minor illnesses or an urgent supply of medication.  |
| 67 | Royal College of Nursing  | Statement 1 | May need to articulate what is meant by “Integrate” for example encourage partnership working and collaboration in order to support existing care and referral pathways. |
| 68 | Royal College of Nursing  | Statement 1 | Whilst we acknowledge the role of Community Pharmacists and the support they can offer, there must be an agreement on what is within their scope of practice i.e. it may be acceptable for a pharmacist to refer to an exercise club, slimming group (but be impartial), however, it would not be acceptable for them to signpost to a consultant level without referring the person back to their assigned general practitioner. There is a risk that a person could be acutely unwell including mental and physical health needs requiring medical assessment, in these instances the person must be directed to an appropriate clinician. |
| 69 | Royal Pharmaceutical Society | Statement 1 | This will require PCNs to work with their LPCs so that community pharmacies are integrated into local care and referral pathways. As social prescribing develops, community pharmacies should be included in these pathways so they can refer people to link workers. The referral pathways need to be supported by a digital infrastructure which facilitates the sharing of information between community pharmacies and other providers, including, but not limited, to general practices. The NHS Digital and Professional Record Standards Body Pharmacy Information Flows project provides a basis for this. The pathways need to be clearly defined to make the experience seamless for patients. If a community pharmacist refers a person to another provider then this should be actioned as a priority referral and the person should be seen as soon as possible and not put to the back of the queue. Referral information and data is not yet part of the Pharmacy Quality Scheme so if this was to be collected in this way than related criteria would need to be incorporated into the PQS. In terms of data collection around patient satisfaction, then this could be measured as part of the Community Pharmacy Patient Questionnaire. As part of this statement it says that They also ensure that local arrangements allow community pharmacy teams read and write access to NHS summary care records. The SCR is obtained from information drawn from the person’s record held within the GP practice. Community pharmacies will not be able to write to this record, in fact no one is able to actually write to a SCR. However, as Local Health and Care records (LHCR) develop we would expect community pharmacies to have both read and write access to these. |
| 70 | The Hepatitis C Trust | Statement 1 | The Hepatitis C Trust supports the statement that community pharmacies and local commissioners work together to integrate community pharmacy services into existing care and referral pathways. Integration is particularly important for people who have, or are at risk of contracting, hepatitis C and other blood-borne viruses (BBVs) through the sharing of drug-taking equipment. Over 90% of new incidences of hepatitis C infection occurs through this route, and around half of all people who inject drugs in the UK have had or currently have hepatitis C. This population has frequently been under-served by public services and as such are likely to be reluctant to access GP clinics or secondary care services. However, community pharmacies have greater success at engaging with this group, particularly if individuals are collecting Opioid Substitution Therapy (OST) or accessing Needle and Syringe Programmes (NSPs). As such, pharmacies are in a unique position to engage people in BBV testing, particularly hepatitis C testing, and to promote a joined-up care pathway with Operational Delivery Networks (ODNs), who are responsible for hepatitis C treatment. The treatment pathway for hepatitis C can be complex and has a high rate of attrition and ‘did not attends’ (DNAs) for appointments, something that community pharmacies can alleviate through their relationships with people using their services and contacts with the wider care system. |
| 71 | The Pharmacists’ Defence Association | Statement 1 | We welcome Quality Statement 1 and the acknowledgment that commissioners should integrate community pharmacies into existing care and referral pathways.NG 102 states:“1.6.1 Local commissioners and pharmacies could consider establishing a formal referral process with other pharmacies and services. This includes GP services and those offered by local authorities and organisations in the community and voluntary sectors. Specifically: • Consider basing pharmacy assessments, triage activities and referrals on agreed tools that support continuing treatment. • Consider designing triage activities to reduce multiple assessments and waiting times after people are referred.”However, to do this effectively requires specific skillsets. The word triage has very specific context in terms of healthcare. It requires a great deal of training, skill, judgement and experience to triage effectively without imposing unnecessary burdens on other services already in place.The Responsible Pharmacist (RP), has overall responsibility for the “safe and effective” operations of the pharmacy and it is not realistic to expect a RP to assume responsibility for this without full and proper training and robust processes being in place. It is often the case that these processes will be put into place by remote Head Offices with insufficient knowledge of the full training and experience and skillsets of all members of staff in a particular pharmacy or of local priorities. This is especially relevant and challenging when dealing with local referral pathways for which remote Head Offices may not allow sufficient time or resourcing. We have feedback from our members of many occasions where Head Offices agree to services without adequately resourcing these services. There are also issues surrounding responsibility and liability were a formal referral pathway overlooked. This is noted in the NG102 guidance consultation response by NHS England:“Formal referral processes require robust governance and a consistent approach. Once defined, all patients meeting referral criteria must be consistently referred. It should be considered the impact on time this would create for community pharmacy staff and possible governance/regulatory issues if a referral were “missed”.”Whilst we welcome the integration into the wider NHS that referral pathways would provide, we are also mindful that this has to be done in a structured, auditable and properly resourced manner. |
| 72 | NHS England and Improvement | Statement 1 - audience descriptors |  What the quality statement means – service providers Local pharmaceutical committees do not provide services – they represent service providers |
| 73 | NHS England and Improvement | Statement 1 - audience descriptors | Should mental health trusts and acute trusts be included as service providers here? Without their input it’s not going to be possible to implement referrals to those sectors/providers locally  |
| 74 | NHS England and Improvement | Statement 1 - audience descriptors | Refers to patients being able to be referred to services without returning to their GP – this will need clarification, as primary care (GP’s) are the gatekeeper to secondary care. |
| 75 | PHE | Statement 1 - audience descriptors | Local Pharmaceutical Committees are not providers, but support community pharmacies in the delivery of services. |
| 76 | PHE | Statement 1 - audience descriptors | NHS England should be replaced by NHS England/Improvement (NHSE/I).Public Health England is not a commissioner (Please note this throughout the document). |
| 77 | Skills for Care  | Statement 1 - audience descriptors | Suggest adding ‘social care workers’ to the ‘health and social care practitioners’ section. Social care workers are mentioned in the same section in Statement 2 so keeps consistency and highlights that practitioners includes frontline workers and registered managers.  |
| 78 | Company Chemists’ Association  | Statement 1 - measures | This data may be difficult to accurately collate. For example, local collaborative relationships between community pharmacies and other health settings including community and voluntary organisations can facilitate effective sign posting. These instances of pharmacy teams referring, or signposting patients may not always be captured. |
| 79 | Company Chemists’ Association  | Statement 1 - measures | This statement is unclear and implies that referral pathways should be established between community pharmacies. The structure of the community pharmacy network is such that they are competitors, therefore any referral arrangements would need to consider implications for anticompetitive behaviour. |
| 80 | Company Chemists’ Association  | Statement 1 - measures | With more clinical services being delivered in community pharmacies it is crucial that timely and relevant information is available to support pharmacists’ clinical decision making. Information about patient care undertaken in pharmacies should then be reported back to other healthcare professionals, including GPs. Enhanced information sharing between healthcare settings will bring benefits for patients including through providing more seamless care and potentially improving patient safety. Better interoperability will also bring workflow efficiencies and we support the call for improved access to records in community pharmacy. This will create more joined-up patient care by preventing duplication of work in different health settings, and avoid patients having to repeatedly explain their situation. However, the term ‘read and write’ access should be used with caution. It is paramount that data is inputted in a structured and coded format, using standards set by the PRSB, for example. Furthermore, consideration should be made to ensure that information is accessed based on clinical need and to improve delivery of patient care.  |
| 81 | Company Chemists’ Association  | Statement 1 - measures | As mentioned above, it is not possible to quantify all referrals and signposting from community pharmacies as this information will not always be captured. For example, in a routine conversation with a patient, a pharmacy team member may identify an opportunity to signpost the patient to a community or voluntary organisation for further support. These recommendations may not be currently recorded by the pharmacy team. Furthermore, this outcome only refers to the number of direct referrals from community pharmacies, however, true integration involves referrals from other healthcare settings into community pharmacies e.g. as is the case with the CPCS. The wording of this outcome statement should be altered to reflect this, e.g.: ‘Numbers of direct referrals into and from community pharmacies to other health and social care services’ |
| 82 | Healthwatch England  | Statement 1 - measures | Although the number of direct referrals (Outcome A) will be useful, they are outputs rather than outcomes. It would be helpful to consider whether the referrals are appropriate and successful – for example, the outcome of the referral. Although this would be harder to measure, it would give a clearer picture of what has been achieved and prevent success been measured by a large number of referrals with little impact. |
| 83 | Healthwatch England  | Statement 1 - measures | Satisfaction (Outcome B) will give a view of the people who use pharmacy services (the denominator) but will not include the views of people who do not or cannot use pharmacy services. The guidance elsewhere notes the importance of tackling inequalities so it would be useful at this point to consider also how the views of under-served groups are used. Local Healthwatch should also be considered as a potential source of information for this indicator. |
| 84 | Healthwatch North Yorkshire | Statement 1 - measures | Measuring referrals does not necessarily translate to access and integration of services. We know that people in rural communities find it difficult to access services which are far away due to a lack of rural transport support. So whilst a referral may be made to health and wellbeing support, it’s important that they be realistic to a person’s location/transport availability. However, the integration of pharmacies working out at local community support groups, luncheon clubs, social activities in rural areas would be great and a much needed priority.  |
| 85 | Managing Adult Malnutrition in the Community | Statement 1 - measures | As the role of community pharmacists is evolving they are in a good position to record and collate weight and heights of patients and work out BMI. Encouraging this is not only beneficial for treatment and prevention of obesity and its related morbidities (hypertension, musculoskeletal disorders, diabetes) but the same data can be utilised to identify those at risk of both obesity and malnutrition. A sequential record of weight would facilitate trends in weight (both unintentional weight gain and loss) and trigger further action – weight management advice/advice on managing poor appetite and undernutrition. Unexplained weight loss would also be a red flag for potential underlying disease e.g. cancer. We would recommend that community pharmacists are made aware of the Malnutrition Universal Screening Tool ‘MUST’ which calculates BMI and unintentional weight loss to give a score for risk of malnutrition which can then be actioned and the malnutrition pathway (https://www.malnutritionpathway.co.uk/library/managing\_malnutrition.pdf ) guidance can be followed. |
| 86 | McKesson UK | Statement 1 - measures | ‘Data source: Local data collection, for example, review of actions taken by commissioners or primary care networks and community pharmacies to facilitate integration’This data may be difficult to accurately collate. For example, local collaborative relationships between community pharmacies and other health settings including community and voluntary organisations can facilitate effective sign posting. These instances of pharmacy teams referring, or signposting patients may not always be captured.  |
| 87 | McKesson UK | Statement 1 - measures | ‘Evidence of referral arrangements agreed between community pharmacies.’This statement is unclear and implies that referral pathways should be established between community pharmacies. It would be helpful to give examples of when referral between pharmacies is appropriate e.g. CPCS for an urgent medicine which the pharmacy does not have available or referral into a locally commissioned service available from selected pharmacies in the area. |
| 88 | McKesson UK | Statement 1 - measures | ‘Evidence of local arrangements to ensure read and write access for community pharmacy teams to NHS summary care records.’With more clinical services being delivered in community pharmacies it is crucial that timely and relevant information is available to support pharmacists’ clinical decision making. Information about patient care undertaken in pharmacies should then be reported back to other healthcare professionals, including GPs. Enhanced information sharing between healthcare settings will bring benefits for both patients, and workflow efficiencies and we support the call for improved access to records in community pharmacy. This will create a more joined-up journey of patient care by preventing duplication of work in different health settings, and avoiding patients having to repeatedly explain their situation. To enable optimal integrated healthcare, the quality measure should be to ensure read and write access to NHS patient care records, as the summary care record is limited and does not provide a comprehensive view. As the Local Health and Care Record (LHCR) programme develops community pharmacy should be included as this will support care co-ordination.However, the term ‘read and write’ access should be used with caution. It is paramount that data which is added by any healthcare professional into a patient record is done so in a structured and coded format, using standards set by the PRSB, for example. Patient information should be accessed based on clinical need and to improve delivery of patient care.  |
| 89 | McKesson UK | Statement 1 - measures | ‘Outcome: Numbers of direct referrals from community pharmacies to health and social care services.’As mentioned above, it is not possible to quantify all referrals and sign posting from community pharmacies as this information will not always be captured. For example, in a routine conversation with a patient, a pharmacy team member may identify an opportunity to signpost the patient to a community or voluntary organisation for further support. These recommendations may not be recorded by the pharmacy team. Furthermore, this outcome currently only refers to the number of direct referrals from community pharmacies, however, true integration involves referrals from other healthcare settings into community pharmacies e.g. as is the case with the CPCS. The wording of this outcome statement should be altered to reflect this, e.g.: ‘Numbers of direct referrals into and from community pharmacies to other health and social care services’ |
