

EVALUATION OF THE
HEALTHY LIVING PHARMACY
PATHFINDER WORK PROGRAMME
2011 - 2012



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FOREWORD

This report is most encouraging. We have known for a long time how important pharmacies are to their local communities. They can support all of us in reaching our maximum potential for health, and help in managing illness when we are unwell. Now we have a growing body of evidence to demonstrate just how effective they can be. We face a battery of health challenges as we move through the next few decades and local community pharmacies clearly offer one of the best possible investments for the NHS in promoting wellbeing and safeguarding health.

Professor Richard Parish, Chair of Pharmacy and Public Health Forum

From the original aim to develop community pharmacies as healthy living centres in the White Paper Pharmacy in England 2008, we worked collaboratively to make the vision the reality we see today. The way community pharmacy owners, pharmacists and their teams have responded to the opportunity has been inspiring and rewarded the significant effort and investment made. This report clearly illustrates the benefits to the public's health, to pharmacy and to commissioners; we must now maintain the momentum and embed the model in a contractual framework so that all have the opportunity to benefit from the outcomes. The initiative is now gaining global recognition with many countries looking to adopt the concept; it is an initiative to be proud of.

**Michael Holden, Chief Executive of NPA
Lead on behalf of the sponsoring pharmacy organisations**

I am hugely encouraged by this Report. Following the publication of the White Paper Pharmacy in England in 2008, we worked hard in Portsmouth, with fantastic support from the local LPC, to build on the concept of a community pharmacy being a Healthy Living Centre. We wanted to develop an innovative systematic way of delivering public health interventions in the heart of communities and thereby reduce health inequalities. We achieved our first healthy living pharmacies in 2010 and they produced some good results. With the support of the Department of Health and others, and underpinned with a growing body of evidence, we further developed this embryonic model into the one that is now being rolled out nationally. It is so rewarding to see this evaluation now confirming that the initial results in 2010 can be replicated in many different places with varying demographics. We have also seen from further academic evaluation, that this can be sustained from year to year. It is great to see how this model has grown "bottom up" and spread across the country showing this concept is scalable. A fantastic testament to all those involved and to all those who had faith along the way.

**Dr Paul Edmondson-Jones, Chair of the HLP Task Group
Pharmacy and Public Health Forum, Director of Public Health and Wellbeing, York**

ACKNOWLEDGEMENTS

Many people have been involved in the implementation of the Healthy Living Pharmacy (HLP) concept and I am delighted that participation has now extended to the point where the number concerned has meant there are too many to mention. However, there are some individuals and groups for which a specific mention is important to acknowledge their involvement.

Healthy Living Pharmacy's (HLP) roots are in several strategic papers, the last of which, *Pharmacy in England: Building on Strengths, Delivering the Future*¹ set out the vision of pharmacies becoming Healthy Living Centres and being repositioned, recognised and valued by all as healthy living and health-promoting centres. All involved in setting this strategic intent and establishing multi-party engagement should be acknowledged for creating the environment for the initial development work in Portsmouth, particularly Dr Keith Ridge, Chief Pharmaceutical Officer, England.

Dr Paul Edmondson-Jones (City of York Director of Public Health & Well-being and the then Director of Public Health, NHS Portsmouth and Portsmouth City Council) and Michael Holden (Chief Executive, National Pharmacy Association and the then, Chief Officer of Hampshire and Isle of Wight Local Pharmaceutical Committee) had the aspiration to realise the potential from local community pharmacies in the city of Portsmouth. Their leadership and the support from Gul Root (Principal Pharmaceutical Officer at the Department of Health) meant this project was enabled and launched.

The multi-functional local project team within NHS Portsmouth, which I had the pleasure to lead, designed, developed and delivered the HLP concept and included Janet Bowhill, Vicky Griffin, Mike Holden, Katie Hovenden and Claire Petfield with some initial work from Liz Morgan. We built our implementation programme on the insights from a local public representative group, local pharmacy stakeholder group and local multi-disciplinary group; all of which helped to shape our thinking and direction as we moved towards launch. Our thanks go mostly to the energy and engagement of the local pharmacy teams who invested their passion, time and effort into making the difference shown in the interim results, which generated so much excitement and interest in the concept and helped to inform the pathfinder programme. They have gone on to sustain their performance and quality of outputs, as will be demonstrated later in this report.

Whilst delivering the programme in Portsmouth, we worked on a parallel piece of work to consider how the experience in Portsmouth could inform the development of a national framework. This would not have been possible without the continued support of Gul and input from the HLP Operational Research Group who oversaw the work undertaken by the

¹ Department of Health, April 2008

Universities of Portsmouth and Wolverhampton to inform development and underpin the framework with evidence from the literature. In addition, colleagues from other pharmacy and non-pharmacy organisations helped to shape our strategic thinking through input on a National Reference Group, which included representation from the Association of Independent Multiple Pharmacies, Centre for Pharmacy Postgraduate Education, Company Chemist Association, Department of Health, Faculty of Public Health, General Pharmaceutical Council, Healthy Living Alliance, Higher Education Institution (Queen's University Belfast), Independent Pharmacy Federation, LINK patient representative (Robin Kenworthy), National Pharmacy Association, NHS Employers, Pharmaceutical Services Negotiating Committee, Primary Care Trust (Heart of Birmingham) and Royal Pharmaceutical Society.

The pathfinder programme, which is the focus of this evaluation report, was initiated in response to a question from Lord Howe, Parliamentary Under-Secretary of State for Quality in the Department of Health. Lord Howe visited Portsmouth in December 2010 and impressed with what he experienced within the HLPs he saw, asked whether the results seen in Portsmouth could be replicated elsewhere in the country in areas of different demography and geography. With this Ministerial support, the pharmacy organisations collaborated to launch the pathfinder programme and representatives of these organisations formed the Pathfinder Support Group, led by myself and included Chris Cutts (CPPE), Catherine Duggan (RPS), Leyla Hannbeck (NPA), Barbara Parsons (PSNC), Gul Root and Omar Shakoor (CCA). There have also been many individuals behind the scenes within the pharmacy organisations who have supported the pathfinder rollout and I would like to thank them all for their contribution. This has been a terrific example of collaborative working across all contributors and the leadership of the Chief Executives, Rob Darracott, Helen Gordon, Mike Holden and Sue Sharpe is much appreciated.

Particular mention is warranted of the work of Erika Kennington (RPS), Ross Leach (DH), Catherine Duggan (RPS) and Elizabeth Shepherd (community pharmacy consultant) who have put this evaluation together and without whom we would not have a report showing proof of concept and the effectiveness, albeit through an evaluation rather than a trial, to offer.

As the rollout of HLP accelerates, the HLP Task Group of the Pharmacy and Public Health Forum under the chairmanship of Dr Edmondson-Jones, are overseeing further development and will have work to do following this report. We are also very grateful to Professor Richard Parish, Chief Executive of the Royal Society for Public Health, who continues to champion HLP following his visit to Portsmouth in July 2011 and chairs the Pharmacy and Public Health Forum.

I wish to acknowledge the many people within the 20 pathfinder areas themselves including dedicated project managers, community pharmacy leads within PCTs, Public Health professionals and Local Pharmaceutical Committees, all of whom have made the leap into

the HLP concept despite the significant uncertainty as the NHS transitions into the new system architecture. In addition, we now have a number of areas outwith the pathfinder programme that are implementing the HLP concept and I wish them the very best and encourage them to capture their outcomes as if contributing to a report of this type. The evidence of the difference we make will continue to be critical to inform decision-making, particularly within the current economic climate and demands on NHS and public health services.

Finally, none of these results would exist without the day-in, day-out contribution of the many pharmacists, managers, area managers and Health Champions who make this vision possible on the ground, in their pharmacies. I have been truly inspired by the many stories from around the Country where Health Champions, pharmacists and their teams have made a real difference to the lives of the public they serve. Their commitment to the health and wellbeing of their communities is outstanding.

Leadership at all levels, local and national, has made the difference, from setting ambitious vision through to excellent execution.

At the time of writing this report there are now 478 HLPs and over 1400 Health Champions. All of the above have played a part in the HLP journey, which is only just beginning.

Deborah Evans MRPharmS, National HLP Lead and Director of Pharmacy, NPA

As ever, it's the input of many individuals that makes a scheme successful at every stage. With that in mind, a separate acknowledgement of the championship of the scheme is reserved for Deborah Evans. Without her enthusiasm, motivation and problem solving, we would not have seen the uptake and roll out of the scheme across localities nationwide.

Dr Catherine Duggan FRPharmS, Director of professional development and support, RPS

EXECUTIVE SUMMARY

There is evidence to indicate that the results seen in Portsmouth could be replicated in other areas with differing demography and geography. For example, the level of service activity is higher in the majority of services delivered by HLPs, both prior to becoming an HLP and relative to non-HLPs, where evidence was available. Furthermore, benefits have been realised by commissioners, contractors and employees. The public have welcomed the HLP concept and their feedback has suggested that HLPs do deliver benefits for the public and patients. Indications from the public reported survey of services accessed in HLPs are that there could be benefits for a wider population base if the concept were to be rolled out more extensively.

Community pharmacy continues to play an important and increasing role in delivering health and wellbeing services and the HLP framework appears to be a significant platform through which pharmacy's role in delivering public health services can be maximised.

The Healthy Living Pharmacy (HLP) framework is a tiered commissioning framework aimed at achieving consistent delivery of a broad range of high quality services through community pharmacies to meet local need, improving the health and wellbeing of the local population and helping to reduce health inequalities.

The HLP concept has been reported in a number of key policy documents² as a case study including the NHS Future Forum's report on the NHS's role in the public's health.

The HLP concept provides a framework for commissioning public health services through three levels of increasing complexity and required expertise with pharmacies aspiring to go from one level to the next. It is also an organisational development framework underpinned by three enablers of: workforce development – a skilled team to pro-actively support and promote behaviour change, improving health and well-being; premises that are fit for purpose; and engagement with the local community, other health professionals (especially GPs), social care and public health professionals and Local Authorities.

Community pharmacies wishing to become HLPs are required to consistently deliver a range of commissioned services based on local need and commit to and promote a healthy living ethos within a dedicated health-promoting environment.

² *NHS 2010 - 2015: from Good to Great. Preventative, People-centred, Productive.* Department of Health 2009

White Paper Healthy Lives, Healthy People. Department of Health 2010

NHS Future Forum: Summary report on proposed changes to the NHS. Not dated

Lord Howe, Under-Secretary for State for Quality and the lead Minister for Pharmacy visited Portsmouth Healthy Living Pharmacies in December 2010. He was impressed with the passion and commitment of the pharmacy teams he met and the delivery of health and wellbeing services within the communities they served. He then set the question, could the notable and promising results seen in Portsmouth be replicated in other areas with differing demography and geography?

The HLP pathfinder programme was created in response to this question; the national pharmacy organisations all agreed to support broader rollout of the initiative with the aim of evaluating against the following objectives:

Objectives of evaluation

1. Is there better uptake and delivery of services in HLPs compared to baseline (i.e. before being an HLP or against other non-HLP pharmacies)?
2. Does geography and demography impact on HLP performance?
3. What is the effect of HLP services on public-reported experiences?
4. What are the benefits of HLP implementation for the public, commissioner/NHS, contractor, and employer?
5. Is each individual service delivered through HLP cost-effective?

This evaluation was set up to appraise the impact of the HLP concept on community pharmacy practice across England and to determine whether the outcomes achieved in Portsmouth are replicable in areas of different demography. This is a practice-based evaluation, which may lead to further evaluation or detailed research. The data collected are, by necessity, pragmatic and reflective of the practice setting in which is gathered, and subject to a number of limitations, which will be described within the main body of the report.

1. IS THERE BETTER UPTAKE AND DELIVERY OF SERVICES IN HLPS COMPARED TO BASELINE (I.E. BEFORE BEING AN HLP OR AGAINST OTHER NON-HLP PHARMACIES)?

Over the evaluation period, the strength of the improvements seen in the delivery of most of the services was notable despite the limitations stated. Gains were seen across different services, with different specifications, in geographically varied areas with different levels of health need and deprivation. In the very few areas where improvements were not seen, further review is required to understand the reasons for this and whether all elements of the HLP programme were delivered during implementation. Stop Smoking services were the most commonly evaluated and HLPs delivered more quits than non-HLPs or prior to becoming an HLP. In most cases quit rates remain similar between HLPs and non-HLPs or

prior to becoming an HLP suggesting that HLPs were more proactive with engaging members of the public but that further work is required to fully understand the impact on service provision.

2. DOES GEOGRAPHY AND DEMOGRAPHY IMPACT ON HLP PERFORMANCE?

There appeared to be no negative effects of geography, deprivation or type of pharmacy reported in terms of service delivery, benefits to commissioners, benefits to contractors, or public approval. The data suggest that in different geographies and demographics there is consistent performance across different services delivered by HLPs. This evaluation suggests that these results and therefore the HLP concept could be replicated in other areas, not just the deprived, urban context within Portsmouth. The engagement and outcomes delivered by HLPs gave commissioners the confidence to commission more services to meet local health needs, within the defined quality criteria.

Not every pathfinder area has yet reported the impact of HLP implementation and this could be worthy of further investigation.

3. WHAT IS THE EFFECT OF HLP SERVICES ON PUBLIC-REPORTED EXPERIENCES?

Based on a sample of 1034 individuals there is strong evidence to suggest that the public have a positive opinion of the services delivered by HLPs. The public rated the services delivered by HLPs highly and this did not vary by pharmacy type. Endorsement and acceptability was seen in all localities that reported, and for all services evaluated.

Teams within HLPs engaged with people who would otherwise have done nothing and would not have sought out healthy lifestyle support or advice – over 20% of the people surveyed said they would not have gone anywhere else for the service, demonstrating the impact of HLPs in helping people lead healthier lifestyles. 60% of individuals participating would otherwise have gone to their GPs, showing that there may be opportunities for community pharmacy to support GP practices in delivering health and wellbeing support, which could reduce the workload burden within GP practices.