| 90 | NHS England and Improvement | Statement 1 - measures | Summary Care Records is a national platform, so I’m unsure what local measures could be taken to ensure access if the national platform wasn’t fit for purpose or couldn’t facilitate it. Also, data collection for Pharmacy Quality Scheme is done nationally, not locally |
| 91 | NHS England and Improvement | Statement 1 - measures | PharmOutcomes and Sonar are not universally used or funded, so may not be a good measure |
| 92 | NHS England and Improvement | Statement 1 - measures | Numerator and denominator: How could either of these be measured? The pharmacy’s own patient survey wouldn’t reflect this data as it only captures those who respond. Are users of the service those who go to the pharmacy, or anyone who gets a script? What about advice – how would you record those patients as they aren’t in any data we currently have. Very difficult to define and measure |
| 93 | NHS West Hampshire CCG | Statement 1 - measures | This statement is hard to measure because there are several pathways that could be pursued. Does the organisation meet the standard if only one pathway or 2 pathways integrated? |
| 94 | PAGB | Statement 1 - measures | PAGB welcomes community pharmacies and local commissioners working together to integrate pharmacy services into existing care and referral pathways, we have been calling for this for some time. We believe Primary Care Networks are a key opportunity to develop this integrated approach. |
| 95 | PAGB | Statement 1 - measures | PAGB believes community pharmacies should have read and write access to people’s medical records to enhance patient safety and support continuity of care. We therefore welcome quality measure d) evidence of local arrangements to ensure read and write access for community pharmacy teams to NHS summary care records; however, we would urge NICE and local NHS Commissioners to extend this access to the full medical record. |
| 96 | PAGB | Statement 1 - measures | PAGB also believes community pharmacists should have the ability to directly refer people to other health and social care services as necessary and therefore also welcomes outcome a) the numbers of direct referrals from community pharmacies to health and social care services. We believe this referral should be fast-tracked where the pharmacist deems, in his/her clinical judgement that this is necessary and would recommend this outcome is measured in terms of routine and fast-tracked referrals. |
| 97 | Pharmacy Complete | Statement 1 - measures | The new Community Pharmacy Contractual Framework (CPCF) proposes that standard metrics will be gathered on the mandatory health campaigns. This should be gathered simply through existing IT systems and assimilated nationally but monitored locally through the Community Pharmacy Assurance Framework. The same should apply for contractual and monitoring arrangements under General Medical Services, Optometry and Dental contracts. |
| 98 | PHE | Statement 1 - measures | The data collected through the pharmacy quality scheme on referrals may not provide all the answers. |
| 99 | PHE | Statement 1 - measures | Data could also be obtained from community pharmacy (CP) satisfaction surveys. These can be found on nhs.org for individual pharmacies. Guidance can be found at: https://psnc.org.uk/contract-it/essential-service-clinical-governance/cppq/. |
| 100 | Skills for Care  | Statement 1 - measures | Page 5 c) Data source – In response to consultation question 2, re: review of referral arrangements, this may be a challenge to measure due to the potentially large number and variety of social care providers within a PCN boundary. A feasibility suggestion would be to include social care provision as part of the PCN asset mapping. There could also be a challenge with data sets not matching up with local willingness to share data within the rules.  |
| 101 | The Hepatitis C Trust | Statement 1 - measures | It is essential that community pharmacists are supported to test and refer people who use OST and NSP services so that, if necessary, they can be supported through treatment. Outcomes for this could be included in the outcome already listed as: Numbers of direct referrals from community pharmacies to health and social care services.  |
| 102 | The Hepatitis C Trust | Statement 1 - measures | The Hepatitis C Trust is aware that discussions are ongoing as to how community pharmacies can get around current structural barriers to dispensing treatment. We fully support efforts to allow pharmacies to dispense treatment; the London Joint Working Group on Substance Use and Hepatitis C community pharmacy hepatitis C testing pilot in 2018 found that almost four in five (78%) of people accessing the service would have preferred to collect their medication in the pharmacy. Community pharmacists often have a close relationship with people accessing services and are in a good position to support people to take treatment, as well as being a convenient place for patients to collect medication from if accessing services regularly anyway. |
| 103 | The Pharmacists’ Defence Association | Statement 1 - measures | We would suggest that access to a read/write facility is well outside the remit of local commissioning arrangements. It would also cause confusion and not be in the public interest as there is substantial evidence of variances in how services are currently being commissioned locally. Read/Write in SCR should be left as a national framework objective. |
| 104 | The Pharmacists’ Defence Association | Statement 1 - measures | The suggested quantitative measure of merely recording the number of referrals does not take into account the quality of the referrals. The NHS, in toto, is working at near full capacity and simplistic quantitative measures risk inappropriate referrals being used as a false measure of effectiveness. There must be some element of quality embedded within the referral process to ensure that only appropriate referrals are made. |
| 105 | The Pharmacists’ Defence Association | Statement 1 - measures | The suggested denominator for the quantitative evaluation of satisfaction is not measurable. It is not possible to measure the number of people visiting a pharmacy in this simplistic way. A better measure would be if the denominator only included those that visited the pharmacy for that prevailing condition or service that was being commissioned.  |
| 106 | Cancer Research UK | Statement 1 - question 1 | Cancer Research UK is pleased to see this statement included in the draft quality standard as “integrating community pharmacy services into existing care and referral pathways” reflects a key area for quality improvement. It is integral that community pharmacy services are integrated with existing health and social care services, including smoking cessation, alcohol treatment and weight management services to improve uptake of local services and improve community pharmacy reach, reduce service duplication and improve service efficiency. For example, locally-commissioned stop smoking services, which offer people who smoke access to specialist behavioural support and pharmacotherapy, are the most effective way to quit; people using these services are around three times more likely to quit compared to going it alone. However, evidence suggests that fewer and fewer people are accessing these services: In 2011, 9.5% of people who smoke set a quit date using a stop smoking service and 4.7% successfully quit. In 2018 these rates have more than halved: services have remained just as effective, but fewer people are accessing them (Taskforce for Lung Health, 2020). If service access and standards had been maintained at 2011 levels from 2012–2018 then an extra 1.97 million people who smoke would have set a quit date and nearly 1 million more would have successfully quit (Taskforce for Lung Health, 2020). Cancer Research UK believe that community pharmacies must play an important role in referring or signposting people who smoke, are dependent on alcohol or are overweight/obese to evidence-based services where they’re available, with the primary purpose to improve uptake of these effective services and support people to adopt healthier behaviours. Conversely, locally-commissioned services can play a role in signposting people to community pharmacy services or health and social care services should they identify a need.  |
| 107 | Coeliac UK | Statement 1 - question 1 | We believe this is a key area for development. Within the context of coeliac disease this could strengthen the role of community pharmacies in the diagnosis pathway. In a proof of concept study, community pharmacies carried out point of care tests for coeliac disease in customers who were accessing prescription and/or over the counter medications for irritable bowel syndrome (IBS) and anaemias (iron, B12 and folate).[1] During the project, 9.4% of patients tested had a positive result. For adults, an endoscopy with biopsy is required to confirm the diagnosis of coeliac disease.[2] In the proof of concept project, pharmacists were unable to refer directly to secondary care for further investigation and patients were signposted to their primary care team for further investigations for coeliac disease. If there were established routes for pharmacists to be able to refer directly to secondary care then the demand on GPs in primary care could be reduced and referral for further investigations (as shown by the proof of concept project in coeliac disease) could be initiated by community pharmacy. [1] Urwin H, Wright D, Twigg M, McGough N. Early recognition of coeliac disease through community pharmacies: a proof of concept study. International Journal of Clinical Pharmacy 2016;38:1294–300. <https://doi.org/10.1007/s11096-016-0368-4>. [2] National Institute for Health and Care Excellence (NICE), NG20 Coeliac disease; recognition, assessment and management. 2015. |
| 108 | Community Pharmacy NI  | Statement 1 - question 1 | We welcome this statement which should help formalise the valuable role community pharmacy already plays. Community pharmacies in NI will soon have access to a secure HSC email address which will enhance integration and enable community pharmacies to become a recognised part of existing care and referral pathways. This should also support data collection in relation to statement 1. |
| 109 | Community Pharmacy Wales | Statement 1 - question 1 | CPW feel that integration into health and social care pathways is an essential requirement if health and well-being services provided by community pharmacies are to become core services. Community pharmacies are the most accessible part of NHS Wales with the highest footfall. They are particularly accessible to people living in areas of deprivation where their concentration is greater. In addition community pharmacy is the only other healthcare provider capable of delivering at the scale required for a meaningful change in people’s wellbeing. Whereas community pharmacy has always been able to signpost to other providers, where this is appropriate, we need to move to a more formal electronic referral system. Data collection: Wales has invested in a community pharmacy IM&T platform called Choose Pharmacy. This could provide a vehicle for measuring referral rates into and out of community pharmacy. Providing read and write access to the Welsh GP Record in Wales would facilitate closer integration. |
| 110 | National Pharmacy Association | Statement 1 - question 1 | Yes. The NPA supports the rationale outlined in this statement, and suggest that for a full integration of the primary care system, effective digital interoperability across the system should also be considered as a quality standard.  |
| 111 | Cancer Research UK | Statement 1 - question 2 | Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.Integrating community pharmacy services into existing care and services pathways is not only achievable, but both efficient and necessary too. Where they don’t exist already, community pharmacies and local services would need to work together to develop appropriate pathways and agreements between the two; however, any resource required to set this up is likely to:1. Be cost saving to the community pharmacy and the local health and social care service as it will improve existing service reach, reduce service duplication and improve efficiency;2. Improve community pharmacy and local health and social care service utilisation;3. Improve health and/or social outcomes for the patient by ensuring patients are consistently referred to appropriate and evidence-based services available in the community; and4. Broker important working relationships between community pharmacies and local health and social care services, which can provide further opportunity for service integration and greater collaboration to improve public health and wellbeing locally. |
| 112 | National Pharmacy Association | Statement 1 - question 2 | In some areas, community pharmacies have piloted a number of digital processes that allow for digital interoperability between healthcare settings to support effective patient care. These are still to be applied at scale. Many of the systems and structures outlined in the draft standard are still to be implemented nationally. If not, how feasible would it be for these to be put in place? The NPA understands that this work stream is being undertaken in collaboration with NHS Digital. As a key stakeholder, the NPA would welcome to opportunity to provide feedback into this. Commissioned services:As part of the service level agreements, community pharmacies would need to record each element of the service that has been undertaken. However, there are instances when the community pharmacist provides ad hoc advice or signposts into a service. The NPA suggests that it would be useful to include these in the dataset. Evidence of referral arrangements:Referrals from the pharmacy into the system and vice versa, have always taken place albeit on an informal basis, and it is only very recently through the new Community Pharmacist Consultation Service, that this has now been formalised. However, NPA members inform us that this is still not a seamless service with a few teething issues still to be resolved. For example, a patient may be referred into the pharmacy, who after a consultation with the pharmacist requires further medical attention. The process for “referring on” is still not possible through the digital platform, and hence, may still require additional telephone calls. Evidence of referral arrangements agreed between community pharmacies, primary care networks, health, social care and support service providers. Currently, there is not a formal referral process between community pharmacists and the social care and support service providers. Often the community pharmacist provides the medicines supply to patients in social care, and although may become aware of any social changes in the patients’ life, the usual referral route would be through the GP surgery. Formal systems and pathways would need to be in place for this element of the quality standard to be applied and measured. Question 3: Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment. Over the last few years, much of the public health budgets have been reduced and/or cut, leading to a leaner spend on local resources. In some parts this has led to the de-commissioning of pharmacy services that support the prevention of ill-health. This may impact an effective delivery of this quality standard.  |
| 113 | Obesity Group of the British Dietetic Association | Statement 1 - question 2 | We agree that integration of community pharmacies into care and referral pathways is needed if not already in place locally. In our view this can be measured by auditing local care and referral pathways particularly those relating to long-term conditions.  |
| 114 | Obesity Group of the British Dietetic Association | Statement 1 - question 2 | The 40+ health checks also offer a potential mechanism within an integrated care pathway for community pharmacists to identify lifestyle changes needed and signpost individuals accordingly.  |
| 115 | Pharmaceutical Services Negotiating Committee | Statement 1 - question 2 | Local systems and structures are not in place to collect data for the proposed ‘structure’ quality measures, but it would be possible for pharmacy contractors to provide evidence of whether and how they have met the measures. We are not convinced that such data collection at contractor level would be a good use of constrained human and financial resources and therefore suggest that as local commissioners and Local Pharmaceutical Committees (LPCs) will often be facilitating and leading this quality improvement work at a local level, it may be more efficient for them to collect this evidence once. However, a case would still have to be made for those organisations to spend time and resources collecting such data, when they will generally have conflicting priorities, which are likely to be of greater immediate importance. On the ‘outcome’ quality measures, the number of direct referrals from community pharmacies to health and social care services will be recorded in some pharmacy IT systems, such as those referenced in the draft document, but such IT systems are generally commissioned to support the provision of commissioned services provided by pharmacy contractors and hence ad hoc referrals are unlikely to be able to be recorded in them.On evidence of patient satisfaction with pharmacy services, we believe the data source given in the example should be the Community Pharmacy Patient Questionnaire, not the Community Pharmacy Assurance Framework.  |
| 116 | Pharmacy Complete | Statement 1 - question 2 | This has long been an ambition but limited incentive or capacity to make it happen. With the advent of a more integrated health system through Integrated Care Systems, Integrated Care Partnerships and Primary Care Networks (PCN) one would hope this would be facilitated. However, a lack of capacity and capability within local commissioning organisations may be a barrier. |
| 117 | National Pharmacy Association | Statement 1 - question 3 | Over the last few years, much of the public health budgets have been reduced and/or cut, leading to a leaner spend on local resources. In some parts this has led to the de-commissioning of pharmacy services that support the prevention of ill-health. This may impact an effective delivery of this quality standard.  |
| 118 | Pharmacy Complete | Statement 1 - question 3 | To be implemented effectively it should be a requirement of all providers, not just commissioners, (e.g. in the planned Health Inequalities PCN Directed Enhanced Service [DES]) and metrics for key actions and timelines built in.  |
| 119 | Pharmacy Complete | Statement 1 - question 3 | All providers need to understand the benefits of a consistent message to the public and to be able to refer to the appropriate provider for patient support through brief advice/interventions and services. Both support options must be recognised and funded contractually. |
| 120 | Community Pharmacy NI  | Statement 2 | Community pharmacies play a huge role providing healthcare services and support to the public. We recognise that there can be a lack of awareness of the skills and services a community pharmacist has to offer. We are continually trying to raise awareness of the impact community pharmacy teams can have on public health and welcome this statement to enhance that role further. Living Well Campaigns are currently being promoted in almost all community pharmacies in Northern Ireland and results have shown the enormous level of engagement with the public and have provided the opportunity to raise awareness of the pharmacy services on offer.  |
| 121 | Community Pharmacy Wales | Statement 2 | While CPW recognises the need to promote the support available from community pharmacy CPW is surprised to see that NICE only recommend this happening at a lower level and as a consequence the proposed quality measures only apply to local promotion. If the NHS is to secure a significant shift in workload from GP practices and other providers then surely the NHS at national level has a role in communicating to its people. For example; community pharmacies in Wales now support more people to quit smoking than any other provider and this has been facilitated by the creation and promotion of the Help Me Quit service by the Welsh Government with community pharmacy being a key part of Help Me Quit. This evidences what can be achieved through a national coordinated approach to informing the public where they can access health and wellbeing support. CPW would also strongly recommend that any messaging aimed at promoting the role of community pharmacy is also provided within the NHS as so many NHS practitioners are unaware of the support available from community pharmacy and do not themselves leverage these services. |
| 122 | Company Chemists’ Association  | Statement 2 | We welcome the recognition of the need to better promote healthcare services and support available from community pharmacies, to ensure that patients and the public can make the most of these services to meet their health and wellbeing needs. Ensuring community pharmacy services are fully harnessed will involve improving awareness among patients as well as other health and care professionals. Therefore, as well as community pharmacies and local commissioners, we would suggest that the quality statement should also refer to other health and care providers. For example, greater awareness among GPs of the full range of healthcare services as well as advice and support offered by community pharmacies will encourage them to recommend pharmacy as the first port of call for patients when they have a minor illness. This could potentially release capacity in general practice by encouraging patients to visit their local pharmacy instead of booking a GP appointment, where appropriate. While community pharmacies themselves have an important role to play in promoting the services they provide, arguably, it is the patients and members of the public who do not use community pharmacies that will benefit most from greater awareness of the services and support available. This may include people living in areas of high deprivation or underserved groups, such as the homeless. Therefore, as above, promoting pharmacy in other healthcare settings, as well as in public places and wider national campaigns, could bring great benefits across the health and care system.  |
| 123 | Company Chemists’ Association  | Statement 2 | Local initiatives to raise awareness of community pharmacy services can be important to inform local populations about what their local pharmacy can offer, given that healthcare service provision may depend on local commissioning. However, there is also a very important role for a national approach to raising public awareness of community pharmacies and the services they provide. We strongly believe that it will be more efficient and effective to deliver campaigns at a national level to address the lack of awareness and knowledge among members of the public about pharmacy teams’ skills. For example, the ‘Help Us, Help You’ Pharmacy Advice campaign delivered by Public Health England encourages the public to use community pharmacies as their first port of call for minor health concerns. The campaign makes use of TV advertising, social media and posters in public places to reach a national audience.  |
| 124 | Healthwatch Birmingham | Statement 2 | It is important that the perception of community pharmacies is changed or improved such that people are aware and are confident of the skills and knowledge of the staff. Some people have told Healthwatch Birmingham about their concerns with the skills and experience of pharmacists as this service user indicated “they don’t give you appointments with GP, to my surprise they send you to healthcare assistant or community pharmacist for minor health issues. Which is rubbish they don’t know anything and its waste of time & effort”. We have also heard positive experiences from people who trust in the skills of pharmacists:“Staff are very friendly pharmacy are very knowledgeable I always talk to pharmacist before GP. Staff do seem stressed at times due to poor management on rota I think as there needs to be more staff on pharmacy”.“I have used this Pharmacy for a number of years. I have regular reviews of my medication with the Pharmacists. I can always ask questions about my medication and get advice easily”.“The pharmacist is professional and is interactive with customers which stood out”.We therefore agree that this is an important quality statement that needs to be included in this standard.  |
| 125 | Healthwatch North Yorkshire | Statement 2 | We agree that raising awareness of pharmacists’ abilities and the various support they can offer is an area for improvement. However, we have found that when people who do not speak English as a first language approach pharmacies “as a first port of call”, they are often not offered access to interpreters so they would struggle to understand or follow any health and well being advice given. As you can see from our report, the NHS “Guidance for commissioners: Interpreting and Translation Services in Primary Care” is often not followed as people are not asked if they need interpreters, incorrectly use google translate or they signpost back to the GP for interpreting needs. We feel that the Quality Standards should refer to NHS “Guidance for commissioners: Interpreting and Translation Services in Primary Care”, as they refer the Accessible Information Standard. In terms of pharmacies knowing the needs of their local population, we feel there is a need to ensure clear, open channels of communication between community pharmacies and local authorities to ensure that pharmacists are aware of the changing needs of the population, so that pharmacies can prepare for, for example, refugee resettlement programmes. Reference: Healthwatch North Yorkshire (2020) Policy vs Practice: Interpreting in Health and Social Care Services [Online] Available at : https://healthwatchnorthyorkshire.co.uk/wp-content/uploads/2020/01/HWNY-Refugee-Report-January-2020.pdf Outcome b) suggests ‘Local data collection, for example, surveys carried out with people accessing GP services’. However, this will not measure public awareness of those who do not currently access GP services, identified elsewhere in the document as a target group for Community Pharmacy services. Surveys need to be carried out with other community services used by underserved groups. Local Healthwatch such as Healthwatch North Yorkshire can be a source of information about levels of public awareness as well as levels of satisfaction with the services provided (Quality Standard 4). They have particular skills in reaching underserved groups. Information gathered through local Healthwatch can contribute to building an accurate picture of local population needs.  |
| 126 | McKesson UK | Statement 2 | ‘Community pharmacies and local commissioners promote healthcare services and support available from community pharmacies.’ We welcome the recognition of the need to better promote healthcare services and support available from community pharmacies, to ensure that patients and the public can make the most of these services to meet their health and wellbeing needs. Ensuring community pharmacy services are fully harnessed will involve improving awareness among patients as well as other health and care professionals. Therefore, as well as community pharmacies and local commissioners, we would suggest that the quality statement should also refer to other health and care providers. The introduction of the CPCS service will also drive greater awareness among GPs of the full range of healthcare services as well as advice and support offered by community pharmacies. This should increase the recommendation of community pharmacy as the first port of call for patients when they have a minor illness. Evidence of the impact of this service has already demonstrated that this development can release capacity in general practice by encouraging patients to visit their local pharmacy instead of booking a GP appointment, where appropriate. The Primary Care Network model of care should also encourage sharing of knowledge and awareness raising. While community pharmacies themselves have an important role to play in promoting the services they provide, arguably, it is the patients and members of the public who do not use community pharmacies that will benefit most from greater awareness of the services and support available. This may include people living in areas of high deprivation or underserved groups, such as the homeless. Therefore, as above, promoting pharmacy in other healthcare settings, as well as in public places and wider national campaigns, could bring great benefits across the health and care system.  |
| 127 | NHS West Hampshire CCG | Statement 2 | This is a useful aim but not a standard as such |
| 128 | Pharmaceutical Services Negotiating Committee | Statement 2 | Local systems and structures are not in place to collect data for the proposed quality measures, but it would be possible for pharmacy contractors to provide evidence of whether and how they have met the measures. We are not convinced that such data collection at contractor level would be a good use of constrained human and financial resources and therefore suggest that as local commissioners and Local Pharmaceutical Committees (LPCs) will often be facilitating and leading this quality improvement work at a local level, it may be more efficient for them to collect this evidence once. However, a case would still have to be made for those organisations to spend time and resources collecting such data, when they will generally have conflicting priorities, which are likely to be of greater immediate importance. We welcome the suggested role of Primary Care Networks (PCN) in supporting the achievement of this quality statement, however we also note the relative organisational immaturity of PCNs at this time and their other, likely higher priority, conflicting calls upon resources. Consequently, their potential involvement in supporting the achievement of this quality statement may be best recognised as a longer-term objective. |
| 129 | Pharmacy Complete | Statement 2 | Since the advent of Healthy Living Pharmacy (HLP) and the requirement of a qualified Health Champion (achieved the Royal Society for Public Health Level 2 Award in Understanding Health Improvement: https://www.rsph.org.uk/qualification/level-2-award-in-understanding-health-improvement-2017.html), the knowledge and skills of the pharmacy team have been enhanced. This has resulted in increased levels and improved quality of proactive health promotion, healthy lifestyle interventions and health protection services (e.g. stop smoking, sexual health, flu immunisation).  |
| 130 | Pharmacy Complete | Statement 2 | There have been a number of evaluations of the benefits of the HLP initiative including: https://psnc.org.uk/wp-content/uploads/2013/08/HLP-evaluation.pdf and https://www.networks.nhs.uk/nhs-networks/hlp-pathfinder-sites/messageboard/hlp-forum/358672516/600199395/healthy-living-pharmacy-electronic-3-pdf |
| 131 | PHE | Statement 2 | Suggest replacing “recognition of ill health” to “early recognition of ill health”. |
| 132 | PHE | Statement 2 | Replace “community pharmacies and local commissioners promote healthcare services and support available from community pharmacies” with “community pharmacies and local commissioners promote health and wellbeing services and support available from community pharmacies”. |
| 133 | Royal College of General Practitioners | Statement 2 | Can the committee consider adding “Appropriately trained” to the quality standard? Encouraging patients to seek help from community pharmacists who have had no training in minor illness or local referral processes may simply increase the workload for other services, particularly primary care. E.g. Community pharmacies and local commissioners promote healthcare services and support available form appropriately trained community pharmacies. |
| 134 | Royal Pharmaceutical Society | Statement 2 | From April 2020 all community pharmacies will be level 1 Health Living Pharmacies (HLP). This will make it easier to promote the services they provide nationally as there will be consistency in provision. Locally, PCNs will need to work with their community pharmacy colleagues to promote more localised services that are tailored to local needs. Examples of good practice on healthcare services and support from community pharmacies need to be collated and promoted to demonstrate to the public what to expect. |
| 135 | The Pharmacists’ Defence Association | Statement 2 | This whole section is very confused and very confusing. It moves randomly from describing a provider within the pharmacy sometimes as a “pharmacist” or sometimes as the undefined and opaque “pharmacy team”. This is a central reason why pharmacy is so often overlooked as a service provider of quality. We suggest using the consistent terminology “pharmacist” as it is a Responsible Pharmacist who is accountable by law for all the activities that occur within a pharmacy setting.  |
| 136 | Healthwatch England  | Statement 2  | The statement focuses on promoting the services available which will be useful; although implicit, it may be useful to be more explicit about the need to increase public confidence in pharmacies which will support the overall outcome of uptake of pharmacy services. Although more difficult to measure, an indication of how much work is being moved ‘upstream’ should be considered. Local Healthwatch receive a lot of feedback about difficulty in accessing GP services, so a sense of how much of this could – and was being mitigated by people using appropriate pharmacy services would be valuable. Insight from local Healthwatch could provide useful additional information for this standard. |