The services were universally well received, with almost all users comfortable to receive services in the pharmacy setting, happy with how they were treated by the pharmacy staff, and they felt that the pharmacy staff gave them enough information. This was further reflected in the fact that 98% would recommend the service they used to others.

4. WHAT ARE THE BENEFITS OF HLP FOR THE COMMISSIONER, NHS, CONTRACTOR, AND EMPLOYER?

Analysis of pathfinder reports indicate the value of HLPs for commissioners, showing that community pharmacies are able to deliver health and wellbeing services to meet local health needs. Public health teams in turn, understood the potential for HLPs to deliver public health services effectively.

The results of the quantitative survey to assess the benefits of HLP status on contractors, employees and the public showed that the effect on income, prescription volume, demand for services, motivation and productivity of staff was positive for all types of contractor; and implementation of the HLP concept was seen as worthwhile for the business by over 70% of contractors. Over 90% of contractors saw benefits for staff development. The benefits for contractors varied between different types of pharmacy including employee development, motivation, public engagement with services, increased service income and referral to other services. There appeared to be little, if any, negative impact.

For reasons of commercial confidentiality no “hard” data was available on the effect of HLP on income. However, the uptake of the HLP concept by a range of independent and multiple-owned pharmacies may be evidence in itself of the benefits to the business.

5. IS EACH INDIVIDUAL SERVICE DELIVERED THROUGH HLP COST-EFFECTIVE?

The contractor survey offered further insight into how a range of public health services were being delivered in HLPs and sought to offer some evidence on the cost effectiveness of HLP service delivery.

Overall, there was a breadth of public health services being delivered in HLPs. In terms of service frequency across HLPs, Stop Smoking was the most common service delivered by most HLPs. A majority of HLPs in the sample also delivered Emergency Hormonal Contraception, targeted MURs and Chlamydia Screening services. The survey indicates that Alcohol and Weight Management services were delivered in around one-fifth of HLPs.

Pharmacy employees other than pharmacists played a role in delivering most of the services. However, they played a more substantial role in the delivery of Alcohol and Weight Management services. A pharmacist was involved in the majority of Stop Smoking, Chlamydia Screening and Emergency Hormonal Contraception services with other members of the pharmacy team also contributing to service delivery. There is clear evidence from the evaluation that all pharmacy staff were engaged and enthused by the opportunities being presented to them, and this has the potential to spill over into better service outcomes, with some Health Champions using innovative and creative models of delivery.

Making use of the larger sample of Stop Smoking service data, some further analysis has indicated that Stop Smoking services delivered by non-pharmacist staff perform at least as

well as when a pharmacist is involved in service delivery. Crucially, this indicates that Stop Smoking services can be delivered more effectively i.e. making best use of each staff member's skills; as well as more cost-effectively as a pharmacist's time has a higher business cost. The evaluation indicates the potential to generate positive health outcomes, without compromising the quality of service delivered. Making optimal use of each staff member's time flags the potential of service delivery in HLPs.

There are now³ 478 HLPs across 28 areas with interest growing in the HLP concept across England, in other areas of the UK and across the world.

HLP status has been the differentiator when recruiting a high calibre pre-registration trainee when we had another equal offer to consider. This has been a really demonstrable benefit to us and in the medium term we are looking to increase our Health Champion resource. We believe this demonstrates our continued commitment to the HLP programme.

HLP branding in our local promotional materials has helped raise awareness of pharmacy services. This has seen the uptake of a number of services increase, and a large increase in public awareness of the enhanced role of the pharmacy.

We have used HLP as a means to introducing the pharmacy to a number of local community groups about the services we offer. One recent example was the local secondary school that was looking for some condoms for their sexual health topic; they had contacted their school nurse, who hadn't been able to help. As a HLP we are signed up to a holistic view of public health - we made some phone calls and were able to arrange a supply via the local Contraception and Sexual Health clinic.

Mike Hewitson, Beaminster Pharmacy, Dorset

³ 29 March 2013

CHAPTER 1 - INTRODUCTION TO THE HEALTHY LIVING PHARMACY PATHFINDER PROGRAMME

1.1 BACKGROUND TO HLP

NHS Portsmouth recognised the significant role community pharmacies could play in helping reduce health inequalities by delivering consistent and high quality health and wellbeing services, promoting health and providing proactive health advice and interventions. The HLP framework aims to increase the delivery of high quality public health services by providing a structure for commissioning, delivery and organisational development.

The Department of Health commissioned Portsmouth City PCT (on behalf of South Central SHA) in early 2009 to develop a national framework for Healthy Living Pharmacies, informed by their local model. Hampshire and Isle of Wight Local Pharmaceutical Committee supported the PCT in this work.

The HLP framework is a tiered commissioning framework aimed at achieving consistent delivery of a broad range of high quality public health services through community pharmacies to meet local need, improving the health and wellbeing of the local population and helping to reduce health inequalities. The framework is based on public health need and informed by research and evidence-base, where possible. This framework was presented to and ratified by the Public Health Leadership Forum for Pharmacy in January 2010 (see Appendix 1).

A Healthy Living Pharmacy:

- Consistently delivers a range of health and wellbeing services to a high quality
- Has achieved defined quality criteria requirements and met productivity targets linked to local health needs e.g. a number of Stop Smoking quits at 4 weeks
- Has a team that proactively promotes health and wellbeing and proactively offers brief advice on a range of health issues such as smoking, physical activity, sexual health, healthy eating and alcohol
- Has a trained Health Champion (also known as Healthy Living Champion and Health Trainer Champion), who is proactive in promoting health and wellbeing messages, signposts the public to appropriate services and enables and supports the team in demonstrating the 'ethos' of an HLP
- Has premises that are fit for purpose for promoting health and wellbeing messages as well as delivering commissioned services
- Engages with the local community and other health and social care professionals
- Is recognisable by the public through the display of the HLP logo

There are several principles that underpin the HLP concept. Firstly, the services provided are tailored to local health needs with the aim of reducing health inequalities by improving

health and wellbeing outcomes in their communities. Secondly, a HLP builds on existing core pharmacy services (Essential and Advanced) with a series of Enhanced Services at three different levels of engagement. Finally, the delivery of services is supported by three enablers: workforce development, engagement with others and pharmacy environment. Before a pharmacy can be considered as an HLP, it must already be meeting all the contractual requirements for Essential and Advanced Services provided within the community pharmacy contractual framework. In addition there are requirements for:

- A minimum of one Health Champion, who has achieved the Understanding Health Improvement Level 2 Royal Society for Public Health award, must be appointed to support the important health and wellbeing role of the HLP – this is a suitable role for a Medicines Counter Assistant
- Leadership training must be undertaken by an individual involved in a leadership or management position so that they can support the development of the pharmacy team and change from providing reactive to proactive health interventions
- The consultation room should be equipped appropriately depending on the services offered
- Every interaction in the pharmacy should be seen as an opportunity for a health promoting intervention, ‘making every contact count’
- The pharmacy should be actively participating in all PCT directed public health promotion campaigns listed as a specific requirement of their HLP criteria and as a requirement of the essential services component of the community pharmacy contractual framework
- HLPs are required to commit to and promote a healthy living ethos within a dedicated health-promoting environment
- HLPs should meet output targets for the services commissioned in accordance with the PCT’s requirements.

Whilst the concept helps to drive outputs and quality improvements, it should be recognised that the HLP status is the means to the end, rather than the end itself i.e. community pharmacy’s further engagement in supporting the public’s health. The concept packages what pharmacies may already be doing and allows the pharmacy to see what else they could be doing to deliver against local health needs. It also supports consistent delivery within defined quality criteria.

Aside from the potential gains to local population health there are a number of additional benefits that were shown for Portsmouth local commissioners, contractors and their teams:

- Improvements in quality and productivity
- Focused pharmacy services on local needs
- Opportunity for staff development – e.g. Health Champions and leadership development

- Engaged and motivated community pharmacy teams to deliver proactive health and wellbeing interventions and improved performance in service delivery
- Enhanced credibility of pharmacists, pharmacy teams and services with other health care professionals as well as the public
- Enhanced engagement with other health and social care professionals
- Ability to demonstrate to future commissioners what the community pharmacy offer is for public health services, which could lead to continued or increased commissioning of services
- Increased public awareness of the health and wellbeing services available within community pharmacy
- An HLP logo that can be recognised by the public, which can also demonstrate that community pharmacy is joined-up in an area
- Opportunity to optimise provider sustainability through professional fees and other pharmacy income

Locally commissioned community pharmacy enhanced services are not new, but the HLP concept allows for a structured, strategic, joined-up and proactive approach to commissioning and delivery to enable maximum benefit to be derived from these services. HLPs are also required to deliver a range of services commissioned by the commissioner, with set deliverables.

The HLP model was initially developed and tested by Portsmouth City Primary Care Trust recognising the contribution of community pharmacy in the reduction of the significant health inequalities in the City. It was thought that community pharmacy could play a more pro-active role in promoting health and well-being messages to help well people from getting lifestyle diseases and maintain the health of people who are already sick. In other words, working upstream to intervene early on for issues such as smoking, risky sexual behaviour, obesity and alcohol. Community pharmacies also play an important role in supporting medicines optimisation within a health and wellbeing environment, supporting self-care and enabling individuals with long-term conditions live a healthier life. The HLP framework was developed with this broader role in mind, recognising the interdependencies between self-care, medicines optimisation and health and wellbeing interventions.

Community pharmacy teams were engaged early in the development of the HLP concept (June 2009) with the framework and expectations launched in a prospectus in December 2009 for implementation from January 2010. By June 2010, there were 6 quality-marked HLPs, increasing to 17 by the end of the year and currently at 20 (just over 50% of all pharmacies in Portsmouth). Evaluated by Portsmouth University, the interim outcomes achieved in Portsmouth (September 2010) have impressed many and interest in the concept and the way it is being implemented has attracted attention across the UK and the world.

The initiative has come to the notice of government officials with mentions in *NHS 2010 - 2015: from Good to Great. Preventative, People-centred, Productive* and the *White Paper, Healthy lives, Healthy people: our strategy for public health in England*.

Headline findings from Portsmouth include:

- 140% increase in smoking quits from pharmacies compared with the previous year
- 75% of the 200 smokers with asthma or chronic obstructive pulmonary disease who had a medicines use review (MUR) accepted help to Stop Smoking
- Smokers walking into an HLP in Portsmouth were twice as likely to set a quit date and give up compared to a person walking into a pharmacy which is not an HLP
- Smoking quits delivering 142% of target and with a quit rate of 67% (2010 to 11)
- Over 3500 individuals received brief advice on safe alcohol consumption; 36% were at increasing risk and 10% at high risk from current levels of use
- Over 1100 patients with a respiratory condition have been supported in the effective use of their medicines
- 70% of patients with a respiratory condition showed an improvement in the management of their condition as a result of the pharmacist intervention. Quality and productivity has been sustained
- 126 clients successfully lost weight with more than half achieving a total weight loss of greater than 5%⁴
- Thirty-three of the 36 pharmacies participated in the EHC services; all HLP pharmacies participated (n=17) and 16 non-HLP pharmacies, resulting in 4,082 supplies. HLPs supplied a significantly higher proportion of EHC (χ^2 , $p < 0.001$)⁵.

Qualitative research undertaken by Portsmouth University⁶ undertaken with pharmacies in Portsmouth in the early days of HLP implementation showed that there were a number of reasons why individuals engaged in the HLP concept including:

- Enhanced standing with the public as health professionals
- Positive effect on morale
- Counter staff more able to engage in health and wellbeing discussions
- Public increasingly request services
- Improved collaboration with GP practices
- Customer loyalty
- More able to demonstrate ability as a Public Health service provider

⁴ April 2012 to January 2013

⁵ April 2011 to March 2012

⁶ Qualitative evaluation of Health Living Pharmacies on file, Zac Nazar, Portsmouth University

- Provides a Quality Mark for future commissioning
- Gives recognition for what is already done well
- Increased revenue and footfall.

These interim results have now been followed up in a full report, some of details of which are reported further on in this document⁷.

1.2 ROLL-OUT PROGRAMME

Following success in Portsmouth, the aim was to roll out HLPs in other geographical areas to strengthen the evidence base for the concept and also to determine whether the results could be replicated across the country with different demographics. It was critical that further evidence of HLP delivery in a non-Hampshire setting was gathered to inform national policy and provide contractors and their teams with confidence that engaging in the HLP concept brought benefits to the population, NHS and the contractors. A key question, posed by Lord Howe after a visit to Portsmouth had to be answered; **can this concept and the results shown above be replicated in other geographical areas with different demography's such as ethnicity, age, deprivation index, post-code?**

The national pharmacy organisations⁸ had the desire to lead the development of the HLP concept on behalf of community pharmacy and establish whether this was an initiative that could work in other areas and of benefit to the public, contractors and their teams. They therefore agreed to support a pathfinder programme across England and set an aim to have at least 100 community pharmacies as HLPs across a range of locations by end of March 2012 (the programme was initiated in September 2011) and to provide data, which could be evaluated to help determine the direction of travel nationally. PCTs were invited to express interest in becoming pathfinders; 47 areas (66 PCTs) applied. Twenty areas representing 30 PCTs were identified and selected as HLP pathfinders following a review process against pre-agreed criteria. These criteria were defined in advance by the Pathfinder Support Group and included within the expression of interest form (see Appendix 2). These were:

- Commissioner commitment to support the programme until April 2012 (minimum)
- LPC support and leadership
- Evidence of an HLP implementation plan including identified funding to support the enablers and public communications campaign
- Minimum of two enhanced services to be commissioned from potential HLPs

⁷ From Community Pharmacy to Healthy Living Pharmacy: Early Experiences in Portsmouth. Rutter, Jane Portlock, Zachariah Nazar, Janet Bowhill, David Brown

⁸ Company Chemist Association, National Pharmacy Association, Pharmaceutical Services Negotiating Committee, Royal Pharmaceutical Society with support from Centre for Pharmacy Postgraduate Education and Department of Health

- Provide specific data at the end of the pathfinder programme to support this evaluation
- Each HLP must have at least one Health Champion (RSPH Understanding Health Improvement Level 2 Award)
- HLPs must as a minimum satisfy the Quality Criteria defined by the HLP National Reference Group
- Plan to award HLP status by the end of March 2012.

Quality was to be driven by having in place the enablers of workforce development (leadership and skill mix of the pharmacy team), engagement (with community, other healthcare and social care professionals) and premises fit for purpose (including the provision of a dedicated health promotion zone). This is captured through the Quality Criteria. Delivery is defined as the achievement against predetermined service performance indicators such as a number of Stop Smoking quits at 4 weeks (usually validated by carbon monoxide monitor) and carrying out a number of targeted Medicine Use Reviews.

As part of the HLP accreditation process, PCTs issue 'Quality Marks' to those HLP premises that meet the quality and productivity criteria outlined in their local HLP prospectus. This quality mark then allows members of the public to identify which pharmacies are considered HLPs. The National Pharmacy Association (NPA) on behalf of community pharmacy has registered the HLP logo as a trademark.

The pathfinders were supported by the national pharmacy organisations with:

- A national project lead to answer queries, support and coordinate activity
- An NHS Network area where they could share ideas, resources and communicate
- Seven masterclasses to enable different pathfinder areas to meet with others facing similar challenges and to share success
- Quality Criteria developed following the experience in Portsmouth and by a multi-functional National Reference Group for HLP
- Resources to engage key stakeholders
- Framework for the world café pharmacy team engagement events including key note speakers
- Resources developed to promote the concept to the public (available from the NPA)
- Guidance on evaluation of the outcomes.

Having recruited pathfinder areas to drive the concept further within local areas, the key objective for the pathfinder programme was to have sufficient HLPs accredited to provide an evaluation of the impact.

By end of March 2012, there were 163 HLPs across 15 pathfinder areas and 199 in total⁹. Since that time, areas have been collating their results and continue to support further engagement in the programme.

By end of March 2013, there were 478 HLPs across 28 areas¹⁰ and despite significant change within the NHS and Public Health system architecture; the number of areas taking forward the concept continues to increase.

⁹ Non-pathfinder areas rolling out the HLP concept contributed to a higher number

¹⁰ Data available 29th March 2013

CHAPTER 2 - THE EVALUATION: SCOPE AND OBJECTIVES

The aim of this evaluation is to appraise the impact of the HLP concept on community pharmacy practice across England and determine whether the outcomes achieved in Portsmouth are replicable in areas of the country with different demography to Portsmouth. An evaluation protocol was developed, which the pathfinders committed to completing as part of the application process. This is a practice-based evaluation, which may lead to further evaluation or detailed research. The data collected is, by necessity, pragmatic and reflective of the practice setting in which it is gathered and subject to a number of limitations, which are described below.

2.1 EVALUATION QUESTIONS

To meet the purpose of the Pathfinder Programme, two evaluation questions were developed:

Question 1: What will be the impact of HLP on community pharmacy practice across England?

Question 2: Are the outcomes from the HLP project in Portsmouth reproducible in areas of the country with different demography to Portsmouth?

2.2 AIMS

The Pathfinder Programme was established to enable the implementation of the HLP concept in different types of community pharmacies in selected areas across England with various geography, deprivation, health need and commissioning environments.

The programme was set up as a before and after study based on changes seen from a baseline state before implementation, during development of community pharmacies towards becoming HLPs and as accredited HLPs. Multi-method and multi-disciplinary approaches to the study and data collection were used to create a wide-ranging assessment of the outcomes¹¹.

A number of principles underpinned the evaluation:

- This was a practice-based evaluation which may lead to further evaluation or detailed research
- Evaluation should be pragmatic and practical to reflect the practice setting in which it is gathered and any limitations associated with gathering the data

¹¹ Green and Thorogood. *Qualitative Methods for Health Research* 2nd ed 2009. Sage London

- Data collection must be simple and easy to gather for individual contractors; ideally through an IT platform
- Data would, wherever possible, be collected on a per case basis and in real-time.

2.3 OBJECTIVES

Objectives were set to answer the evaluation questions and obtain information about service uptake, activity and outcomes; cost effectiveness of service delivery in HLPs; whether locality affected the impact of Healthy Living Pharmacy; acceptability of HLP development to commissioners, contractors, pharmacists and staff, and the public.

The objectives are listed below:

1. Is there better uptake and delivery of services in HLPs compared to baseline (i.e. before being an HLP or against other non-HLP pharmacies)?
2. Does geography and demography impact on HLP performance?
3. Is each individual service delivered through HLP cost-effective?
4. What are the benefits of the HLP concept for the public, commissioners/NHS, contractors, employers and employees?
5. What is the effect of HLP services on public reported experiences?

2.4 LIMITATIONS TO THE EVALUATION

As is often the case with evaluations of service implementation, there are limitations in this evaluation. It should be noted that it is not always appropriate or feasible to evaluate innovations in practice through trials or cohort studies, whereby certain variables can be controlled so that any change can confidently be ascribed to the variables under investigation. The evaluation described in this report was specific in the aims described above and did not seek to prove the effect of HLP as an intervention, rather to evaluate the effect of uptake and delivery across areas with varying demography. In order to fully scrutinise the data and make conclusions appropriately, it is necessary to state and understand the limitations in order to mitigate against them, where possible.

The following is a list of known limitations of the evaluation methods and resulting data:

- There was no ideal way to establish a control sample. Those pharmacies not engaging in the HLP initiative were unlikely to provide data for comparison and pharmacies that become HLPs may have been more motivated to deliver in the first place. This could potentially introduce some bias
- Some pathfinder areas may have introduced bias to the evaluation by selecting those pharmacies who were more likely to deliver based on past experience. Pathfinders were instructed to describe the selection process, where one existed, in their

regional reports. This bias could be consistent across all areas who implement this approach

- Some pathfinder areas may have targeted specific geographical areas based on high deprivation and local need to reduce health inequalities and therefore influenced the demographic sample. Pathfinders were instructed to describe their selection process in their reports
- Practice evaluation, and the outcomes for individuals using services, may be influenced by many different variables which can neither be controlled for, nor comprehensively monitored for consideration in subsequent analysis
- Not all pathfinder areas implemented their programme at the same time
- Not all pathfinder areas commissioned the same services, so it may be difficult to generalise some results, and service specifications varied
- Cash resources were limited. Support for this evaluation was provided within current RPS resource and infrastructure, supported by the national pharmacy organisations, and no additional funding or resource was made available to pathfinders.

There are additional challenges associated with the choice of services to be evaluated:

- There appear to be very few services commissioned widely by pathfinder areas. Stop Smoking and emergency hormonal contraception were commissioned most frequently
- Some pathfinder areas asked their pharmacies to deliver from a menu of services. This is because services were commissioned on local health need, and not all services were available for all pharmacies to provide
- Enhanced services commissioned have different service specifications in different areas
- The measures currently associated with enhanced service delivery tend to be activity indicators rather than outcome measures
- The data was collected in a number of ways and was often paper-based. The Pathfinder Support Group was unable to agree with pathfinders and stakeholders a universal data collection methodology.

2.5 THE APPROACHES TAKEN IN THIS SERVICE EVALUATION

Service uptake, activity and outcomes

The most robust way to evaluate the impact of HLPs would have been to compare HLPs with a control group of non-HLPs at one time point or over a series of time points, using a sample large enough to allow the effect of HLP intervention to be isolated from effects due to variables. Unfortunately, this would require a very large sample for which resources (time and funding) were not available, as well as removal of any HLP related services from non-HLP areas to ensure controls were in place, which would have deprived the public of access to services in community pharmacy known to be beneficial. 100 HLPs were anticipated

during the development of the evaluation protocol and a 'trial' would have required sign-up of non-HLP pharmacies, which would be aware of HLP but would not undertake any HLP activity or engagement. These pharmacies may have not been unwilling to invest time to record and return data without the incentive of the potential benefits that HLP could give them.

Given the short timeframe and small sample size in each area, a 'before (baseline), during and after' approach was agreed. This approach was deemed to be effective if pharmacies were able to accurately capture data over their transition period to becoming an HLP. PCTs were asked to provide data for the 'before' period, an equivalent period prior to HLP implementation to minimise the impact of seasonal variation.

Data was collected at pre-defined time points, including (but not limited to) baseline, at some time during working towards HLP status, and after achieving HLP status. The intention was to carry this out at a minimum of quarterly intervals to ensure that changes in performance were captured.

Ideally, all individual pharmacies participating in the HLP initiative within all pathfinder areas would have provided individual client service intervention data comprising a standardised dataset of reporting measures and metrics (coded to be anonymous) to the RPS for analysis. However, it was recognised that this would create significant challenges regarding data collection and interpretation (see limitations). It was known that there was variation in service specifications and data requirements between PCTs, so a pragmatic and realistic approach was adopted.

Given the spread of services and criteria required by PCTs, it was felt that the pathfinder area was best placed to determine the timing and collection of 'baseline' data to reflect their own implementation programme. Each pathfinder area was asked to agree the timing and collection of 'baseline' data in their organisation to reflect their local datasets agreed in the pre-existing service specifications and their implementation programme. Some pathfinder areas were able to provide information within their evaluation service activity in pharmacies that were not working towards HLP status and this has been included in the analysis. The baseline data was to be made clear within the report provided by each pathfinder.

Pathfinders were asked to provide the data, their analysis and interpretation to the RPS for synthesis. These data are shown in Chapter 3. This was to help mitigate against some of the limitations and was deemed a pragmatic solution to the issue of data collection methodology.

The pathfinder areas were to provide an evaluation of a minimum of two services that were measured at baseline, three months and six months following HLP implementation (defined

as being after the HLP programme has been launched to community pharmacies and they are moving towards and have achieved their HLP status).

The timeline of the evaluation activity and when HLPs were quality-marked has led to some areas not being able to fulfil this requirement.

Data to support a cost-effectiveness analysis were gathered through an online survey of contractors. The findings are presented in Chapter 4.

Benefits to commissioners, contractors, employers and employees

Qualitative data about commissioners' views were gathered from the pathfinder reports. Contractors were asked to complete a survey (See Appendix 4) to capture business and staff development outcomes. These data are presented in Chapter 5.

Public reported experiences

HLPs within the pathfinder areas were asked to collect service evaluation information from clients using the services (see Appendices 3 and 4). The results of the surveys are presented in Chapter 6.

2.6 PATHFINDER AREA PARTICIPATION

One of the conditions of taking part in the pathfinder programme was a commitment to provide an evaluation report, for which a template was provided. However, the pathfinders did not all complete the template as set out, mainly due to resource constraints. The pathfinder areas and their participation are shown in Table 1 below, with the index of multiple deprivation for the local authorities¹² in their areas:

¹² Index of Multiple Deprivation 2010
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/6871/1871208.pdf accessed 8 February 2013

Table 1: The distribution of deprivation in pathfinder areas and their participation in the programme

<i>Pathfinder Area</i>	<i>Deprivation rank of local authority</i> 1=most deprived 326=least deprived	<i>Participation</i>
NHS Portsmouth		76 Pathfinder template report returned Academic paper
Heart of Birmingham tPCT	Birmingham District	13 Pathfinder template report returned
	Solihull	212 Academic paper (expected)
NHS Buckinghamshire and NHS Milton Keynes	Wycombe	258 Pathfinder template report returned
	Aylesbury Vale	288 Supplementary data
	Chiltern	312
	Milton Keynes	211
Blackburn with Darwen tPCT and East Lancashire	Blackburn with Darwen	28 Pathfinder template report returned
	Burnley	21
	Hyndburn	40
	Pendle	41
	Ribble Valley	285
	Rossendale	90
Brighton and Hove Group (Brighton & Hove City PCT, East Sussex Downs and Weald PCT and Hastings and Rother PCT)	Brighton & Hove	67 Pathfinder template report returned
	Wealden	250
	Hastings	23
	Rother	132
NHS Dudley		113 Pathfinder template report returned Supplementary data
Shropshire PCT and NHS Telford	Shropshire	166 Pathfinder template report returned
	Telford	105
NHS Plymouth		80 Pathfinder (not on template) report returned Supplementary reports Academic paper
South Staffordshire PCT		247 Pathfinder template report returned
North Staffordshire PCT and NHS Stoke on Trent	Newcastle-under-Lyme	152 Pathfinder template report returned
	Staffordshire Moorlands	181
	Stoke-on-Trent	18
NHS Lambeth		14 Pathfinder template report returned
NHS Hull and NHS East Riding of Yorkshire	Hull	15 Pathfinder template report returned
	East Riding of Yorkshire	216
Gateshead PCT, South Tyneside PCT and Sunderland teaching PCT	Gateshead	42 Pathfinder template report returned
	South Tyneside	47
	Sunderland	38
NHS Sheffield		84 Pathfinder template report returned
NHS Dorset	West Dorset	179 No report received
	North Dorset	215
	East Dorset	304
NHS Great Yarmouth and Waveney	Great Yarmouth	57 No report received
	Waveney	112
NHS Ashton, Leigh & Wigan	Other districts? Wigan	85 No report received

<i>Table 1: The distribution of deprivation in pathfinder areas and their participation in the programme</i>			
<i>Pathfinder Area</i>	<i>Deprivation rank of local authority</i>	<i>of</i>	<i>Participation</i>
	1=most deprived 326=least deprived		
NHS West Kent	Sevenoaks	279	No report received
	Tonbridge	268	
	Tunbridge Wells	246	
	Maidstone	227	
	Dartford	168	
	Gravesham	143	
NHS Isle of Wight		106	No report received
South Essex PCT cluster (South West and South East Essex)	Castlepoint	198	No report received
	Southend	117	
	Rochford	299	
	Basildon	141	
	Thurrock	146	
	Brentwood	295	
	Billericay	NA	
	Wickford	NA	

Fourteen of the areas returned some or all of the data required; three areas provided supplementary reports or data and three areas returned academic papers on the evaluation. Of the areas that did not return reports inspection of the IMD column shows that most of the local authorities in these pathfinder areas had medium or low deprivation. One of the aims of the pathfinder work programme was to explore the impact of HLP in areas of varying deprivation and health need and there could be concerns of the results being skewed if there were insufficient data from medium or low deprivation areas. However, four of the areas that were able to return data had medium or low deprivation and the data that demonstrate whether there was a difference in HLP impact in different deprivation environments is shown in section 7.4.