| 137 | National Pharmacy Association | Statement 2  | Yes |
| 138 | Company Chemists’ Association  | Statement 2 - audience descriptors | We fully support the call for commissioners to ensure that services commissioned through community pharmacies are promoted among health and social care providers as well as to patients and the public. However, a blanket approach to promoting services will not necessarily yield optimum patient outcomes. For example, local service specifications often set out specific patient cohorts to target who would benefit most from the service. Therefore, these patients should be targeted and informed of the benefit of the health service being offered by pharmacy. Otherwise, pharmacies may provide care to patients who won’t get the most benefit. |
| 139 | McKesson UK | Statement 2 - audience descriptors | ‘Commissioners (such as NHS England, Public Health England, clinical commissioning groups, local authorities) ensure that the services they commission from community pharmacies are promoted among local health and social care providers as well as members of the public accessing those services.’ We fully support the call for commissioners to ensure that services commissioned through community pharmacies are promoted among health and social care providers as well as to patients and the public. However, a blanket approach to promoting services will not necessarily yield optimum patient outcomes. For example, service specifications often set out specific patient cohorts to target who would benefit most from the service. Therefore, these patients should be targeted and informed of the benefit of the health service being offered by pharmacy. Otherwise, pharmacies may provide care to patient who won’t get the most benefit.It should also be noted that certain services cannot be promoted to the public. For example, through the CPCS community pharmacies can supply an urgent medicine supply if a patient has run out. However, this should not be used regularly by patients as an alternative to ordering a repeat prescription.  |
| 140 | PHE | Statement 2 - audience descriptors | Add “for health improvement services”, after, “Community pharmacies fulfilling their full potential”. |
| 141 | PHE | Statement 2 - audience descriptors | Health and social care practitioners also highlight the CP as the first port of call for minor ailments – the NHSE/I campaign “Help us Help You” campaign supports this. The campaign can be found here: https://campaignresources.phe.gov.uk/resources/campaigns/81-help-us-help-you/overview. |
| 142 | Skills for Care  | Statement 2 - audience descriptors | People section - Suggest adding social care workers to the list for making people aware of the services and support available.  |
| 143 | The Pharmacists’ Defence Association | Statement 2 - audience descriptors | The draft QS suggests: “This allows community pharmacy teams to accept as well as make referrals…”We suggest that this is wholly inappropriate as this could include delivery drivers as suggested during the developmental phase of NG102. To maintain confidence in the referral process we would suggest rewording so that only pharmacists (these are the only professionals with 5 years of recognised training within any pharmacy setting) are able to make or receive referrals from other health care professionals.  |
| 144 | The Pharmacists’ Defence Association | Statement 2 - audience descriptors | We would suggest the following rewording of Quality Statement 2 (by the addition of words in bold italics)“Community pharmacies and local commissioners promote specific healthcare services and support available from community pharmacies in a manner that can be audited and based on robust evidence.” The consultation responses for NG102 came from a multitude of disparate organisations and entities all with their own patient cohorts. It would be unmanageable if pharmacists were expected to provide “health and wellbeing” advise to such a magnitude of groups. We would further propose that any promotion of health and well being support be based on robust evidence of effectiveness and cost-effectiveness, especially in light of the acknowledged lack of evidence or the low quality of evidence that informed the publishing of NG102 (and which is the primary development source for this QS) |
| 145 | Skills for Care  | Statement 2 - EIA | Suggest including social care workers under the proactive approach for people who are homebound, as relevant for domiciliary and supported living services for people who may not have friends/family involved. |
| 146 | McKesson UK | Statement 2 - measures | ‘Evidence of local initiatives to raise awareness of the services and skills available within community pharmacies among health and social care practitioners.’ Local initiatives to raise awareness of community pharmacy services are important to inform local populations about what their local pharmacy can offer, given that healthcare service provision may depend on local commissioning. However, there is also an important role for a national approach to raising public awareness of community pharmacies and the services they provide. Arguably, it will be more efficient and effective to deliver campaigns at a national level to address the lack of awareness and knowledge among members of the public about the skills of pharmacy teams. For example, the ‘Help Us, Help You’ Pharmacy Advice campaign delivered by Public Health England encourages the public to use community pharmacies as their first port of call for minor health concerns. The campaign makes use of TV advertising, social media and posters in public places to reach a national audience.  |
| 147 | NHS England and Improvement | Statement 2 - measures | Statement 2 Quality measures – outcome a) Difficult to measure the uptake of community pharmacy services – if the quality standard is successful patients will self-present / self-refer, and we have no way to measure that (JH) |
| 148 | PAGB | Statement 2 - measures | PAGB welcomes the inclusion of a) local initiatives to raise awareness of the services and skills available within community pharmacies among members of the public. We are concerned that there is currently a lack of awareness of the information and services available. Research we conducted in 2016 found that 47% of people would not go to the pharmacist for advice, with one in five of those saying they didn’t think pharmacists were as qualified as doctors . PAGB would recommend one of these local initiatives to be the ‘recommendation prescription’ or ‘referral to pharmacy’ form. There are still 18 million GP appointments each year for self-treatable conditions. We believe that when an individual presents at the GP surgery with a condition that a pharmacist could have advised on, it is important for the GP to empower that individual to understand why self care would have been appropriate and what to do next time. Evidence from Germany shows that in a similar scheme, 91% of people given a recommendation prescription (gruene Rezept) follow the advice and buy an OTC medicine from a pharmacy, but more importantly people remember the recommendation and the next time they experience the same symptoms, they go straight to the pharmacy. This is a low-cost intervention that helps educate people about self care and the support available from the pharmacy. Clinical Commissioning Groups in Sussex worked together to launch a #HelpMyNHS campaign in June 2017, which included a Self Care Prescription Pad in the campaign resource pack. A printable self care recommendation form is available for HCPs to download from PAGB’s OTC Directory website, otcdirectory.co.uk. |
| 149 | PHE | Statement 2 - measures | Pharmaceutical Needs Assessments, published by individual local authorities, could be used as a data source.  |
| 150 | Royal College of Nursing  | Statement 2 - measures | How would we evidence this? Would need to be able to articulate what is appropriate to refer to pharmacy services and what is not. |
| 151 | The Pharmacists’ Defence Association | Statement 2 - measures | The draft QS suggests “Evidence of local initiatives to raise awareness of the services and skills available within community pharmacies among members of the public.” We would recommend that any awareness campaigns acknowledge that a highly qualified pharmacist is available for consultation on a walk-in basis. This would be the only NHS facility, and one which is readily accessible, besides A&E where this is possible. The availability of a highly qualified pharmacist at all times on a walk-in basis should be at the heart of any promotion campaign to promote the extent of services and skills available via community pharmacy. |
| 152 | Healthwatch England  | Statement 2 - Question 2 | (Structure) Consideration needs to be given at both a system-wide and pharmacy level, including how well they are aligned. The number of initiatives is potentially misleading as it is the effective of initiatives that is important. Local Healthwatch will have insight about people’s experiences of pharmacies, as well as Enter and View visits, which can complement other data. |
| 153 | National Pharmacy Association | Statement 2 - Question 2 | Much of the data sources are heavily reliant on the new NHS structures proposed in the NHS long-term plan. These include but are not limited to Primary Care Networks (PCNs), where discussions pertaining to scope and funding are still to be finalised. The NPA suggests that the measures proposed within this quality standard may be useful in the long term, but in the short term, the NPA recommends that NICE draws on its own guidelines of pharmacy public health services, that include the promotion of community pharmacists and their teams. These include but not limited to: Quality standards: QS111 (2016), QS92 (2015), QS28 (2013), & QS25 (2013)  |
| 154 | British Thoracic Society | Statement 3 | For QS3, it would be useful to include illicit drug users in this group as well because they may also be homeless, likely to have lung diseases related to smoking cigarettes/crack and at risk of TB, DVT/PE and endocarditis as well as any associated alcohol withdrawal. They may present to a community pharmacy for what they perceive as a minor ailment (but could be symptomatic of some of the things I’ve mentioned above) or as part of a needle exchange programme? Also, important to remember that a lot of the ‘homeless’ are actually out of area/asylum seekers displaced and so may not have any GP in the area in which they are currently living rough. |
| 155 | Community Pharmacy NI  | Statement 3 | Community pharmacies are the most accessible healthcare professional and over 123,000 people visit their community pharmacy in NI every day. Community pharmacies do not need appointments and are often located in socially deprived and isolated areas, providing the only healthcare service to a population that relies on it heavily. We have several pilot services that have been put in place due to a local identified need and welcome this statement which supports population needs, gaps in services and action to address health inequalities.  |
| 156 | Community Pharmacy Wales | Statement 3 | The proposal is that community pharmacies work with local commissioners to establish population needs. Whereas this may be an altruistic aim in reality community pharmacies do not have access to the data sources, or the required background skills in many cases, to undertake this sort of analysis nor is it their responsibility to do so. It is for the NHS and Public health institutions to undertake a population needs analysis, to identify unmet needs and to commission services to meet this need. Welsh Government is about to introduce community pharmacy market entry requirements based on these exact principles and this process has been in place for many years in England. Commissioners undertake a full needs assessment and identify unmet needs before publishing these on their respective websites. Clearly there is an opportunity for local pharmacies to signal to a commissioner that their patients are requesting support they are not commissioned to provide, however we do not see this as the primary mechanism. Community pharmacies can of course identify local needs and design their own services to meet these needs however those pharmacies not in an affluent location will find little appetite amongst their local population to pay for these services.  |
| 157 | Company Chemists’ Association  | Statement 3 | We agree that community pharmacy teams are well placed to identify the needs of the local populations they serve and recognise any gaps in locally commissioned services. This valuable insight from community pharmacies can support commissioners to deliver services to meet population needs. However, we would welcome further clarity on the methodology of data collection and how this information will be shared. As above, Local Pharmaceutical Committees (LPCs) can engage with local commissioners on behalf of all pharmacy contractors in their area, thus ensuring that local population needs are met. |
| 158 | Healthwatch Birmingham | Statement 3 | In order to effectively understand health inequalities, pharmacies need to be engaging with different groups as outlined in the equality act and seldom heard groups. Therefore, it is important that one of the quality measures for this statement should include the requirement for pharmacies to engage and listen to the experiences or feedback of people that use its service. It is important that pharmacies are listening to patients and members of the public in changing or improving the service they provide. In addition, the experiences heard should also be used to understand the needs of different groups based on the equality act and those from seldom heard groups. It is important that pharmacies demonstrate that they are seeking service user feedback at key points in decision-making, from planning, shaping priorities, implementation, ongoing decision making, and evaluation of services.  |
| 159 | Healthwatch North Yorkshire | Statement 3 | It would be difficult to measure “Uptake of community pharmacy services among people from underserved groups” because it seems people are not frequently asked about their demographic monitoring information which may identify them as “underserved” at pharmacies. For example, we found that LGBTQ+ are often not asked their sexual orientation or gender identity which leads to misgendering or heteronormative assumptions which results in a poor experience for them. Along with refugees not being asked about interpreting needs, this raises questions about how interventions can be tailored to suit individual needs if individuals are not asked about their individual circumstances. Disabilities, faith, sexual orientation, culture are not always visible and cannot be understood. In addition, many pharmacists are locums who do not understand the area well and therefore are not staff who live in the local area or aren’t able to use their knowledge of the local community to tailor services for individual needs. Reference/Citation: Healthwatch North Yorkshire ([Not yet published, scheduled for 2020]) LGBTQ+ people’s experience of using health and social care services in North Yorkshire: A focus on Mental health [will be available online at: <https://healthwatchnorthyorkshire.co.uk/our-work/published-reports/>). We are pleased that attention has been paid to the health needs of ‘people who are homeless or have no permanent address’. However, we are concerned in light of the briefing notes about the potential implications about access to GP services. Recent work undertaken by other local Healthwatch has indicated that homeless people can struggle to get registered with a GP practice, even though a person does not need a permanent address to register. In this context, and in light of the briefing notes, we are concerned that the phrasing of the Quality Standards may contribute to confusion about the rights of people with no fixed address to access other healthcare services, including GP practices. Reference: Healthwatch Croydon (2018) The Experiences of Homeless People Using Health Services in Croydon [Online] https://www.healthwatchcroydon.co.uk/wp-content/uploads/2017/10/Healthwatch-Croydon-The-Experiences-of-Homeless-People-using-Health-Services-in-Croydon-February-2018.pdf  |
| 160 | McKesson UK | Statement 3 | ‘Community pharmacies work with local commissioners to establish population needs, identify gaps in services and agree actions to address health inequalities.’ Given the fact that community pharmacies are more accessible in areas of high deprivation and the frequent contact pharmacy teams have with the communities they serve, pharmacies are well placed to play a central role in helping to address health inequalities. We believe the quality statement should be refined to clarify the role of pharmacies in service design and commissioning. While pharmacy teams have frequent contact with their patients and may be able to identify where increased support could be provided, it will be difficult for individual community pharmacies to be able to ‘agree actions to address health inequalities’. However, within the context of Primary Care Networks, the multi-disciplinary approach to population health management will support the identification of gaps and areas for health improvement. Local Pharmaceutical Committees (LPCs) can also engage with local commissioners on behalf of all pharmacy contractors in their area. Furthermore, consideration should be made to developing a national approach to addressing local variation in health outcomes. For example, recorded rates of obesity-related diseases or secondary care admissions could be used to target weight management service commissioning through community pharmacies.  |
| 161 | NHS West Hampshire CCG | Statement 3 | Should include local public health colleagues and the DPC as well. The Local Pharmaceutical Committee Chief Officer is a member of the District Prescribing Committee. |
| 162 | Pharmaceutical Services Negotiating Committee | Statement 3 | Local systems and structures are not in place to collect data for the proposed quality measures, but local commissioners and Local Pharmaceutical Committees (LPCs) may be able to collate such evidence. However, a case would still have to be made for those organisations to spend time and resources collecting such data, when they will generally have conflicting priorities, which are likely to be of greater immediate importance. |
| 163 | Pharmacy Complete | Statement 3 | HLPs are already required to understand local health needs and inequalities (JSNA, Health Profiles etc – see HLP Criteria: https://www.gov.uk/government/publications/healthy-living-pharmacy-level-1-quality-criteria).  |
| 164 | Pharmacy Complete | Statement 3 | Community Pharmacies are in a position to support the proposed PCN Health Inequalities DES but this will need to be recognised and funded through the CPCF and/or local service commissioning. |
| 165 | Royal College of General Practitioners | Statement 3 | Pharmacists, like GPs, are very focused on the care of the patients in front of them, and generally unaware of the needs of those who don’t consult. Using pharmacies to consider health inequalities is a positive step, but they may not be able to reach the whole population unless specific activities are programmed to promote pharmacy services to those hard to reach groups. Just because there is a pharmacy on a high street, does not mean it will be used by those who access healthcare less. The perceived cost of using a pharmacy (which is a business), may be a barrier for some. |
| 166 | Royal College of Nursing  | Statement 3 | Could be invaluable for disadvantaged groups of people who have a problem with accessing healthcare, including the homeless and those experiencing discrimination e.g. the LGBT community etc. Could be integrated into the local health & wellbeing hubs. |
| 167 | Royal Pharmaceutical Society | Statement 3 | Currently the intelligence that community pharmacy staff may have in relation to the local population and their health needs remains within the pharmacy as there is no process in place that facilitates the sharing of this information. In order for this standard to be implemented in practice, community pharmacies need to become much more integrated into their local PCNs. The services that community pharmacies provide need to be highlighted to link workers so they can be included in social prescribing services. Health inequalities is a broad definition so needs to be more clearly defined in the context of this statement. Following a definition then tools that allow healthcare providers to recognise health inequalities and also approach and discuss sensitive topics should be developed. |
| 168 | The Hepatitis C Trust | Statement 3 | Hepatitis C disproportionately affects under-served and marginalised communities; prevalence is highest among people who inject drugs, people in prison, and people experiencing homelessness. As such, it is a serious health inequalities issue, and one which can be addressed by preventing hepatitis C infections; identifying people with the virus; and getting them onto treatment. Community pharmacies are in a good position to do all three of these things. It is surprising and disappointing that both the draft quality standard and the briefing document makes no mention of the potential interventions pharmacies could make by engaging with people using OST and NSP services. Community pharmacies comprise around 80% of NSP outlets in England, and over a fifth (22%) of community pharmacies are part of an NSP. Additionally, the majority of OST-dispensing in the UK is done by community pharmacists. Supporting people with substance misuse dependencies is crucial to addressing health inequalities and this should be recognised as an outcome in the quality standard.  |
| 169 | The Hepatitis C Trust | Statement 3 | While it is encouraging that the draft quality standard has recognised people who are homeless, it is worrying that the briefing paper highlights research showing only one third (33%) of pharmacists were confident in their ability to advise an appropriate medicines management strategy for people who are homeless and almost all (95%) had not covered the topic of homelessness during their training. As a NICE-identified at-risk group for hepatitis C, it is crucial that community pharmacists are supported to offer tailored interventions, including hepatitis C testing and harm reduction strategies. |
| 170 | The Pharmacists’ Defence Association | Statement 3 | We would suggest the following rewording of Quality Statement 3 (by the addition of the words in bold italics):“Community pharmacies work with local commissioners to establish population needs, identify gaps in services and agree actions to address health inequalities where there is clear evidence of efficacy for these services and that the improvements in outcome can be audited in a qualitative and quantitative way.” |
| 171 | Company Chemists’ Association  | Statement 3 - audience descriptors | Given the fact that community pharmacies are more accessible in areas of high deprivation and the frequent contact pharmacy teams have with the communities they serve, pharmacies are well placed to play a central role in helping to address health inequalities. We believe the quality statement should be refined to clarify the role of pharmacies in service design and commissioning. While pharmacy teams have frequent contact with their patients and may be able to identify where increased support could be provided, it will be difficult for individual community pharmacies to be able to ‘agree actions to address health inequalities’. Local Pharmaceutical Committees (LPCs) can engage with local commissioners on behalf of all pharmacy contractors in their area, thus ensuring that local population needs are met.Furthermore, consideration should be made to developing a national approach to addressing local variation in health outcomes. For example, recorded rates of obesity-related diseases or secondary care admissions could be used to target weight management service commissioning through community pharmacies.  |
| 172 | Company Chemists’ Association  | Statement 3 - audience descriptors | While community pharmacy teams have frequent contact with the patients in their local population, establishing where health inequalities exist requires thorough evaluation to ensure that any actions taken to address inequalities have the desired health outcomes for underserved groups. To develop an understanding of the extent of local health inequalities, different health providers must share intelligence to build a full picture of health outcomes and gaps in service provision. Local Pharmaceutical Committees (LPCs) can engage with local commissioners on behalf of all pharmacy contractors in their area and share information with commissioners, thus ensuring that local population needs are met. In this way, community pharmacies can collectively share data to enable the development of an understanding of local inequalities. Furthermore, it may be difficult to identify health inequalities at a local scale and national evaluation of local data may be needed to fully establish where there is variation in health outcomes.  |
| 173 | Company Chemists’ Association  | Statement 3 - audience descriptors | We agree that health outcomes for patients can be enhanced through commissioners being engaged with service providers to fully understand the health priorities of the local population. Further clarity is needed on how this engagement will be delivered, for example, Local Pharmaceutical Committees (LPCs) could facilitate this engagement between service providers i.e. community pharmacies.  |
| 174 | McKesson UK | Statement 3 - audience descriptors | ‘Community pharmacies can support other agencies, primary care networks and commissioners in establishing the population’s needs as well as gaps in locally commissioned services.’ As already mentioned, we agree that community pharmacy teams are well placed to identify the needs of the local populations they serve and recognise any gaps in locally commissioned services. This valuable insight from community pharmacies can support commissioners to deliver services to meet population needs. However, we would welcome further clarity on the methodology of data collection and how this information will be shared.  |
| 175 | McKesson UK | Statement 3 - audience descriptors | ‘Service providers (such as community pharmacies, primary care networks, GP practices, social care providers, community and voluntary sector organisations) share their knowledge and intelligence with local commissioners and each other to develop a good understanding of the local population and the extent of local health inequalities.’ While community pharmacy teams have frequent contact with the patients in their local population, establishing where health inequalities exist requires thorough evaluation to ensure that any actions taken to address inequalities have the desired health outcomes for underserved groups. To develop an understanding of the extent of local health inequalities, different health providers must share intelligence to build a full picture of health outcomes and gaps in service provision. Furthermore, it may be difficult to identify health inequalities at a local scale and national evaluation of local data may be needed to fully establish where there is variation in health outcomes.  |
| 176 | McKesson UK | Statement 3 - audience descriptors | ‘Commissioners ensure that they commission services that reflect the health and social care needs and priorities of the local population. They work with service providers to gain a better understanding of priority areas, to identify under-served populations and to agree actions to address health inequalities.’We agree that health outcomes for patients can be enhanced through commissioners being fully engaged with service providers to fully understand the health priorities of the local population. Further clarity is needed on how this engagement will be delivered, for example, how Local Pharmaceutical Committees (LPCs) could facilitate this engagement between service providers i.e. community pharmacies.  |
| 177 | Company Chemists’ Association  | Statement 3 - measures | While we fully support the idea of using intelligence from community pharmacies to inform local commissioning of services to address health inequalities, further consideration should be made as to how this information will be collated and shared. LPCs could be used as a forum for sharing intelligence from local pharmacy contractors for example.  |
| 178 | Company Chemists’ Association  | Statement 3 - measures | We agree that a key outcome for this quality statement is the uptake of community pharmacy services by underserved populations. However, collecting data to quantify this poses challenges and it may be difficult to evaluate service delivery to these patients. It may be possible to use metrics to help identify pharmacies in areas with higher populations of people from underserved groups. The service uptake in these areas could then be monitored and used as an indicator for service use among underserved groups. Furthermore, it would be useful to define ‘underserved groups’ in the Quality Standard, as is the case in NICE guideline [NG103] Flu vaccination: increasing uptake.  |
| 179 | McKesson UK | Statement 3 - measures | ‘Evidence of using intelligence from community pharmacies to inform which services should be commissioned locally.’ While we fully support the idea of using intelligence from community pharmacies to inform local commissioning of services to address health inequalities, further consideration should be made as to how this information will be collated and shared. Public Health teams in localities already undertake significant collection of data and detailed analysis of the health needs of a population using nationally agreed datasets, it would therefore be appropriate to base commissioning decisions on this information. However, decisions about how services are delivered and what opportunities there are available from the community pharmacy sector in a local area should be informed by LPCs and Primary Care Network Leads. |
| 180 | McKesson UK | Statement 3 - measures | ‘Outcome: uptake of community pharmacy services among people from underserved groups.’ We agree that a key outcome for this quality statement is the uptake of community pharmacy services by underserved populations. However, collecting data to quantify this poses challenges. Community pharmacy teams may not always detail, or even know, that a patient they interact with is from an underserved group and thus the true level of service use among these populations may not be demonstrated in the data. It may be possible to use metrics to help identify pharmacies in areas with higher populations of people from underserved groups. The service uptake in these areas could then be monitored and used as an indicator for service use among underserved groups. It would be useful to define ‘underserved groups’ in the Quality Standard, as is the case in NICE guideline [NG103] Flu vaccination: increasing uptake.  |
| 181 | NHS England and Improvement | Statement 3 - measures | Isn’t this what Local Pharmaceutical Committees (LPC) should be doing, in representing the findings of all pharmacy contractors locally? I’m not sure that commissioners would want to deal with multiple pharmacy contractors locally, if the LPC could offer that as a single voice. |
| 182 | NHS England and Improvement | Statement 3 - measures | Should this also include Pharmaceutical Needs Assessments (PNAs) as well as JSNA’s, as they are both produced by local authorities and are normally co-dependent documents. |
| 183 | NHS England and Improvement | Statement 3 - measures | Who would review the records in community pharmacy? And how would that indicate if the patient was from an underserved group, as pharmacy systems do not record any significant demographic information? (JH) |
| 184 | PHE | Statement 3 - measures | Motivational interviewing could be cited as training for community pharmacy teams as it would equip team with the skills to help people change behaviours.  |
| 185 | The Pharmacists’ Defence Association | Statement 3 - measures | The QS suggests: “Uptake of community pharmacy services among people from underserved groups.” being used a measure of the efficacy for this QS. Quite often there are hidden inequalities and groups thus affected who are totally overlooked.There needs to be some qualitative measure to ensure that all underserved groups are treated equitably. |