3.1 CHAPTER SUMMARY

This chapter reviews the evaluation of community pharmacy services in the pathfinder areas. Thirteen areas returned data and interpretations for eight advanced or enhanced services. The services were provided in diverse environments, with different levels of deprivation, city centre, urban or rural localities, in different types of community pharmacy from single independents to pharmacies from the large multiples with differing approaches to implementation of HLP. Pathfinder areas took different approaches to implementation of HLPs and this was encouraged so that the implementation of the concept could be developed beyond Portsmouth's experience. The effect of HLP status on activity and quality of service delivery was analysed.

Activity improvements were seen in the majority of services evaluated: Stop Smoking services, emergency hormonal contraception, minor ailments, alcohol awareness, medicines use reviews, new medicines service, substance misuse and pill dispenser (Pivotell™) services.

The strength of the improvements seen was notable as, despite the limitations of the evaluation and variation of service delivery and evaluation between areas, gains were seen across different services, with different specifications, in geographically varied areas with different levels of health need and deprivation. The service data suggest that the HLP concept is consistent with increased service delivery, improved quality measures and outcomes, and is applicable in areas with high or lower levels of health need and deprivation.

3.2 INTRODUCTION

The purpose of this section of the programme was to meet Objectives 1 and 2 shown in section 2.3. These were:

- To assess whether there was better uptake and delivery of services in HLPs compared to baseline (i.e. before being an HLP or against other non-HLP pharmacies)?
- To assess whether geography and demography had impact on HLP performance?

The level of activity was measured quantitatively for the services selected by the individual pathfinder areas, measured before the implementation of HLP, while pharmacies were working towards HLP status and after becoming HLPs.

This information can be used by future commissioners to assess the value to the NHS and public health of commissioning public health services through community pharmacy, and specifically HLPs.

3.3 METHODS

Individual pathfinder areas were asked to assess a minimum of two services. The methodology was outlined and discussed at one of the Pathfinder Support Group masterclasses. Pathfinder areas were expected to select services for which:

- Reliable data could be collected before, during and after HLP implementation
- There was sufficient activity to detect changes in activity at the different stages
- The service was expected to be commissioned long enough for the data to be collected at the different stages.

The aim was to agree a minimum data set for the services, particularly those that were being assessed in more than one pathfinder area. However, due to the differences between local service specifications and data requirements in each PCT this was not feasible. The most common services commissioned and evaluated were Stop Smoking and emergency hormonal contraception (EHC) so a dataset of core reporting measures were recommended. The pathfinders were strongly recommended to use the dataset provided.

Because of the different service specifications and data collection methodology applied locally, the service results could not be aggregated for similar services, for example, smoking cessation. Results from individual areas demonstrated some trends in uptake and delivery; one potential benefit of this approach was that similar trends were seen in uptake and delivery in different areas, with different demographics, different service specifications and different data requirements.

A reporting template was produced for pathfinder areas to use to encourage standardised reporting and ensure that essential information was provided across all areas. The template is attached in Appendix 3.

3.4 RESULTS AND OUTCOMES OF THE ANALYSIS

Fourteen of the twenty pathfinder areas returned a report for one or both of their services. The areas and services are shown in Table 2.

Table 2: Pathfinder areas and the services selected for data collection

<i>Pathfinder Area</i>	<i>Service 1</i>	<i>Service 2</i>
Birmingham and Solihull	Stop Smoking	Minor Ailments
West Yorkshire (non-pathfinder)	Submitting data July 2013	
Buckinghamshire and Milton Keynes	Stop Smoking Respiratory MUR	EHC Alcohol awareness
Blackburn with Darwen and East Lancashire	Stop Smoking	Substance Misuse
Dudley	Stop Smoking	Alcohol Identification and Brief Advice (IBA)
Brighton and Hove Group	Stop Smoking – only baseline data provided	No data
Hull and East Riding	NMS	EHC
Lambeth	Stop Smoking	EHC
North Staffordshire	Pivotell™ automated pill dispenser	n/a
Portsmouth	Respiratory MUR Stop Smoking Weight Management	Alcohol Awareness EHC
Sheffield	Stop Smoking	Minor Ailments
Shropshire	Stop Smoking (no data)	MURs/NMS
South of Tyne and Wear	Stop Smoking (no data)	EHC (no data)
South Staffordshire	Stop Smoking	EHC (no data)
Stoke-On-Trent	Pharmacy First (Minor Ailments)	EHC

Table 2 shows that 12 areas returned data on at least one service, with one area which was not part of the formal pathfinder group expected to return data in 2013. The table also shows that some areas were not able to report data for both services and the reasons for this were investigated.

Six pathfinder areas did not return data for a number of different reasons including HLP rollout delayed within the timeline required for evaluation and resource not available to evaluate the results at a time of significant change within the NHS.

The data for the different services are shown below.

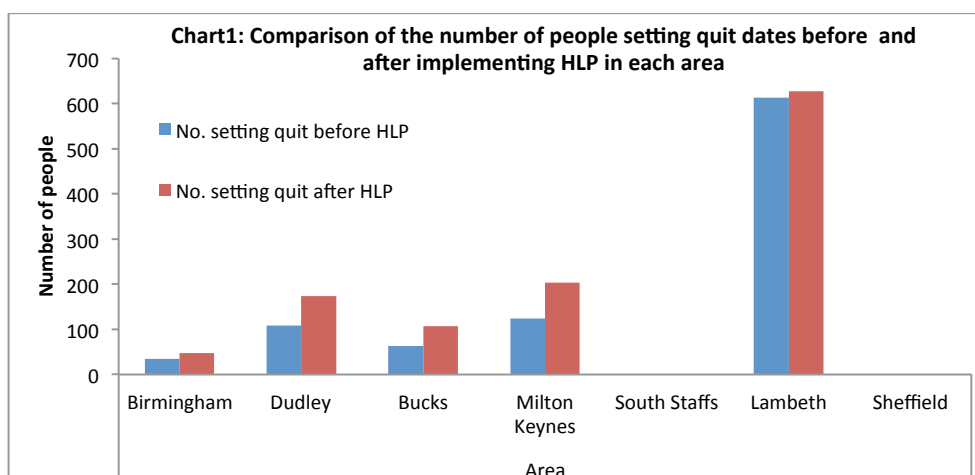
3.4.1 STOP SMOKING SERVICES

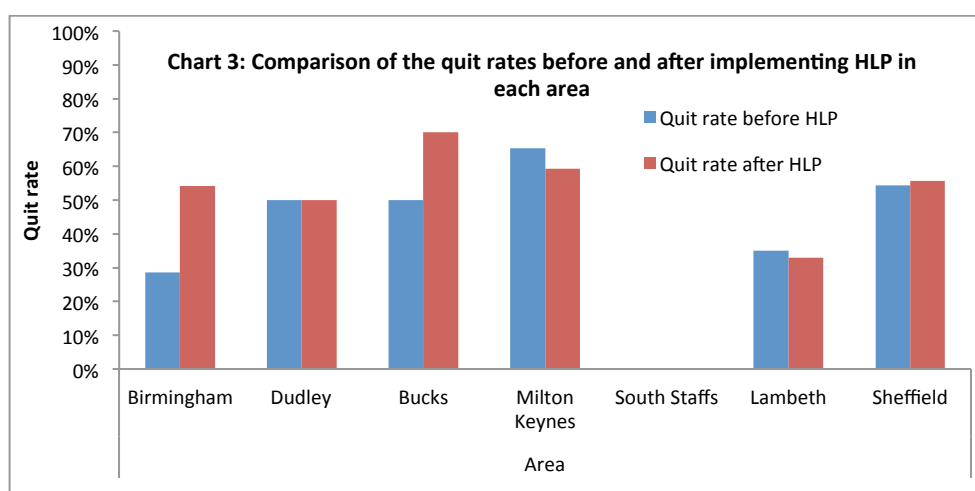
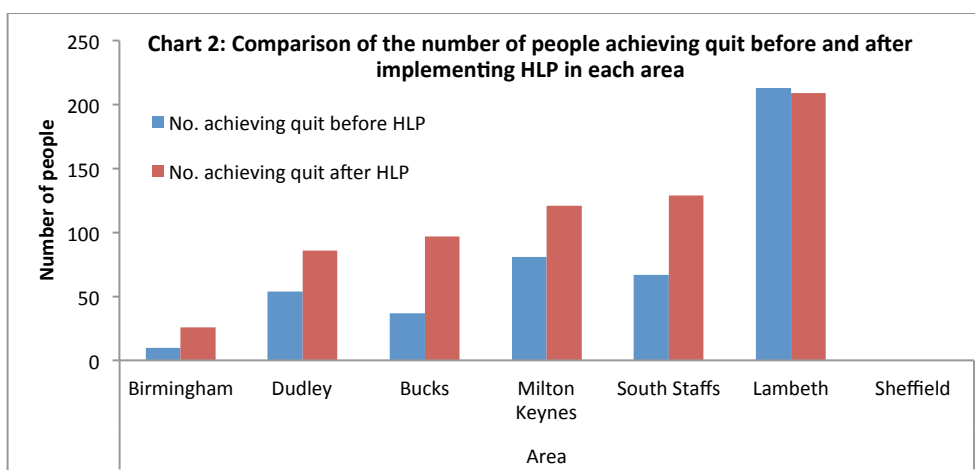
Stop Smoking services are the most widespread public health services delivered by HLPs. This is reflected in the evaluation data submitted, where nine pathfinder areas returned data for Stop Smoking service delivery. One pathfinder area (Plymouth) reported that a Stop Smoking service had been commissioned for the first time through community pharmacy as a result of being chosen as a pathfinder area. Eleven of the areas reporting data, had Stop Smoking services commissioned and chose to report on this service. Two areas did not return data on Stop Smoking despite having this service commissioned.

A pharmacy-based Stop Smoking service relies on awareness and willingness of clients to ask for the service, but also the ability and willingness of pharmacy staff to actively recruit clients to the service. The service does not necessarily require the input of a pharmacist; however, services required Stop Smoking advisors to have had appropriate training. In many pharmacies customer-facing employees were the Stop Smoking advisors, including the Health Champions. As explained above, there was variation between areas in the service specifications, data collection and evaluation. The details of the methods used in each area are shown in Appendix 7. Broadly areas chose one of two different methods for evaluation: one was before and after the implementation of HLP, using a time period for the before/baseline data chosen locally; the other method was comparison of pharmacies that had received their HLP quality mark compared with those that had not. The charts below show the summaries of the data for the two groups of areas.

Charts 1-3 show the summary results for the areas which used a 'before' and 'after' approach.

Charts showing the impact of HLP implementation on the uptake and effect of Stop Smoking Services in seven of the pathfinder areas, where the comparison was of 'before' and 'after' implementation of HLP





Notes to Charts 1 – 3: Baseline time period South Staffordshire was a different six months from the HLP time period; Buckinghamshire and Milton Keynes baseline period was six months, data collection was three months. The area covered two PCTs with different service specification, remuneration and measures so were evaluated separately.

The charts show that:

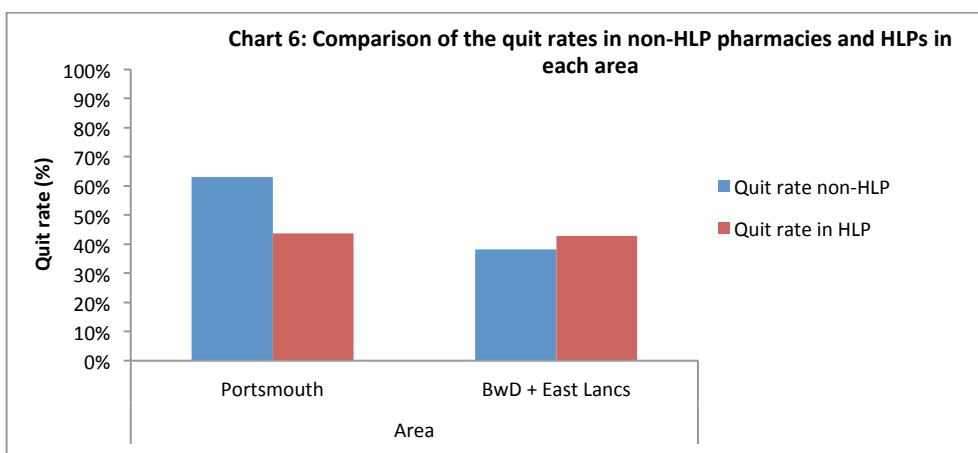
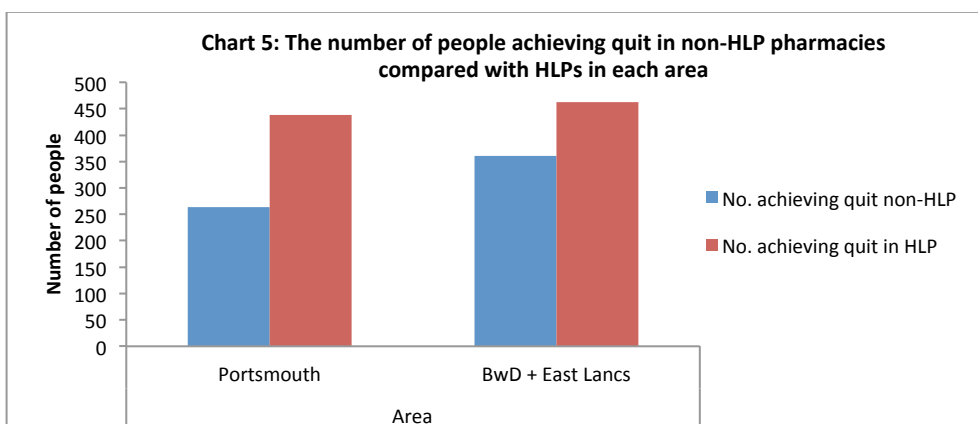
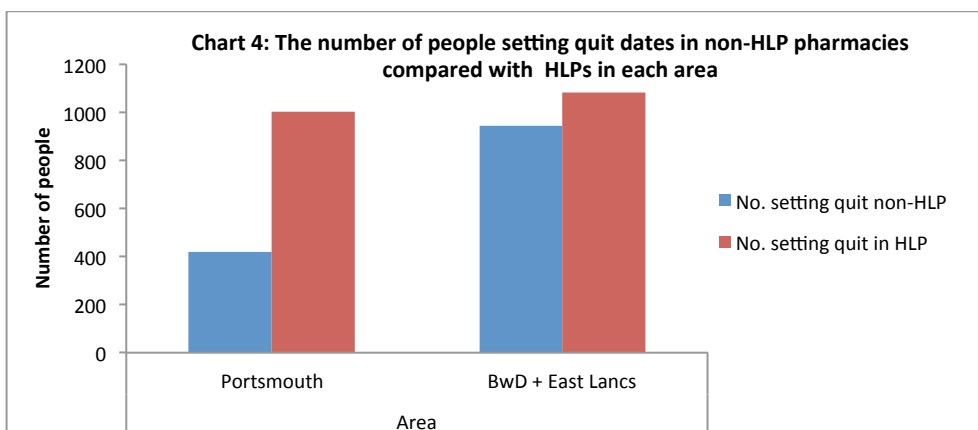
- In all the areas that recorded setting quit dates, the number of people setting quit dates increased
- In the areas that recorded quit numbers, the number of quits increased in all but one
- The quit rates increased in three areas, remained the same in one, and decreased in two
- Quit rates were 50% or higher in five out of six areas which reported.

In Lambeth, the number of people quitting and the quit rate decreased by 4% and 2% respectively; however, the absolute numbers of people setting quit dates and quitting were much higher than all the other areas that reported on Stop Smoking¹³.

¹³ Service delivery from GPs/nurses was changed during HLP implementation to include provision of NRT for 2-4 weeks, whilst pharmacy provision is one week only. This may have impacted on individual's preference of service; further investigation is underway

In summary, the findings consistently show that the number of people setting quit dates, and the number of people quitting smoking is higher after pharmacies become HLPs. This is consistent with the data presented from Portsmouth.

Two areas used a different approach to evaluation; they were able to compare non-HLP and HLP pharmacies over the same time period. The summary data for these areas are shown in Charts 4 - 6 below.



Charts 4-6 show that:

- The number of people setting quit dates and achieving quits, and the percentage quit rates in HLPs was similar in In both areas, showing that the Portsmouth results could be achieved in another area
- In both areas more people set quit dates in HLPs than non-HLPs
- In both areas, more people achieved a four week quit in HLPs than non-HLPs
- In Portsmouth the quit rate was lower in HLPs than non-HLPs although more people quit overall. More people accessed the Stop Smoking services
- In Blackburn with Darwen and East Lancashire, the quit rate was a little higher in HLPs than non-HLPs

Further analysis of Stop Smoking services is included in Chapter 4.

I am the Health Champion at Boss Pharmacy and am delighted with my new role as I can make an even greater contribution to the health of our public. I enjoyed the training and was especially pleased to receive a certificate in recognition of achieving Health Champion status. Our patients have seen a difference and respond really well often asking me how I'm getting on. I especially enjoy helping people to give up smoking and hope to be even more involved in the future"

Geri, Health Champion

"Another client using the Health Kiosks for information on cough asked advice from our health champion. She gave him advice and as he was a smoker asked him if he would like to join our Stop Smoking service. He has successfully quit smoking for the last 8 months, his cough has gone and he has become more aware of keeping healthy. Through him we had 4 referrals for our Stop Smoking service. Overall HLP is a good thing for the benefit of the public and hopefully in future it will save NHS some money"

Deepak, Independent contractor

"One of our Health Champions in a HLP in Lewes was presented with a lovely bunch of flowers from a grateful customer who had managed to quit smoking after 25 years as a smoker. This lady had tried many times to give up but had never succeeded. She found the encouragement she received from the Health Champion to keep her on the Smoking cessation programme really helpful"

Jan, East Sussex LPC

"We went to Weymouth College before Christmas with our Smoke Stop Service. We set up a display table where we had the smoke-stop advisors demonstrating with the Smokerlyser, giving out leaflets and advice. We were targeting the students but were surprised by the interest from the teachers and staff as well. We will be starting this up again after Easter on a weekly basis up to the beginning of the Summer Holidays"

Marianne, Pharmacist

"Two pharmacies now deliver a Stop Smoking service, which they had not previously done"

Jo, commissioner

3.4.2 EMERGENCY HORMONAL CONTRACEPTION

Emergency Hormonal Contraception (EHC) was the second most common service chosen for evaluation by six of the pathfinder areas that returned data. Whilst this service requires pharmacist input, the first point of contact is usually the counter staff, for example, the Health Champion. The EHC service is dependent on clients requesting the service and activity therefore requires availability of the service in the pharmacy, but also client awareness of the service, and willingness to request the service from community pharmacy. For the EHC services reported, there were variations between the areas for service specifications and data collection. In addition to these variations, two PCTs in one area experienced changes to the way data was collected as a result of the clustering of PCTs. The methods used for evaluation are shown in Appendix 8.

Findings are summarised in Table 3 below.

Table 3: Findings for the evaluation of EHC services in pathfinder areas

<i>Pathfinder Area</i>	<i>Findings for EHC service</i>	<i>Associated services</i>
Buckinghamshire	Over full year Baseline 76% of all EHC provided by pharmacies which went on to work towards and become HLPs One year later 86% of all EHC activity was provided by HLPs or pharmacies aspiring to be HLPs	Condom supply increased by 13% and discussion of Chlamydia screening increased by 6%
East Riding and Hull	Over full year Average consultations in HLP 123 Average consultations in non-HLPs 73	Average condom supply to 16-19 year olds in HLP 22.6% Average condom supply to 16-19 year olds in non-HLP 16.1%
Lambeth	Decrease in consultations to 3005 from 3189 (-6%) year on year ¹⁴	
Milton Keynes	PCT changed data collection to electronic system which not all pharmacies used, data were incomplete and conclusions could not be drawn	
Portsmouth	Average consultations in HLP 160 Average consultations in non-HLPs 85 (significant at p<0.001) Increases in consultations in both types of pharmacies seen compared with before implementation of HLP	
Stoke-on-Trent	Increase in consultations from 1600 to 1848 (+16%) year on year	Increase in Chlamydia screening from 740 to 956 (+29%) Increased signposting

The data show that in three of the six areas (East Riding and Hull, Portsmouth and Stoke-on-Trent) the number of consultations increased in HLPs, suggesting that demand and willingness to use the community pharmacy service increased. In two areas the number of consultations decreased (Buckinghamshire and Lambeth) although data were available from Buckinghamshire to show that the proportion of EHC delivered in community pharmacies working towards HLP increased. These two areas represent differences in health profiles: the health profile¹⁵ for Buckinghamshire showed a significantly lower teenage pregnancy rate compared with the England average and; in Lambeth, the health profile showed that

¹⁴ It is understood that since submitting the evaluation report, anomalies in the EHC data from Lambeth have been discovered; this is currently under investigation

¹⁵ Health Profiles for England 2012. The Association of Public Health Observatories.
http://www.apho.org.uk/default.aspx?QN=HP_FINDSEARCH2012 accessed 28 Jan 13

the area had a significantly higher rate of teenage pregnancy than the England average. Further work is required to understand why the EHC performance in Lambeth as well as Stop Smoking service outputs has not realised the benefit of HLPs seen in other areas, although there appears to be differing reasons suggested.¹⁶

Three areas reported on associated services that were included in their PCTs' service specification for provision of EHC. These were condom supply and Chlamydia screening. The data from Buckinghamshire and East Riding and Hull showed that condom supply increased. The data from Buckinghamshire and Stoke-on-Trent showed that Chlamydia screening also increased. It is notable that the health profiles of these areas show considerable differences: Buckinghamshire and East Riding both have rates of teenage pregnancy significantly lower than the England average while Hull and Stoke-on-Trent have rates of teenage pregnancy significantly higher than the England average. The geography and levels of deprivation and health inequalities were similarly split.

The absence of data from Milton Keynes was disappointing. This was due to the clustering of the PCT with Northamptonshire, reductions in staffing and changes to the way data were collected and recorded.

“One of our HLPs went to the local university and did a Chlamydia awareness day - they took their free Chlamydia pants and headphones and were encouraging students to attend the pharmacy for Chlamydia screening. They also took along some information from our alcohol awareness campaign - their light-hearted message along the lines of - watch your alcohol or you'll need to get another pair of Chlamydia pants!”

Gill, South Staffordshire

¹⁶ There appear to be discrepancies in the data and these are under investigation

3.4.3 MINOR AILMENTS SERVICES

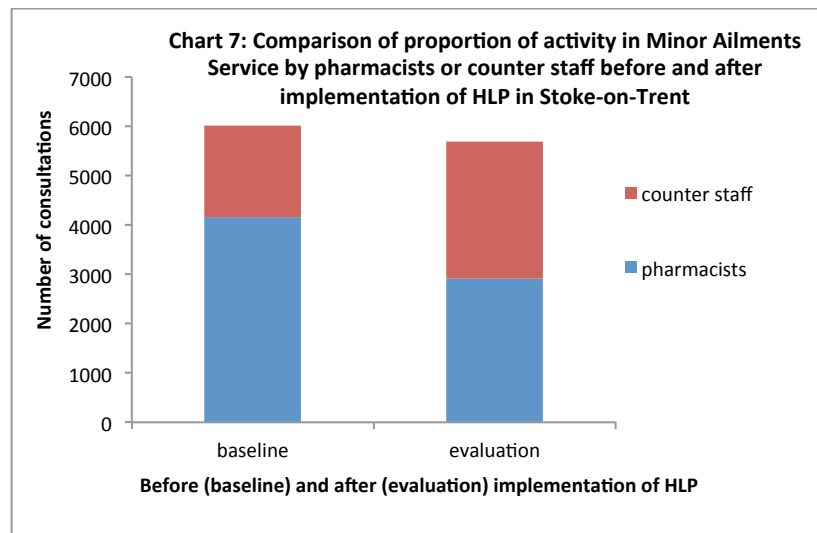
Three pathfinder areas evaluated Minor Ailments Services. These services were demand-led by the public and relied on public awareness of the services. Consultations for minor ailments did not have to be dealt with by the pharmacist and could be handled by customer-facing staff, such as Health Champions. Minor Ailments Services were typically commissioned in areas of high health deprivation to improve access for the public to medicines for common conditions without having to go to their GP. The Health Profiles support this: Birmingham and Sheffield had mixed profiles with some areas of low deprivation and others of high deprivation compared with the England average; Solihull had predominantly less deprivation than the England average; and Stoke-on-Trent had higher levels of deprivation and health needs than the England average.

Similarly to the other services the local service specifications, formularies and data collection methodology varied between areas. It must be noted also that the service specification changed in one area, Stoke-on-Trent, between the baseline data period and the evaluation period, so real comparisons could not be drawn.

The evaluation data are shown below in Table 4:

<i>Pathfinder area</i>	<i>Activity before HLP implementation</i>	<i>Activity after HLP implementation</i>	<i>Comments</i>
Birmingham and Solihull	170.5 consultations per month average	178.3 consultations per month average while working towards HLP quality mark 173.7 consultations per month average after achieving HLP quality mark	2 pharmacies only
Sheffield	105 consultations per month average	170 consultations per month average (61.6% increase)	7 pharmacies saw increase in activity 2 pharmacies saw decrease in activity One pharmacy saw no change in activity
Stoke-on-Trent	4155 consultations by pharmacists 1860 consultations by counter staff 6015 consultations total	2914 consultations by pharmacists 2773 consultations by counter staff 5687 consultations total	Top five pharmacies for activity were HLPs Increase in proportion carried out by counter staff Change in service specification between baseline and evaluation

Stoke-on-Trent provided additional data about who provided the service in pharmacies; the data showed that counter staff were providing more of the Minor Ailment Service following implementation of HLP, as shown in Chart 7 below, and it was reported that the five pharmacies providing the highest activity were HLPs.



The data shown in Chart 7 suggest that the workload has shifted from pharmacists to counter staff in HLPs, who may be Health Champions. This indicates that members of the team were developed in HLPs to provide the Minor Ailments Service.

Birmingham and Solihull selected two pharmacies only for HLP implementation. In these two pharmacies activity appeared constant before and after implementation of HLP.

Pharmacies in Sheffield saw over 60% increase in activity overall, indicating that they were able to better meet a local health need following implementation of HLPs. It was noted that activity increased in only 7 of 10 pharmacies, showing variation between pharmacies; this is considered in the conclusions and recommendations.

3.4.4 ALCOHOL AWARENESS SERVICES

Alcohol awareness service evaluations were reported by three pathfinder areas; Dudley, Milton Keynes (part of the Buckinghamshire and Milton Keynes pathfinder area), and Portsmouth. The health profiles for Dudley, Milton Keynes and Portsmouth showed that hospital stays due to alcohol related harm were significantly worse than the England average.

These services did not require the input of a pharmacist and customer-facing staff such as Health Champions played a considerable role in providing this service opportunistically and proactively.