| 186 | Cancer Research UK | Statement 3 - question 1 | Does this draft quality standard accurately reflect the key areas for quality improvement? Cancer Research UK is pleased to see this statement included in the draft quality standard as “establishing population needs, identifying gaps in services and agreeing actions to address health inequalities” is a key area for quality improvement in England. We believe that community pharmacies are well-placed to be providing people with information and support about smoking cessation, alcohol use and weight management, and given their regular interactions with the local population, have a good understanding of local needs and the challenges some individuals face in their community. Community pharmacies have a duty to be advising local services of the local needs and identifying service gaps where they exist, with the primary purpose to reduce health inequalities and improve local population health. For example, because tobacco is so damaging to health, differences in smoking rates among groups or subgroups of the population translate to different rates of illness and mortality, or health inequalities. In England smoking rates vary across local authorities, and on average are two and a half times higher in routine and manual workers compared with those in managerial and professional occupations (25% versus 10%) (Office of National Statistics, 2019). Evidence suggests smoking accounts for approximately half of the difference in life expectancy between the lowest and highest income groups (Marmot, 2010). The latest data also shows that this gap in smoking prevalence between those in routine and manual occupations and those in other occupations has widened, significantly, since 2012 (Office of National Statistics, 2019). In England local stop smoking services, which offer people the best chance of quitting for good, are being increasingly threatened as a result of central government cuts to public health funding: now, only 59% of local authorities offer a specialist stop smoking service available to everyone who smokes locally (ASH & CRUK, 2020). If England is serious about addressing health inequalities, reinstating universal services is paramount and this relies on meaningful central funding uplifts. Community pharmacies can identify the needs of local people who smoke, map service gaps and work with service providers to support them to deliver evidence-based stop smoking services that target the reduction of health inequalities. As well as stop smoking services, Cancer Research UK are also concerned that the impact of cuts to weight management services and to local obesity prevention measures could be felt most in the more deprived parts of the country, exacerbating existing health inequalities. Cancer Research UK believe community pharmacies are in a unique position to be identifying service needs and gaps supporting other health and social care services to agree actions to address health inequalities related to weight management and overweight/obesity. In addition, local and regional authorities, including community pharmacies, are well-placed to champion a ‘health in all policies’ approach that addresses the wider determinants of health – including environmental, social, economic and commercial determinants. As these local services are being increasingly streamlined, cut back or decommissioned altogether, community pharmacies can and must work with other agencies, primary care networks and commissioners to establish local needs and highlight gaps in locally commissioned services. Only then can they agree actions to address health inequalities together and deliver meaningful change. |
| 187 | National Pharmacy Association | Statement 3 - question 1 | Yes |
| 188 | Healthwatch England  | Statement 3 - question 2 | (Structure) The measure is unclear in that it talks about “intelligence from community pharmacies” when it is as important – if not more so – that community pharmacies use intelligence from a variety of sources. Some of this may influence the Joint Strategic Needs Assessment but there may be insight that may be valuable across all sectors. This is partly reflected in the ‘Definitions’ section but it would be helpful to include it at the head of the standard. It may be more useful to present this as an iterative cycle rather than a linear process as it currently appears. As above, local Healthwatch will have a lot of insight about their community, and often undertake work with under-served groups which will give a rounded view of their experience; this is important so there is an understanding of the way in which the service was delivered as well as the service itself. |
| 189 | Healthwatch England  | Statement 3 - question 2 | Although the uptake of services by under-served groups is an essential factor in tackling inequalities, it would be helpful to take account of the experience of people in under-served groups. Although this will include those who use services, there may be people who feel that they are excluded – for whatever reason – and their views can provide valuable insight into what may be needed to close the inequalities gap. Again, local Healthwatch can be valuable partners in this. |
| 190 | National Pharmacy Association | Statement 3 - question 2 | As with all local systems and services, there is some variation of the services that are being commissioned across the community pharmacy network. This variation is apparent in both the funding and service specifications, which may lead to health inequality across the nation. A number of joint assessments, including Pharmaceutical needs assessments have been set up to address the health inequalities, however, there still appears to be a lack of uniformity in their application. For example, NPA members inform us that often, they are not consulted to inform this process. Using this measure as a quality standard may not be able to provide the desired outcome, and the NPA suggests that NICE applies a wider strategic view including the health and social care system to address health inequalities. This may include a national mapping of services, coupled with a robust evaluation of services. From April 2020, all community pharmacies in England would be required to have achieved level 1 HLP status. This means that under the leadership and supervision of the responsible pharmacist all pharmacy teams would be trained to provide healthy living advice to their local population. They will also be able to signpost patients into a number of local community services that support the health and improvement of the local population. The NPA suggests that elements of this accreditation may be utilised as quality measures for this standard.  |
| 191 | Cancer Research UK | Statement 4 | Cancer Research UK recommend this statement refer to “healthier behaviours” rather than “healthier lifestyles”. Smoking, alcohol consumption and overweight/obesity are all risk factors for cancer and are influenced by a range of environmental, social and genetic factors. By using the term “lifestyle”, it suggests people have made a choice to smoke, consume alcohol or be overweight/obese; in reality, these behaviours are much more complex. In many instances, tobacco and alcohol dependency and overweight/obesity might be considered long-term, relapsing medical conditions. |
| 192 | Coeliac UK | Statement 4 | Statement 4 refers to access to support for people with a long term health condition from community pharmacy.Coeliac disease is a lifelong condition and the only treatment is a gluten free diet. An example of existing practice which underpins this quality standard is the Scottish Gluten Free Food Service (GFFS) The GFFS provides support to people with coeliac disease through both the provision of gluten free food on prescription and through the annual health check. The annual health check is carried out by pharmacists to review how patients are managing with their gluten free diet and to identify if they need further clinical support. [3] NHS Inform, Gluten-Free Food Service https://www.nhsinform.scot/care-support-and-rights/nhs-services/pharmacy/gluten-free-food-service [accessed 13 February 2020] |
| 193 | Community Pharmacy NI  | Statement 4 | Community pharmacies play a key role in supporting people with long-term conditions and providing health and wellbeing advice. Community pharmacy is a uniquely placed healthcare provider as it sees not only the sick, but also the well. This data is regularly collected as part of our Living Well Campaigns which has demonstrated the positive impact community pharmacies can have on the health and wellbeing of the communities they serve. The Stop Smoking service and numerous successful pilots such as alcohol awareness demonstrate the impact community pharmacists have on encouraging the public to adopt healthier lifestyles.  |
| 194 | Community Pharmacy Wales | Statement 4 | The quality statement particularly mentions people who have long-term conditions as recipients for community pharmacy advice on health and wellbeing. CPW feel that while this group of people would benefit from this advice so would many other people and the payback to the NHS of having a younger person adopt a healthier lifestyle is likely to be greater than an older person with a long-term condition who could, apart from their condition, be leading a very healthy lifestyle. CPW would therefore suggest that the words ‘long-term health condition’ are dropped from the Quality Statement. CPW agrees that the more informal setting of a community pharmacy provides a less threatening and less official environment for many people taking the first step towards a healthier lifestyle. While the rationale section quite correctly identifies that community pharmacies can offer a range of health and wellbeing services to their local population, as Governments in both England and Wales have implemented a freeze in funding over a number of years NICE need to recognise that this is only likely to occur via a fully funded and commissioned service. The potential Quality Measures supporting the standard are heavily slanted to pharmacies initiating and funding their own services and CPW suggests that the Quality Measures should have a greater focus on commissioned services and training undertaken by community pharmacy teams to meet the service requirements of these services. |
| 195 | Faculty of Sexual and Reproductive Healthcare (FSRH) | Statement 4 | We suggest signposting the role of community pharmacies in providing sexual and reproductive healthcare services – “Community pharmacy teams can offer support with adopting a healthier lifestyle, including stopping smoking, reducing alcohol consumption and managing weight. They can advise on contraception and preconception care” |
| 196 | Faculty of Sexual and Reproductive Healthcare (FSRH) | Statement 4 | We suggest adding contraception to list of health behaviour advice in paragraphs 1, 2, and 4:Par 1: They also ensure that members of staff have skills and confidence to provide health and wellbeing advice and education, including advice on contraception, stopping smoking, reducing alcohol consumption and managing weight. Par 2: This includes advice on contraception, stopping smoking, reducing alcohol consumption and managing weight”Par 4: They can ask for information about contraception, smoking, alcohol or healthy weight, get advice or receive a referral to another service that they may need. |
| 197 | Healthwatch Birmingham | Statement 4 | We note that one of the data sources for this is from surveys carried out with people using community pharmacy services. This is welcome but it needs to be made clearer that this is the responsibility of the pharmacy to ensure that it is listening to people. If pharmacies are to provide some of the services that are provided by GPs it is important that they offer people recourse to complaints as well as sharing their experience. People need to be made aware that they can also share their experiences of accessing pharmacy services with other independent services such as local Healthwatch. This is a key requirement of the NHS Standard Contract (SC16 16.2.1) which asks for health providers to display clear information about how to make a complaint, share feedback or how to contact local Healthwatch for service users and members of the public. |
| 198 | Healthwatch North Yorkshire | Statement 4 | By offering further health and wellbeing advice to people who use community pharmacies, it could further increase the inequalities faced by those who do not access or cannot access due to their rurality, physical disabilities, personal circumstances etc. The premises of Community Pharmacies are not always accessible to individuals with disabilities, including those who need step-free access, wheelchair access or an induction loop. Services’ facilities accessibility information on the NHS website is often incomplete and cannot be searched making it difficult for a person to find a service which meets their needs. In our view, the statement that ‘Pharmacies should have areas that offer privacy to people who would like to discuss their health and wellbeing in more detail’ needs to make reference to accessibility considerations. With regards to the appropriateness of information, we would also highlight that information should be appropriate and sensitive towards an individual’s gender and sexual orientation, for example the provision of information about cervical screening for transgender men and non-binary people. Care should also be taken to ensure that this information is delivered in ways which maintains patient confidentiality and do not risk “outing” an individual in the community, something which our recent report into LGBTQ+ people’s experiences highlighted as an issue.Reference/Citation: Healthwatch North Yorkshire ([Not yet published, scheduled for 2020]) LGBTQ+ people’s experience of using health and social care services in North Yorkshire: A focus on Mental health [will be available online at: https://healthwatchnorthyorkshire.co.uk/our-work/published-reports/) |
| 199 | McKesson UK | Statement 4 | ‘People who have a long-term health condition or need support to adopt a healthier lifestyle are offered health and wellbeing advice and education when they use community pharmacy services.’ Community pharmacies in England dispense over a billion prescription items every year, and many of these medicines are for the management of long-term conditions, such as hypertension or diabetes. Pharmacy teams therefore have frequent and regular contact with these patients and as well as those accessing treatment over the counter for common ailments. Community pharmacies will provide expert advice to ensure that all patients get the most from their medicines, and they can discuss other matters to improve the health and wellbeing of the patient opportunistically.  |
| 200 | NHS West Hampshire CCG | Statement 4 | Is the expectation that CCGs commission this, or that they are offered as part of the pharmacies business model? |
| 201 | Obesity Group of the British Dietetic Association | Statement 4 | We agree that community pharmacies have an important potential role in supporting people with long-term conditions. However education and CPD for community pharmacists in addition to clear delineation of roles and responsibilities, and limits to those, also need to be in place. Training needs to be evidence-based and accessed on an ongoing basis. It is also our view that in the area of diet and nutrition in particular, the funding for any training provided needs to be transparently declared.  |
| 202 | PAGB | Statement 4 | PAGB agrees that community pharmacies are well placed to offer health and wellbeing advice and education to everyone in the community whether they have a long-term health condition or need to adopt a healthier lifestyle. We welcome the inclusion of stopping smoking as an area where community pharmacy teams can offer support. Community pharmacies are also best placed to offer self care advice and education to people with acute self-treatable conditions and PAGB believes that this should be recognised and specifically included in the rationale for Quality Statement 4, with measures covering advice and support offered to people with self-treatable conditions. This could be linked to the Community Pharmacy Consultation Service, which started in October 2019. |
| 203 | Pharmaceutical Services Negotiating Committee | Statement 4 | Local systems and structures are not in place to specifically collect data for the proposed ‘structure’ quality measures, but it would be possible for pharmacy contractors to provide evidence of whether and how they have met the measures via extraction of data from records or documents they hold. |
| 204 | Pharmaceutical Services Negotiating Committee | Statement 4 | Community pharmacy teams already offer health and wellbeing advice to people who have a long-term condition or need support to adopt a healthier lifestyle. This approach is enshrined in the Healthy Living Pharmacy concept, the requirements of which will apply to all English community pharmacies in contract with the NHS during 2020/21. However, community pharmacies are currently under considerable capacity and financial strain, with cuts to NHS funding having been imposed in recent years and workload increasing, as a result of increased patient and NHS demands. This consequently means that while community pharmacy teams have the skills and desire to be able to provide more health and wellbeing advice to people, they may not have the time or financial capacity to undertake this work at all times. |
| 205 | Pharmacy Complete | Statement 4 | In Cheshire & Merseyside, the local NHS and Local Pharmaceutical Committees have worked together to gather intervention data using PharmOutcomes. This data illustrates the significant reach that community pharmacy has in the community on matters such as risky alcohol behaviours and appropriate use of antibiotics. |
| 206 | PHE | Statement 4 | Consider adding – greater commissioning of health improvement services, as an outcome measure. For example, the main route of access for other services such C Card and emergency hormonal contraception has been through community pharmacies, this may be due to ease of access. This can be viewed at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\_data/file/788240/Pharmacy\_Offer\_for\_Sexual\_Health.pdf; and at NICE guideline 102 at: https://www.nice.org.uk/guidance/ng102. |
| 207 | Royal Pharmaceutical Society | Statement 4 | For this statement to be implemented successfully, community pharmacists and their team members need to be able to access training and education to ensure they have the relevant skills and knowledge. This should be made available to pharmacists and pharmacy staff free of charge. The pharmacy team also need to have access to the services available locally that they can signpost or refer people to for further help and support.Pharmacists should offer people the opportunity to talk in private about their health and wellbeing, in their consultation rooms and should have protected time to deliver this service. |
| 208 | Skills for Care  | Statement 4 | Suggest specifying people with a learning disability and/or autism for this statement, as well as people with a long-term condition or adopting a healthier lifestyle.  |
| 209 | The Hepatitis C Trust | Statement 4 | The Hepatitis C Trust supports the rationale of the fourth quality statement that community pharmacy teams should use the opportunity offered by regular interactions with patients to offer health advice and education. Managing substance use should be included in the list of areas teams should be offering support on, alongside the existing specified areas (namely stopping smoking, reducing alcohol consumption and managing weight).In particular, community pharmacists should offer education about BBVs and the importance of getting tested; the risks of sharing drug-taking equipment; how to minimise the chances of transmission; and what services are available in the local area, such as peer support groups. Pharmacists are also well-placed to reduce stigma by myth-busting and encouraging open conversations. Such interventions can be measured under the outcome: ‘Number of interventions and advice (very brief, brief and extended brief advice) delivered by local pharmacies’. |
| 210 | The Pharmacists’ Defence Association | Statement 4 | We would suggest the following rewording of Quality Statement 4 (by the addition of the words in bold italics):“People who have a long-term health condition or need support to adopt a healthier lifestyle are offered health and wellbeing advice and education when they use community pharmacy services in addition to the advice and education already provided as part of the services contracted within the CPCF.” |
| 211 | McKesson UK | Statement 4  | As well as those points already mentioned in the rationale, reference could be made to the Heathy Living Pharmacy (HLP) framework which aims to improve the health and wellbeing of local populations and help reduce health inequalities. From April 2020, all community pharmacies will be at least level one accredited HLPs, meaning that all pharmacy teams will be adequately trained to promote health, wellbeing and self-care. Some pharmacies may also surpass this as either level two or three HLPs, providing services to aid prevention, and providing treatment. This framework further demonstrates the role of pharmacy teams in supporting the local population with their health and wellbeing needs.  |
| 212 | Company Chemists’ Association  | Statement 4 - audience descriptors | We agree that to deliver the best possible health outcomes for patients and ensure that community pharmacy teams feel confident in providing tailored health and lifestyle advice, pharmacy staff must be well equipped with relevant and up to date education and training. We would welcome the inclusion here of the Healthy Living Pharmacy (HLP) framework which provides a framework for commissioning public health services through pharmacies. The framework consists of three levels of increasing complexity and required expertise, with level 1 focusing on promotion of health, wellbeing and self-care. Given that the latest Community Pharmacy Contractual Framework requires all community pharmacies to be level 1 accredited HLPs from April 2020, all community pharmacy teams will be adequately trained to provide health and wellbeing advice and education. We would welcome clarity relating to this quality measure, about how this evidence will be collated and from whom. Considering the large locum workforce in the community pharmacy sector, it may be difficult to collect this information.  |
| 213 | Company Chemists’ Association  | Statement 4 - audience descriptors | While we recognise that pharmacy teams are well placed to provide information and advice to support patients to live a healthier life, more targeted support commissioned by local CCGs will enable pharmacies to deliver support that will lead to better health outcomes. While opportunistic interventions, brief pieces of advice and resources such as leaflets or posters may raise awareness about living a healthier lifestyle, tailored and ongoing support is often needed to successfully make lifestyle changes to improve a patient’s health, such as quitting smoking. Services commissioned through community pharmacy for weight management, for example, have been found to be both clinically effective and cost effective, delivering savings to the NHS through the prevention of obesity-related health problems. Therefore, the quality standard should include reference to these commissioned services. As well as supporting patients to make lifestyle changes to improve their health and wellbeing, community pharmacy teams are well placed to identify ongoing symptoms which may require signposting to another healthcare professional. For example, community pharmacy teams can help in identifying some early cancer symptoms and then signpost the patient to the relevant healthcare professional. This type of opportunistic intervention may come about following a patient repeatedly purchasing OTC medicines for a persistent cough or self-care treatment for mouth ulcers, for example. We would welcome the commissioning of more structured referral pathways to enable community pharmacies to make referrals and directly book patients for appointments in other health and care settings.  |
| 214 | Company Chemists’ Association  | Statement 4 - audience descriptors | While many interactions in community pharmacies are recorded these are mainly those that occur through the delivery of commissioned services, e.g. for smoking cessation or weight management services. It should not be assumed that every conversation that pharmacy teams have with their patients about health and wellbeing is recorded. Many opportunistic interventions and conversations that occur in pharmacies take place during the dispensing of prescription medicines or sale of OTC products, for example. These brief conversations can be effective in reaching patients who may not have frequent contact with other healthcare professionals and the accessibility of community pharmacy may be welcomed by some members of the public. However, not all these interventions will be, or indeed should be, recorded by pharmacy teams. The real value in community pharmacy is the relationship between the pharmacy team and members of the public. Recording patient interactions is important in ensuring seamless referrals across the health and care system. Without the ability to make formal referrals from community pharmacy, there are limited reasons for pharmacy teams to record information about advice given to the patient if this detail is not then used by a subsequent healthcare professional.  |
| 215 | McKesson UK | Statement 4 - audience descriptors | ‘Service providers (community pharmacies) ensure that systems and protocols are in place to offer advice on health and wellbeing to people who have a long-term health condition or need help to adopt a healthier lifestyle. They also ensure that members of staff have skills and confidence to provide health and wellbeing advice and education, including advice on stopping smoking, reducing alcohol consumption and managing weight. Pharmacies should have areas that offer privacy to people who would like to discuss their health and wellbeing in more detail.’ The contractual framework requires pharmacies to have a consultation room for the provision of more clinical services, such as the CPCS. Consultation rooms provide a private area for delivery of clinical services, including for example, flu vaccinations, and a space for patients to have a confidential conversation with a pharmacy team member about their health and wellbeing. We have already mentioned that from April 2020, all community pharmacies will also be at least level one accredited HLPs, meaning that all pharmacy teams will be adequately trained to promote health, wellbeing and self-care. Some pharmacies may also surpass this as either level two or three HLPs, providing services to aid prevention, and providing treatment. |
| 216 | McKesson UK | Statement 4 - audience descriptors | While we recognise that pharmacy teams are well placed to provide opportunistic information and advice to support patients to live a healthier life, more targeted support commissioned locally enables pharmacies to deliver support that will lead to better health outcomes. While opportunistic interventions, brief pieces of advice and resources such as leaflets or posters may raise awareness about living a healthier lifestyle, tailored and ongoing support is often needed to successfully make lifestyle changes to improve a patient’s health, such as quitting smoking. Services commissioned through community pharmacy for weight management, for example, have been found to be both clinically effective and cost effective, delivering savings to the NHS through the prevention of obesity-related health problems. Therefore, the quality standard should include reference to these commissioned services. As well as supporting patients to make lifestyle changes to improve their health and wellbeing, community pharmacy teams are well placed to identify ongoing symptoms which may require referral to another healthcare professional. For example, community pharmacy teams can help in identifying some early cancer symptoms and then either signpost or directly refer the patient to the relevant healthcare professional. This type of opportunistic intervention may come about following a patient repeatedly purchasing over the counter medicines for a persistent cough or self-care treatment for mouth ulcers, for example.  |
| 217 | McKesson UK | Statement 4 - audience descriptors | ‘Community pharmacists offer people who have a long-term health condition or need help to adopt a healthier lifestyle, health and wellbeing advice and education. This includes advice on stopping smoking, reducing alcohol consumption and managing weight. They provide relevant information and resources or provide a brief intervention suitable to the persons’ circumstances. If they cannot offer the support needed, they offer referrals or signpost to a relevant service. They also record the advice given and the interventions and referrals made.’ While many interactions in community pharmacies are recorded these are mainly those that occur through the delivery of commissioned services, e.g. for smoking cessation or weight management services. It should not be assumed that every conversation that pharmacy teams have with their patients about health and wellbeing is recorded. Many opportunistic interventions and conversations that occur in pharmacies take place during the dispensing of prescription medicines or sale of over the counter medicines, for example. These brief conversations can be effective in reaching patients who may not have frequent contact with other healthcare professionals and the accessibility of community pharmacy may be welcomed by some members of the public. However, not all these interventions will be, or indeed should be, recorded by pharmacy teams. The real value in community pharmacy is the relationship between the pharmacy team and members of the public.  |
| 218 | NHS England and Improvement | Statement 4 – audience descriptors | Why are people only being encouraged to discuss issues with the pharmacist? I would prefer this to reference a conversation with an appropriate member of the community pharmacy team as there could well be other clinically trained staff (eg technicians) or leads/champions designated within a pharmacy that aren’t necessarily a pharmacist  |
| 219 | PHE | Statement 4 - audience descriptors | Suggest replacing ‘community pharmacist’ with ‘a member of the community pharmacy team’, as it is often the team members that communicate with people and in different languages. |
| 220 | Company Chemists’ Association  | Statement 4 - measures | While we agree that patient satisfaction should be a factor in assessing the outcome of services and advice delivered through community pharmacy, this data may be difficult to obtain. Furthermore, sometimes patient satisfaction may not necessarily correlate with positive clinical outcomes and patient centred care. For example, a pharmacist may use their clinical judgement and advise a patient to not purchase an Over The Counter medicine that they requested. The pharmacist is acting in the best interests of the patient, but the patient may be dissatisfied with the advice provided in the pharmacy. It should be noted that pharmacies are already legally obliged to audit and review patient satisfaction. The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 require that all pharmacies must “undertake an approved patient satisfaction survey annually”. |
| 221 | Company Chemists’ Association  | Statement 4 - measures | Accurately quantifying the ‘number of interventions and advice delivered by local pharmacies’ is not feasible. Pharmacy teams regularly offer advice and information to patients who present without appointment in their community pharmacy. One of the key strengths of community pharmacy is the access and volume of footfall, however this restricts the ability to record and quantify every patient interaction.  |
| 222 | McKesson UK | Statement 4 - measures | ‘Evidence of pharmacy staff accessing training that provides them with skills and confidence to offer health and wellbeing advice and education.’ We agree that to ensure the best possible health outcomes for patients, and that community pharmacy teams feel confident in providing tailored health and lifestyle advice, pharmacy staff must be well equipped with relevant and up to date education and training. We would welcome the inclusion here of the HLP concept which provides a framework for commissioning public health services through pharmacies. The framework consists of three levels of increasing complexity and required expertise, with level 1 focusing on promotion of health, wellbeing and self-care. Given that the latest Community Pharmacy Contractual Framework requires all community pharmacies to be level 1 accredited HLPs from April 2020, all community pharmacy teams will be adequately trained to provide health and wellbeing advice and education. We would also ask for clarity relating to this quality measure, about how this evidence will be collated and from whom. Considering the large locum workforce in the community pharmacy sector, it may be difficult to collect this information.  |
| 223 | McKesson UK | Statement 4 - measures | ‘Proportion of people using community pharmacy services who are satisfied with the advice or information they received.’ While we agree that patient satisfaction should be a factor in assessing the outcome of services and advice delivered through community pharmacy, this data may be difficult to obtain. Furthermore, sometimes patient satisfaction may not necessarily correlate with positive clinical outcomes and patient centred care. For example, a pharmacist may use their clinical judgement and advise a patient to not purchase an over the counter medicine that they requested. The pharmacist is acting in the best interests of the patient, but the patient may be dissatisfied with the advice provided in the pharmacy.  |
| 224 | McKesson UK | Statement 4 - measures | ‘Number of interventions and advice (very brief, brief and extended brief advice) delivered by local pharmacies.’Accurately quantifying the ‘number of interventions and advice delivered by local pharmacies’ is not feasible. Pharmacy teams regularly offer advice and information to patients for example, during the sale of an over the counter medicine or in the dispensing of a prescription. These opportunistic interventions may not always be recorded. An alternative to capturing all interventions provided in pharmacies would be to monitor the number of times pharmacies provide a service, such as the New Medicine Service (NMS). This information would be available via the NHS BSA.  |