The team from Portsmouth described the method of data collection:

Adults visiting the pharmacy were invited to complete a scratch card based on the Audit C questionnaire. The card asked three questions about their drinking habits. A score was assigned to each answer with the total score ranging from 0 to 9 or more. People who scored between 0 and 4 were deemed to be drinking safe limits of alcohol (as per UK government guidelines) and positive feedback was given. Those who scored between 5 and 8 were offered advice on safe drinking and provided an alcohol awareness leaflet; if they declined, an alcohol awareness leaflet was provided. Those people scoring 9 or more were signposted to an Alcohol Intervention Team. (Rutter et al 2012)

The methods used for evaluation are shown in Appendix 10. The results are shown in Table 5 below:

Table 5: Findings for the evaluation of Alcohol awareness services in pathfinder areas						
Pathfinder area	Activity before HLP implementation	Activity after HLP implementation	Comments			
Dudley	55 total 13 (24%) given brief advice 10 (18%) followed up 1 referred to specialist service	280 total 82 (29%) given brief advice 32 (11%) followed up 2 referred to specialist service	8 times more people scored over 8 on AUDIT C tool after HLP 3 of 16 pharmacies collected before and after data			
Pathfinder area	Non-HLP	HLP	Comments			
Buckinghamshire and Milton Keynes	31 people average per pharmacy 218 people total 36% scored 5 or above 28% given brief advice 7 pharmacies participated	Working towards HLP 38 People average per pharmacy 424 total 40% People scored 5 or above 34% Given brief advice 11 participated	Achieved HLP 59 People average per pharmacy 535 total 42% People scored 5 or above 33% Given brief advice 9 of 9 HLPs participated	Data from Milton Keynes only. Measured score of 5 or above on AUDIT C tool		
Portsmouth	90 people average per pharmacy 290 people total 7.4% AUDIT C score above 8 35 (12.1%) given brief advice	218 people average per pharmacy 1089 people total 4.4% AUDIT C score above 8 133 (12.2%) given brief advice				

In all areas, using different evaluation methods – before and after implementation of HLP and non-HLP compared with HLPs – the number of people who participated in the service was greater in HLPs than non-HLPs. The numbers of people scoring over 8 in the AUDIT C tool were a similar proportion in Dudley before and after, and in Portsmouth a smaller proportion. The proportions of people given brief advice in Portsmouth were similar for non-HLPs and HLPs. The data from all areas showed that HLPs were more effective at engaging the public in the service than non-HLPs. In Dudley the comparison was made between baseline and following implementation of the concept when public awareness of alcohol intervention in community pharmacy had increased. More people at risk from alcohol harm received advice as a result of implementation of HLP.

“A new online brief intervention tool developed by the Drug and Alcohol Action Team was introduced and piloted within Sheffield HLPs, supported by interactive public health displays. Over the 2-week formal campaign period, 20 of these pharmacies completed 167 screens between them, of which 54 individuals scored 5+, some eligible for referral for support by the specialist team”

Jo, commissioner Sheffield

3.4.5 TARGETED MUR AND NEW MEDICINE SERVICE

Five pathfinder areas chose Medicines Use Reviews (MUR) and/or the New Medicines Service (NMS) for evaluation. Both services were Advanced Services nationally commissioned through the community pharmacy contractual framework. Pharmacies had a choice whether to deliver the services. The purpose of MURs was to help people get the best out of the medicines and the NMS was to support adherence for people newly prescribed a medicine for specified long-term conditions. As NMS was introduced in October 2011, Shropshire could not provide baselines figures.

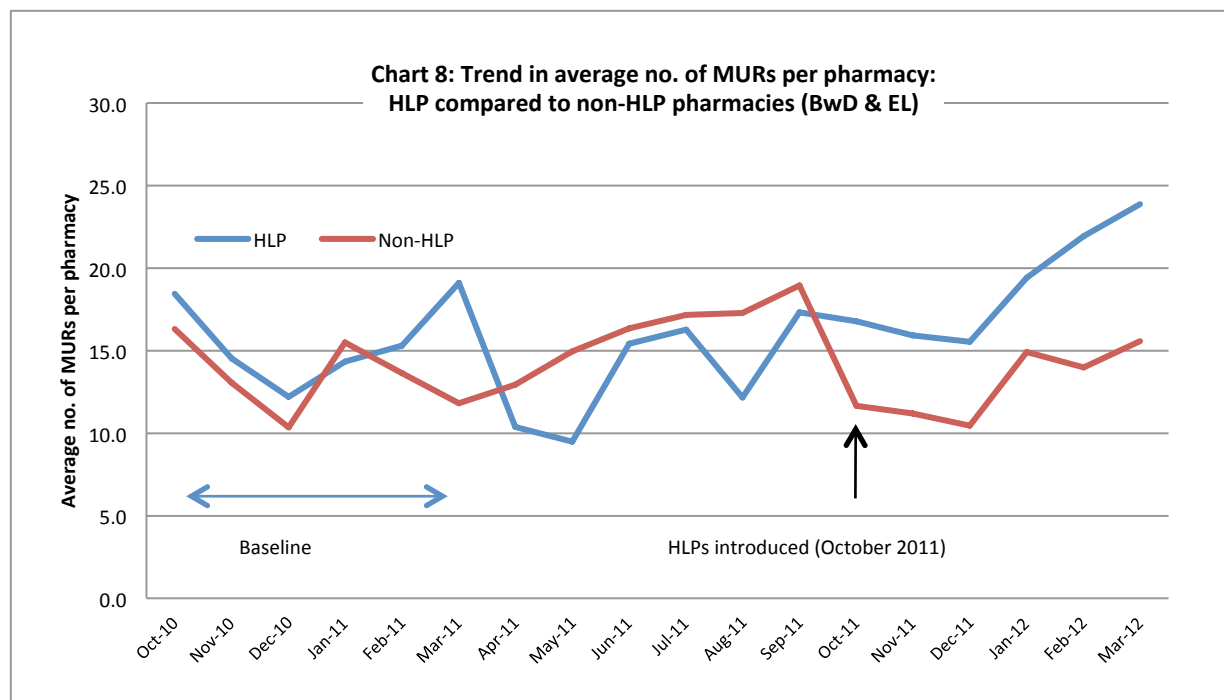
The methods for evaluation chosen by the areas are shown in Appendix 11. The results are shown below in Table 6.

Table 6: Findings for the evaluation of targeted MUR and NMS			
Pathfinder Area	MUR (average per pharmacy over whole measurement period)		Comments
	Non-HLP	HLP	
	Blackburn with Darwen and East Lancashire	80.5 before 77.8 after HLP	
Buckinghamshire	9	16 working towards HLP 30 HLP	Specifically evaluated respiratory MURs for patients with asthma and COPD May 11 – Dec 12
Milton Keynes	30	23 working towards HLP 68 HLP	Specifically evaluated respiratory MURs for patients with asthma Apr 11 – Mar 12
Portsmouth	12	35	Specifically evaluated respiratory MURs for patients with asthma Apr 11 – Mar 12
Shropshire	43.9 before 46.6 after HLP	41.6 before 36.9 after HLP	Before: May – Jul 11 After: May-Jul 12
NMS (average per pharmacy)			
	Non-HLP	HLP	
East Riding and Hull	31.7	64.8	Oct 11 to Jul 12
Plymouth	2.1 before 3.1 after	5.6 before 8.4 after	Monthly data shown in Chart 9 below Before Oct 11 to Feb 12 After Mar 12 to Aug 12
Shropshire	Before NA 5.0 after HLP	Before NA 8.7 after HLP	Before HLP implementation baseline for NMS not possible as service introduced after baselines measured Before: May – Jul 11 After: May-Jul 12

Four areas provided MUR data: Blackburn with Darwen and East Lancashire, Buckinghamshire and Milton Keynes, Portsmouth and Shropshire. Three areas showed that more MURs were carried out in HLPs than non-HLPs. Blackburn with Darwen and East Lancashire and Shropshire were able to compare before with after HLP implementation and

HLPs with non-HLPs. The Buckinghamshire and Milton Keynes pathfinder area covered two PCTs, which introduced respiratory MURs in different ways so the data were evaluated separately.

In Blackburn with Darwen and East Lancashire the pharmacies that went on to become HLPs carried out 16% more MURs in the baseline period than those that did not progress to HLP during the evaluation and after they became HLPs they carried out 46% more than non-HLPs. Detailed data of monthly activity in pharmacies was provided by Blackburn with Darwen and East Lancashire shown in Chart 8 (below).



Buckinghamshire and Milton Keynes and Portsmouth compared HLPs and non-HLPs specifically for respiratory MURs, which had been part of a South Central Health Authority Respiratory project, and were therefore able to provide additional findings.

Buckinghamshire: additional findings:

- 626 respiratory MURs were carried out in community pharmacy during the evaluation period
- The proportions of smokers recruited in HLPs and non-HLPs were similar (19% and 17%) but pharmacies working towards HLP recruited a smaller proportion of smokers (11%)
- At the follow up intervention, 10 out of 28 people who smoked at the first MUR reported that they had quit. Three of these people were patients with poorly controlled asthma at the first intervention and four were patients with poorly controlled COPD symptoms at the first intervention

- 385 (62%) of 626 people who took part were eligible for a follow up intervention to check their progress since the MUR. 133 (35%) took part
- 117 of 133 (88%) follow up interventions were in HLPs or pharmacies working towards HLP
- At the follow up intervention, 71% of people had improved ACT (measure of control of asthma symptoms) scores, 11% had the same score and 19% had worse scores
- At the follow up intervention 7 of 20 patients had improved CAT (measure of control of COPD symptoms) scores, 3 of 20 had the same score and 7 of 20 had worse scores.

Milton Keynes additional findings:

- 1130 respiratory MURs were carried out in Milton Keynes pharmacies during the evaluation period
- Over half the respiratory MURs carried out were in HLPs (54%) and over a quarter in pharmacies working towards HLP (26%)
- 297 of 1130 (26%) people were smokers at the first MUR. HLPs and pharmacies working towards HLP recruited similar proportions of smokers (28% and 27% respectively) compared with non-HLPs, which recruited a smaller proportion (19%)
- 241 people who were smokers at the time of the first MUR reported that they had quit at the second intervention. 122 people with poorly controlled asthma at the first MUR reported that they had quit. 69 people with poorly controlled COPD at the first MUR reported that they had quit.
- 718 people who took part were eligible for a follow up intervention to check their progress since the first MUR. 206 (28%) took part
- 167 of 206 (81%) follow up interventions were in HLPs or pharmacies working towards HLP
- At the follow up intervention, 65% of people had improved ACT (measure of control of asthma symptoms) scores, 20% had the same score and 15% had worse scores
- At the follow up intervention 48% of patients had improved CAT (measure of control of COPD symptoms) scores, 32% were the same and 20% had worse scores.

Portsmouth additional findings:

- The data from Portsmouth showed significantly more MURs performed in HLPs compared with non-HLPs ($p=0.017$)
- HLPs targeted a significantly greater proportion of smokers than non-HLPs. 100 smokers from a total of 420 (23.8%) in HLPs and 25 smokers from a total of 159 (15.7%) in non-HLPs ($p=0.035$)
- 354 of 579 people were eligible for a follow up intervention to check their progress since the MUR. 81 people took part
- 78 of 81 follow up interventions were in HLPs

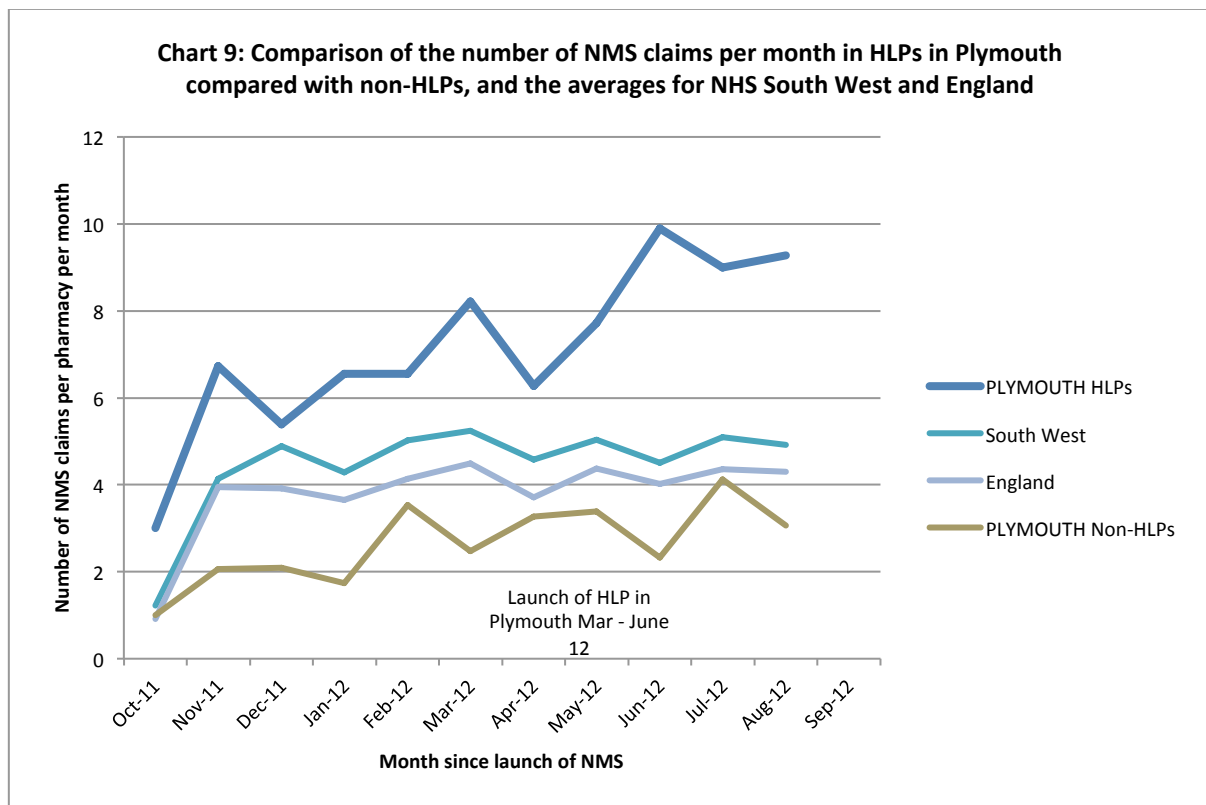
- At the follow up intervention, 38.5% of people had improved ACT scores, 20.5% had the same score and 41% had worse scores.

The MUR findings from Portsmouth, Buckinghamshire and Milton Keynes showed increased activity in HLPs compared with non-HLPs and in Portsmouth and Milton Keynes that HLPs were focusing on smokers, a proportion of whom went ahead and quit smoking. In all three areas, HLPs successfully engaged patients for follow up interventions to check their clinical progress since the first MUR.

Over the two areas (3 PCTs) there were patients who had worse symptom control for asthma or COPD at the second intervention; this would be worth further investigation.

The data from Shropshire suggested that fewer MURs were carried out in HLPs both before and after implementation compared with non-HLPs. Further work is required to understand why this might be.

For NMS, the data show that, on average, HLPs in East Riding and Hull carried out more than twice as many interventions as non-HLPs. In Shropshire and Plymouth the numbers showed that more NMS were delivered in HLPs than non-HLPs. The low figures must be treated with caution. However, the activity in HLPs in Plymouth and Shropshire after HLP implementation was very similar at 8.4 and 8.7 respectively. Plymouth evaluated NMS activity in HLPs, non-HLPs both before and after implementation, and compared local activity with activity across NHS South West and the England averages. The results are shown in Chart 9 below:



The data for Plymouth show that the NMS activity in pharmacies that went on to become HLPs was higher from the start of the service in October 2011 compared with pharmacies which did not go on to become HLPs. After the start of implementation of HLPs in March 2012 the average number of NMS increased in both HLPs and non-HLPs. The HLPs in Plymouth also claimed for more NMS per month than the average for the region and for the whole of England.

“HLPs are more active with MURs than non-HLP pharmacies and an increase in the provision of MURs in the HLP pharmacies on a like for like, year on year basis. Together with the NMS data, this indicates that HLPs are more effective at delivering advanced services. As part of these consultations, the pharmacist provides common public health interventions and therefore more opportunity for lifestyle advice”

Mark Stone, LPC Project Pharmacist, Devon

3.4.6 SUBSTANCE MISUSE SERVICE EVALUATION

Data on this service was provided from one pathfinder area: Blackburn with Darwen and East Lancashire. Clients accessed substance misuse services following referral from specialist drugs services and nominated their chosen pharmacy, which they used for the duration of the supervision phase of their treatment, unless there was a need to transfer to another pharmacy with the knowledge of the specialist team. Therefore the number of people accessing the service in a particular pharmacy depended on the number of clients progressing through the substance misuse treatment service and their choice of pharmacy to receive their supervised treatment in the community. Both the areas of Blackburn with Darwen and Lancashire¹⁷ had significantly higher levels of substance misuse than the average for England in their Health Profiles.

Prior to becoming HLPs, ad hoc advice was provided when requested by the client and this advice was not recorded. .

Service activity was recorded in 23 pharmacies from June to October 2012. As this part of the service was new the baseline measure was zero interactions. Evaluation was of activity related to the new service specification.

¹⁷ The Health Profile was for the whole of Lancashire, and did not specify East Lancashire

The data showed that:

- 328 interactions were made with substance misuse clients, over approximately four months
- 35.7% of interventions were made by the pharmacist
- 26.8% of interventions were made by the Health Champion
- 337 (60%) clients were signposted to other services, for example 34.5% to the pharmacist (presumably by non-pharmacist staff in the team), 10.1% to an NHS dentist
- HLPs with large numbers of recorded interactions provided advice about needle exchange
- 71.6% of the advice given was for needle exchange.

The data showed that the service led to over 300 interactions during a four-month period. However, data is not available for the number or type of interventions made prior to service implementation. The number of clients who received the intervention or refused the intervention was not reported. The pharmacist made about one third of the interventions, and the Health Champion made over a quarter of the interventions, with the rest made by counter assistants (20%), technicians (13%) and other staff (5%). The type of advice and signposting given was linked to harm reduction (for example needle exchange services and safe injecting) and for health and wellbeing, (for example dentistry and Stop Smoking services).

“We have piloted a new service intervention for addiction to medicines available over-the-counter particularly codeine, by using a card in the prescription or pharmacy bag to raise awareness supported with a dedicated support phone line”

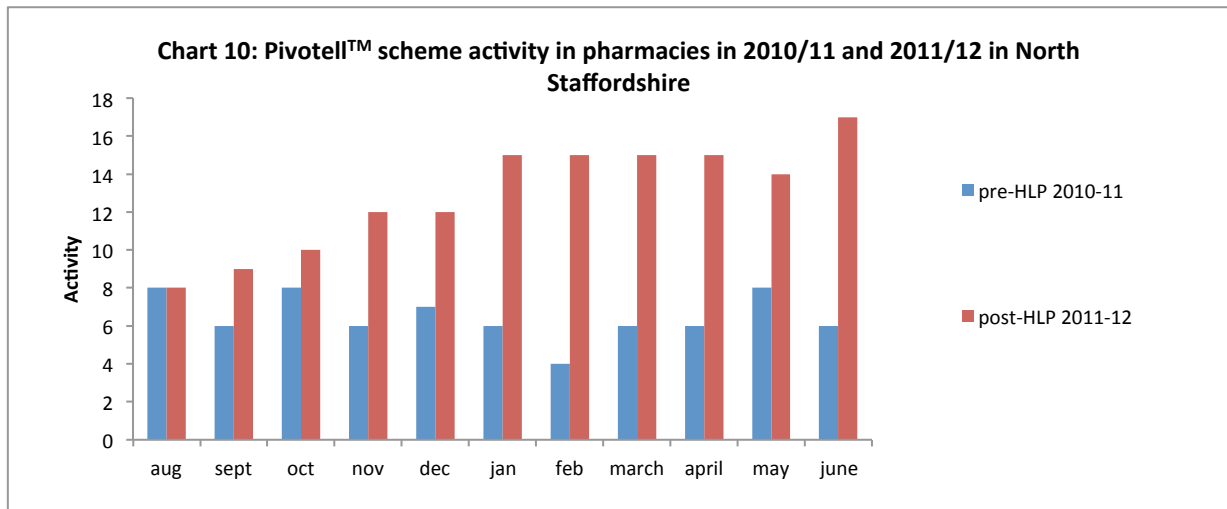
Jo Tsoneva, Commissioner, Sheffield

3.4.7 PIVOTELL™ SERVICE EVALUATION

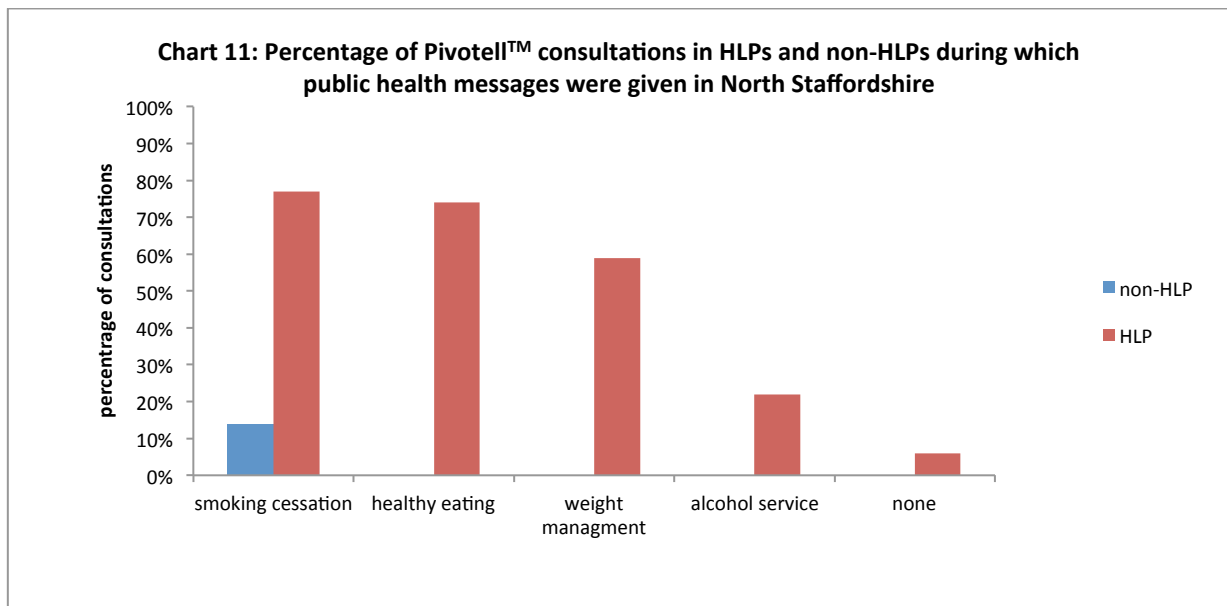
This service was evaluated in one pathfinder area. North Staffordshire Clinical Commissioning Group in partnership with Social Care and Health provided automated pill dispensers to adult patients with specific social and medical needs such as dexterity issues, poor vision, confused, learning disabilities, over or under dosing. The Strategic Health Authority funded this scheme on a pilot basis from April 2010, and each PCT was encouraged to participate and was allocated a number of automated pill dispensers. North Staffordshire PCT was allocated 60 dispensers, which were distributed in the community via Social Care and administered through the community pharmacy Locally Enhanced Service. The use of Pivotell™ aims to promote medicines adherence, reduce hospital admissions

caused by non-adherence/adverse effects of medicines, help to reduce medicines waste and promote long term health promotion support to avoid long term conditions^{18,19}. The service evaluation compared service activity in HLPs before and after implementation, and provision of public health messages in HLPs and non-HLPs over 11 months.

The data are shown in the charts 10 and 11 below



Comparing activity before and after the implementation of HLP showed that activity was higher each month from September to June after HLP implementation.



More public health messages were provided in HLPs than non-HLPs.

¹⁸ Manufacturer's website <http://www.pivotell.co.uk>

¹⁹ Good Practice Case Study. Improvement and Efficiency West Midlands. Not dated. http://www.puttingpeoplefirst.org.uk/library/Resources/Personalisation/EastMidlands/Workstreams/Efficiency/AssistiveTech/West_Midlands_Automated_Pill_Dispenser_Project_Case_Study.pdf accessed 12 February 2013

3.4.8 WEIGHT MANAGEMENT SERVICE

Portsmouth evaluated the weight management service “Healthy Weight” in 2012. The Health Profile reported that the rate of adults eating healthily at 25% was significantly worse than that the national average, although the proportion of obese adults at 23.8% was not significantly different.

The results showed that:

- 329 people were recruited over a six month course of twelve one-one sessions with a trained advisor
- 140 people (43%) completed the course
- 19 pharmacies took part in the service and delivered 2000 sessions, recruiting 30 to 40 participants per month
- Participants were provided with a food diary and pedometer to track eating and activity
- 87 people (26%) lost 5% of their body mass
- 24 people (7%) lost 10% of their body mass
- The average weight loss of people that completed the programme was 6.3 kg

These data show that over a third of participants who were recruited, completed the course and over a quarter lost 5% of their body mass, in line with NICE guidance²⁰ to target 5-10% weight loss through advice about diet and activity in the community.

“The staff at one of our HLPs decided to do more exercise - cycling to work, going to the gym more and one took part in half a marathon. They posted photos of themselves on their display board and found they got very positive feedback from customers”

HLP, East Sussex

“My staff have taken the role of Health Champion very seriously which can be seen from the clients that we have recruited. When doing a New Medicine Service for a client who was put on a new medicine to treat diabetes. I asked him if he would be interested in our My Choice Weight Management service. He joined the service and taking the advice from our Health Champion, he lost 14lbs in 12 weeks. He was so happy, but his doctor was even happier and he informed me that he will refer his patients to this service”

Pharmacist owner, Birmingham

²⁰ CG43: Obesity. NICE Clinical Guideline 2006 <http://www.nice.org.uk/nicemedia/pdf/CG43NICEGuideline.pdf> accessed 12 February 2013

3.5 CONCLUSIONS AND RECOMMENDATIONS

The conclusions drawn from the evaluation of services are shown below.

3.5.1 STOP SMOKING

The evaluations from the pathfinders showed that more people successfully quit smoking in HLPs than non-HLPs, although the differences in some instances were low, either measured before HLP implementation or compared directly with non-HLPs.

- Eight pathfinder areas reported on Stop Smoking services (one area covered two PCTs which were evaluated separately). Two areas provided partial data
- The number of people setting quit dates was higher in HLPs compared with non-HLPs, or after HLP implementation compared with before
- The number of people successfully achieving a quit was higher in HLPs in all areas, except Lambeth where there appeared to be a small reduction although the numbers remained higher than any other area
- Quit rates were lower in three areas
- All but three areas reported quit rates above 50%.

HLPs appeared to be more successful in helping people engage with Stop Smoking services as well as in quitting. This was independent of variations between populations, geography, service specifications and data collection methods, for example, Buckinghamshire with over half the population within the least deprived quintile of England and none within the most deprived quintile with an adult smoking prevalence of 16%, and Portsmouth with over 50% of the population in the two most deprived quintiles with an adult smoking prevalence of 26%. HLPs in Portsmouth were successful in more than doubling the number of people who quit through HLPs. Stop Smoking services in these two areas were related to the respiratory MUR evaluations that both areas included in their pathfinder reports (discussed in section 3.5.5).

3.5.2 EMERGENCY HORMONAL CONTRACEPTION

The overall results indicated that young women were content to access EHC services from community pharmacies and that HLPs delivered more EHC services and associated sexual health services than non-HLPs or before implementation of HLP.

- Reports on associated services of Chlamydia screening, condom provision and signposting in three areas (Buckinghamshire, East Riding and Hull, and Stoke-on-Trent) showed some increase in activity, indicating that HLPs were more successful at engaging clients in wider sexual health matters

- The number of consultations in Portsmouth increased in both HLPs and non-HLPs following HLP implementation, suggesting a ‘halo effect’ of increased pharmacy participation and public awareness of the service
- The number of consultations fell in Lambeth²¹

When EHC services were considered in the context of the health needs shown in Health Profiles, it could be seen that the services were acceptable to clients regardless of the level of deprivation and teenage pregnancy rate. For example, in East Riding with a teenage pregnancy rate significantly lower than the England average compared with Stoke-on-Trent where the teenage pregnancy rate was significantly higher, the number of EHC consultations increased in HLPs, while the provision of condoms in East Riding increased and Chlamydia screening in Stoke-on-Trent increased alongside EHC consultations.