| 225 | NHS England and Improvement | Statement 4 - measures | “…review of community pharmacies’ standard operating procedures submitted through Community Pharmacy Assurance Framework (dispensing)” – this is not within the remit of the NHS England as part of the assurance framework – we are only authorised/required to confirm that pharmacies have standard operating procedures. We would not get involved in the content of them, or advising on the content – that is for pharmacies as independent clinical contractors to determine for themselves. |
| 226 | NHS England and Improvement | Statement 4 - measures | Review of staff training records – who is expected to review them? NHS England does not have the authority to review the, as they belong to the pharmacy as an independent contractor  |
| 227 | NHS England and Improvement | Statement 4 - measures | How would these be measured?  |
| 228 | NHS England and Improvement | Statement 4 - measures | As per comment on Statement 1. Also, the pharmacy may not have any way of recording advice given, as there is no requirement for the patient to give their personal details to obtain advice, and if the pharmacy has not dispensed medicines to the patient, they will not have a patient record of any kind for them against which they could record any advice given  |
| 229 | Royal College of Nursing  | Statement 4 - measures | Is this measurable, would we need to undertake customer surveys, or will this be direct reporting by the pharmacists? How robust will this be if self-reporting? |
| 230 | Skcin - National skin cancer charity  | Statement 4 - measures | The Guidelines exists and to provide, guidelines and they do exactly that. However, the promotion of healthier lifestyles by pharmacist should extend to sun safety and skin surveillance. This is area is consistently overlooked by commissioners. Yet the community pharmacy has a key role to play. The NHS spends £350 million a year treating skin cancer yet there is little or no strategies enforced to support educational intervention.86% of skin cancers are largely preventable as they are due to over exposure to uv/sun The figures for skin cancer are grossly underestimated as the cancer registries do not capture accurately the figures for NMSC non melanoma skin cancer cases due the method of reporting and inconsistencies across NHS trusts. This figures collated by BAD British Assoc of Dermatologists show this figure as 350,000 cases per year in addition to the 15000 people diagnosed a year with melanoma skin cancer ttps://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/melanoma-skin-cancer.. Health campaigns focus on adopting a healthy lifestyle and obesity and stopping smoking, reducing alcohol consumption and managing weight taking exercise. But no campaign at a national level exists for sun safety and skin cancer awareness despite the burden of cost. The national Be Clear on Cancer campaign also misses messaging around sun safety and early detection. A Nice guideline NG34 Sunlight Exposure- Risk and Benefits that highlights in section 34 that there should be a mass market campaign for sun safety and pharmacists have key a role to play in this Pharmacists can easily train on this topic and many professional bodies/Assoc already offer CPD modules for reading about skin cancer. Skcin has developed a highly successful on online e learning training for all HCP that captures data of participants taking part in the training that covers not only skin surveillance, but sun safety advice and risk factors. The data can be captured and used as tool, we also measure successful self-reported data on early diagnoses of skin cancer cases . We are aware nationally that skin check were up 20% as advised in NHS press release . This is due Skcin’s work in skin cancer surveillance and our campaign that reached 2 million.Please see www.masced.uk. www.pro.masced.uk Our well circulated sun safety and skin cancer booklets reach over 150 hospitals are also now featured on all Macmillan health buses and can be distributed to pharmacies and usage and ordering can be monitored in addition to materials for patients and consumers. Metrics exists for all of interventions Please see our web site www.skcin.org |
| 231 | Slimming World | Statement 4 - measures | We welcome this quality standard and are pleased to see that pharmacists will be encouraged to signpost/refer on to weight management services. Pharmacists have been shown to be effective in referring to weight management services within local care pathways\* where systems are in place. It’s vital that community pharmacists have the skills and confidence to raise the issue of weight sensitively and also that they have access to weight management services locally to refer onto or to signpost to. While there are a number of referral programmes to weight management services across England, these are not available everywhere and vary greatly across different locations (and often community pharmacists aren’t included in the care pathway as referrers). For community pharmacies to be able to deliver in this area then it’s vital that they are fully integrated into local weight management pathways and that they have access to weight management services in all areas (rather than the current ‘postcode’ lottery that exists). \*Avery, A., Morris, L., Jones, C. and Pallister, C. (2017). Making every contact count: the potential role of healthy living pharmacies in weight management. Perspectives in Public Health. 137 (4), 203-205 |
| 232 | Slimming World | Statement 4 - measures | We’re encouraged to see within the statement that ‘Evidence of pharmacy staff accessing training that provides them with skills and confidence to offer health and wellbeing advice and education’ is included. It’s vital that when pharmacists are discussing issues such as excess weight with patients that they are skilled to raise the issue sensitively. We would suggest that specific training is given to include skills and confidence in the ability to be able to sensitively raise the issue of weight with people visiting the pharmacy. It’s vital that any conversations around weight are supportive and compassionate and avoid any feeling of judgement or stigma around weight. This is an area which many health care professionals struggle with\* and often leads to any discussion being avoided and should be addressed through nationwide and consistent training for pharmacists to ensure they have the relevant skills and competence to work in this area. \* Lavin, J.H., Pallister, C., Gibson, S. and Caven, J. (2015). Tackling the subject of weight with patients: the difficult conversation. Journal of Primary Health Care, 25(2): 18-22 J.A. Swift, E. Choi, R.M. Puhl, C. Glazebrook. Talking about obesity with clients: preferred terms and communication styles of U.K. pre-registration dieticians, doctors, and nurses Patient Educ. Couns., 91 (2) (2013), pp. 186-191 |
| 233 | The Pharmacists’ Defence Association | Statement 4 - measures | The QS suggests “Evidence of pharmacy staff accessing training that provides them with skills and confidence to offer health and wellbeing advice and education.”We re-iterate that for consistent delivery of any given service that standardised training should be provided by commissioners. |
| 234 | NHS England and Improvement | Statement 4 - EIA | I am concerned about the use of the phrase “culturally appropriate and age appropriate”. Who decides if they are appropriate? What is considered ‘appropriate’ is a very personal, values-based determination. |
| 235 | Cancer Research UK | Statement 4 - question 1 | Does this draft quality standard accurately reflect the key areas for quality improvement? Cancer Research UK strongly support the introduction of this quality statement and believe that community pharmacy services can play an important role in supporting people to adopt healthier lifestyles. This represents an important area for quality improvement in England for a number of reasons:1. Central government cuts to the public health grant have meant a range of important preventative and public health services are being threatened. The introduction and adoption of this quality statement means that people needing support to make healthy changes can attend their community pharmacy and receive information about smoking, alcohol and maintaining a healthy weight, get advice or receive a referral to another service that they may need. Because locally-commissioned services are being threatened, community pharmacies can also play an important role in referring patients to general practitioners or other primary healthcare professionals to provide health and social care services. However, having community pharmacies signposting and referring people to other primary healthcare professionals, rather than to locally-commissioned public health services, is likely to increase primary care workloads. There is no substitute for increased, sustainable public health funding to ensure smoking cessation, alcohol treatment and weight management services can be commissioned to meet local needs. Where local services are available locally, community pharmacies should be integrating into existing care and referral pathways in line with Statement 1.2. General practice workload has grown hugely, both in volume and complexity, placing immense pressure on the general practice workforce. Community pharmacy can provide advice and evidence-based support for people needing support to adopt healthier behaviours, with the hope that this will reduce the number of patients visiting their general practitioner for this advice in the short term. In the mid- to long-term, this will reduce the impact of preventable disease on our health and care system, relieving pressure on general practice, as well as wider NHS and local health and social care services. 3. Community pharmacies are readily available and well-positioned in the community to promote health and wellbeing: 90% of people, and more than 99% of people in the most deprived communities, live within a 20-minute walk of a community pharmacy (Todd et al., 2014). Community pharmacies can provide patients with information about smoking, alcohol and keeping a healthy weight, provide advice and refer patients to other health and social care services available locally. 4. Because risk factors like smoking and overweight/obesity are more prevalent in more deprived communities, the concentration of community pharmacies in the most deprived areas (Todd et al., 2014) means community pharmacies can provide targeted advice and support on healthy behaviours to the most vulnerable in society. This is particularly important given health inequalities among the most and least deprived in England are widening. Concerted action is required to target these high-risk groups to reduce the health inequality gap and improve health outcomes among the most deprived groups. In England local stop smoking services, which offer people the best chance of quitting for good, are being increasingly threatened as a result of central government cuts to public health funding: now, only 59% of local authorities offer a specialist stop smoking service available to everyone who smokes locally (ASH & CRUK, 2020). As services are being increasingly cut back or decommissioned altogether, community pharmacies can and must play a role in motivating their patients to make a quit attempt – whether that be through a service, with pharmacotherapy prescribed by a GP or pharmacist, or by trying e-cigarettes as a quitting tool.  |
| 236 | Healthwatch England  | Statement 4 - question 1 | Our engagement across the country relating to the NHS Long Term Plan - https://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/20200128%20-%20What%20people%20want%20from%20the%20next%20ten%20years%20of%20the%20NHS.pdf – highlights that people wanted support: “People strongly support the NHS’ focus on helping people stay well. They want the NHS to help them make healthy lifestyle choices and to know that there is a trustworthy source they can turn to for such advice.” This could cover both the prevention agenda and helping manage existing conditions. This could be made more explicit in the quality statement. It’s not clear if this could extend to people who use pharmacy services but do not attend the pharmacy themselves (people who use delivery services etc). They may also benefit from the service but may not present in person. |
| 237 | National Pharmacy Association | Statement 4 - question 1 | Yes |
| 238 | Healthwatch England  | Statement 4 - question 2 | (Outcome) Using the outcome on the number satisfied based on the numerator of people using the service gives one aspect of the service, but it would also be valuable to have insight into the views of those who do not use the service to help shape future services. |
| 239 | Healthwatch England  | Statement 4 - question 2 | (Outcome) The number of brief interventions will not, in itself, say anything about the impact or the quality - or even the appropriateness - of the intervention. Some indication of activation should be considered as a base. |
| 240 | National Pharmacy Association | Statement 4 - question 2 | The data source pertaining to the local data collection of standard operating procedures, staff training records, or surveys are in place, however, the NPA cautions against the application of such data as a proposed quality measure. This is a quantitative dataset and may not provide the desired outcomes. The NPA suggests that measures such as longitudinal studies and/or service evaluations may also be considered.  |
| 241 | Cancer Research UK | Statement 4 - question 3 | Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment. NICE guideline Stop smoking interventions and service (NG92) sets out how health, social care and other frontline staff engaging with people who smoke should support patients to quit smoking (NICE, 2018). The guideline recommends frontline healthcare staff be trained to National Centre for Smoking Cessation and Training (NCSCT) standards to deliver very brief advice on smoking. Very brief advice takes less than 30 seconds to complete and can help professionals to start conversations about smoking, provide advice about smoking and support patients to stop. NCSCT training is readily and freely available online, meaning resource requirements to support community pharmacies to “offer health and wellbeing advice and education” about smoking would be minimal.In addition, modelling commissioned by Cancer Research UK has found that smoking cessation interventions such as very brief advice being delivered in general practice which includes either a prescription for pharmacotherapy or a referral to a stop smoking service can provide substantial benefits. This as yet unpublished research predicts that by 2039, improving general practitioner delivery of smoking cessation interventions by 75% could:- Prevent over 400,000 cases of smoking-related disease - Includes over 200,000 cancer cases, and around 120,000 cases of lung cancer - Prevent around 90,000 premature deaths - Prevent around £10 billion worth of smoking-related treatment costs of the health service, including around £700 million worth of primary care costs – enough to fund more than 20 million general practice appointments- Prevent around 700 hospitalisations - Prevent over £15 billion worth of costs to wider society - Reduce smoking rates faster and bring us closer to smokefree (adult smoking prevalence ≤5%) UK ambitions. Modelling shows that by 2030, smoking prevalence was predicted to be 2 percentage points lower in scenarios where general practitioners improved delivery of smoking cessation interventions.It therefore goes to reason that community pharmacy adopting similar smoking cessation interventions, such as very brief advice, would reap substantial health and cost benefits to national, local and individual health.  |
| 242 | National Pharmacy Association | Statement 4 - question 3 | Community Pharmacists already have a long track-record in health promotion, for example helping thousands of people each month to quit smoking. This quality standard helpfully acknowledges the huge potential that pharmacies have to help people stay well, as well as treat people when they are poorly.However, for effective outcomes adequate resources and funding must be allocated.  |

## Registered stakeholders who submitted comments at consultation

* Action on Smoking and Health (ASH)
* British Thoracic Society
* Cancer Research UK
* Coeliac UK
* Community Pharmacy NI
* Community Pharmacy Wales
* Company Chemists’ Association
* Faculty of Sexual and Reproductive Healthcare (FSRH)
* Healthwatch Birmingham
* Healthwatch England
* Healthwatch North Yorkshire
* Managing Adult Malnutrition in the Community
* McKesson UK
* Mencap
* National Pharmacy Association
* NHS England and Improvement
* NHS West Hampshire CCG
* Obesity Group of the British Dietetic Association
* Proprietary Association of Great Britain (PAGB)
* Pharmaceutical Services Negotiating Committee
* Pharmacy Complete
* Public Health England (PHE)
* Royal College of General Practitioners
* Royal College of Nursing
* Royal College of Physicians
* Royal Pharmaceutical Society
* Skcin - National skin cancer charity
* Skills for Care
* Slimming World
* The Hepatitis C Trust
* The Pharmacists’ Defence Association