One area (Milton Keynes) was unable to collect data due to changes within the commissioning organisation, highlighting the context within which HLP implementation was taking place.

Portsmouth, Buckinghamshire and Milton Keynes reported that Health Champions were pro-actively raising public awareness of the service by outreach in their local community, for example, with school nurses, and this could have increased client’s willingness to access the service in a community pharmacy setting.

3.5.3 MINOR AILMENTS SERVICES

The data indicated that provision of services could increase in HLPs based on the data from Sheffield where an overall increase in activity by over 60% was seen and from Stoke-on-Trent, which reported that the top five pharmacies for Minor Ailments consultations were HLPs.

- Additional data from Stoke-on-Trent also showed that counter staff were delivering a greater proportion of the consultations following HLP implementation, thereby releasing pharmacists to focus on other activities. This also demonstrated the value of having trained Health Champions within the pharmacy setting
- The service specification in Stoke-on-Trent was changed which it was thought could have resulted in lower level of activity, although it must be noted that with activity around 5500 – 6000 consultations over five months, or around 1000 consultations per month, the service was providing support to many people, who may have otherwise gone to their GP
- In the third area, Birmingham & Solihull, the activity levels were similar before and after HLP implementation across the two pharmacies.

²¹ Suggested data discrepancies

3.5.4 ALCOHOL AWARENESS SERVICES

The acceptability of community pharmacy as a location for the public to receive the alcohol awareness service and the relatively high levels of activity seen in HLPs compared with non-HLPs showed that HLPs could be a valuable provider of this harm-reduction intervention.

- HLPs recruited 5 times more people in Dudley and 2.5 times more people in Milton Keynes than non-HLPs, while pharmacies working towards HLP recruited 2 times more people. In Portsmouth 3.5 times more people were recruited, than in non-HLPs
- Pharmacies either before becoming an HLP or those who were not HLPs were able to deliver the service, which showed that clients were willing to accept brief advice in a community pharmacy setting, indicating that the public find community pharmacy an acceptable environment to receive this service
- These data suggest that pharmacies working towards HLP status, with Health Champions, were making an impact before receiving their HLP quality mark
- The proportion of people accepting brief advice were slightly higher in Dudley and Milton Keynes in HLPs compared with non-HLPs, showing that HLPs were both effective at engaging people in the service and providing brief advice to people who were consuming alcohol at risky levels
- Milton Keynes showed that HLPs and those working towards HLP status recruited higher proportions of people at risk from alcohol, with at-risk score of 5 or above.

Greater numbers of people recruited to the service in HLPs in all areas shows that members of the public, whether at low or higher risk were content to receive advice on alcohol consumption in HLPs.

Engaging in alcohol awareness is an important public health intervention, with the rising number of people in England drinking at increased levels.

The pathfinder areas that evaluated Alcohol Awareness services had hospital admissions for alcohol related harm higher than the England average. All areas were urban areas so direct extrapolation to the impact of services in other types of geographical area cannot be made.

3.5.5 TARGETED MEDICINES USE REVIEWS (tMUR) AND NEW MEDICINE SERVICE (NMS)

HLPs were effective at delivering increased support for people taking medicines for long term conditions, through both MURs and NMS services. Activity was higher for both services in HLPs than non-HLPs or before HLP implementation in all but one area.

Both NMS and MURs had a national service specification, so there were fewer concerns about variability in service requirements and measures.

The New Medicines Service was evaluated in East Riding and Hull and Shropshire. The data from East Riding and Hull showed clear differences between HLPs and non-HLPs for the numbers of NMS completed per pharmacy over the evaluation period. The data from Shropshire showed smaller numbers of NMS per pharmacy and although there were more carried out in HLPs compared with non-HLPs, it was difficult to draw conclusions from the small numbers. However, the overall trend showed that HLPs were likely to provide more NMS interventions than non-HLPs, which indicated that more patients were being supported to take their medicines as intended with the associated benefits for improved health outcomes, in HLPs.

Medicines Use Reviews were evaluated in Buckinghamshire and Milton Keynes, Portsmouth and Shropshire. The data from Shropshire suggested that slightly fewer MURs were carried out in HLPs compared with non-HLPs.

The data from Buckinghamshire and Milton Keynes showed that HLPs and pharmacies working towards HLP carried out more respiratory MURs than non-HLPs and were more effective at recruiting patients to take part in their follow up interventions to check their progress. HLPs were more effective in recruiting people for following interventions, in supporting people to quit smoking and helping people to improve their symptom control.

The data from Portsmouth showed significant differences between MUR activities in HLPs compared with non-HLPs, with HLPs providing three times as many MURs. MURs were targeted at people with respiratory disease and HLPs significantly carried out more MURs on smokers than non-HLPs, went on to help smokers to quit and successfully engaged 99% of the eligible patients who accepted a follow up intervention.

In both areas (three PCTs) there were some patients who did not report improvement in symptom control at the second intervention. However, they had the opportunity to benefit from a second interaction with the pharmacist and receive enhanced support with their medicines and managing their symptoms, and if they were still smoking, the opportunity to receive support to Stop Smoking.

3.5.6 SUBSTANCE MISUSE SERVICE

Blackburn with Darwen and East Lancashire evaluated a new element of health interventions to the substance misuse service, added in response to being chosen as a pathfinder area.

- The purpose of the additional component to the service was to provide support and advice to clients receiving supervised consumption as part of their treatment for substance misuse in the community
- It was not known how many clients received the intervention as some may have received more than one intervention and it is not known how many clients refused the intervention
- There were 328 interactions to support substance misuse clients advising them about harm reduction (including safe injecting), and to improve health and wellbeing and signpost to other health professionals, such as dentists.

The data showed that the service was addressing an area of health need in both localities where there were significantly higher rates of substance misuse than the England average.

The change to the service was made in the context of HLP implementation so it appears that the commissioners used the HLP concept as a springboard to develop the service for clients and evaluate its value.

3.5.7 PILL DISPENSER (PIVOTELL™) SERVICE

This service provided an opportunity to provide health and wellbeing messages to people using the pill dispenser. The activity for this service was shown to increase after the introduction of HLP.

Public health messages were provided during consultations with around three quarters of consultations including advice on stopping smoking and healthy eating, over half of consultations including advice on weight management, a third providing advice on alcohol consumption. Only 6% of consultations were completed without healthy lifestyle advice being given. As the pill dispenser (Pivotell™) service was provided to people with specific health and social needs, the evaluation showed that vulnerable people received individual health and wellbeing advice alongside advice and support for taking medicines as intended.

3.5.8 WEIGHT MANAGEMENT SERVICE

The outcomes indicate that HLPs in Portsmouth are acceptable places for the public to access weight management advice and support. The service was shown to be effective in helping people lose weight. However, further evaluation in other areas outside of Portsmouth is required to demonstrate replicable outcomes.

The weight management service was evaluated in one pathfinder area, Portsmouth. The service was targeted at a local health need and demonstrated the acceptability of the service to the public in a community pharmacy setting with high numbers of participants recruited and over 40% completing the six-month course. Over a quarter of participants lost at least 5% of their body mass in line with NICE guidance²², indicating the effectiveness of the service.

3.5.9 DISCUSSION ON LIMITATIONS TO THE EVALUATION OF SERVICES

There were limitations to the evaluation due to the nature of the pathfinder programme. The intention was to assess the impact of the HLP programme and investigate whether the results seen in Portsmouth were replicable in different geographical areas with different health needs. Ideally all the pathfinder areas would have evaluated the same package of services studied in Portsmouth, with a common dataset and common methods of evaluation. However, the practical solution to service evaluation was for individual pathfinder areas to choose which services to evaluate and derive their own methods for data collection and evaluation, then submit the results and evaluation for collation into the report of the programme. This led to a variety of services being evaluated in different areas, with individual datasets and methodologies for evaluating services. An evaluation protocol was provided to all pathfinder areas to mitigate variation. Not all PCTs used the protocol for reporting data back; the most common reason quoted for this was the change being undertaken within the local NHS and Public Health system and lack of resources. This resulted in comparisons having to be made for the same service but with different methodologies for collecting the data, making interpretation of the results difficult. Each service was considered individually and broad measures only of increase in activity and improvement in outcomes, determined locally, could be collated, as shown in Table 7.

It was not known whether activity in HLPs increased at the expense of non-HLPs, or whether total activity increased, due to a 'halo' effect of HLP increasing public awareness and community pharmacy recruitment of patients into services. In areas where 'before' and 'after' measures were collected there was evidence that total activity increased after HLP implementation, for example, the MUR activity in Blackburn with Darwen and East

²² Nice Guidance CG43 Obesity 2006

Lancashire and Stop Smoking quits in a number of areas, although some of the increases were small.

Some pathfinder areas had difficulty accessing data, for example where they could not account for seasonal variation due to the timing of data collection or there had been changes in service specifications or data collection methodologies. The pathfinder programme took place against a background of great change in the NHS, with changes to structures, staffing and systems, and against a background of a difficult economic environment.

Directly comparing figures was difficult as not all pathfinders provided data on the numbers of pharmacies delivering each service. It was also difficult to make direct comparisons because of the different service specifications and data collection methodologies. Caution in interpreting the results is necessary.

Only 3 of 16 pharmacies provided data on the alcohol awareness service in Dudley. Variation between pharmacies was a concern and may need further investigation to understand why.

Six pathfinder areas did not report service evaluations. This was a concern as the pathfinder areas could be expected to be motivated to complete the programme, having put themselves forward for HLP pathfinder status and this was part of the requirement for becoming a pathfinder. Several reported that the impact of changes within the NHS system and delays in fully implementing the HLP concept meant that they could not provide evaluation within the timescales required. Some areas have committed to reporting in due course. All pathfinder areas however, reported on the number of HLPs and Health Champions in their area.

3.5.10 SUMMARY CONCLUSIONS FOR COMMUNITY PHARMACY SERVICES

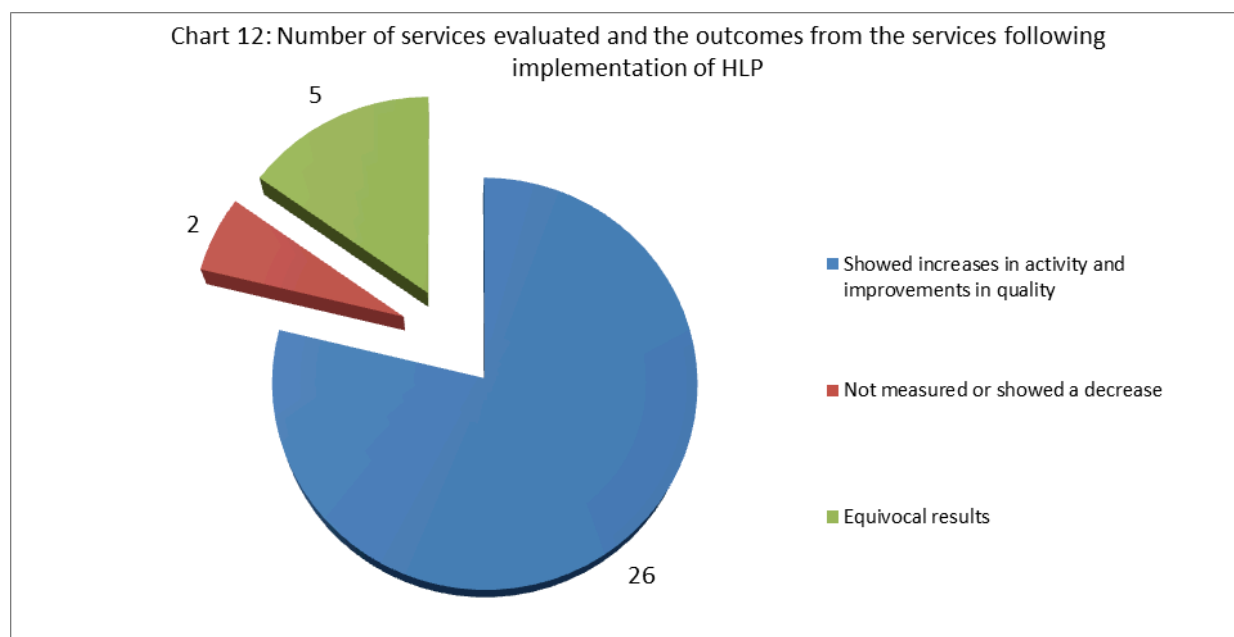
The detailed conclusions for individual services are shown in sections 3.5.1 – 3.5.7 and are summarised below in Table 7. The purpose of the summary is to provide a picture of the overall effect of the HLP programme for a range of services, with differing service specifications and evaluation methodologies, in varied geographical locations with differing health needs.

Table 7: The number of pathfinder areas that saw changes in service delivery in HLPs

<i>Service</i>	<i>Increased activity And improved outcomes (where measured)</i>	<i>No increase in activity or improvement in outcomes</i>	<i>Equivocal results, with no clear effect on activity or outcomes</i>
Stop Smoking 9 areas	7 areas had increased numbers of people setting quit dates 7 areas had increased numbers of people quitting 4 areas had increased quit rates		1 area saw no change in quit rate but total number of quits had increased 2 areas saw lower quit rates but total number of quits had increased 2 areas returned partial data
EHC 6 areas	3 areas saw increased number of consultations 1 area saw the proportion of consultations in community pharmacy increase	1 area was unable to collect evaluation data	1 area saw a reduction in consultations although the total number of consultations was very high
Minor Ailments 3 areas	1 area saw an increase in activity 1 area with service specification change saw increase in proportion delivered by counter staff. Five most active pharmacies were HLPs.		1 area saw similar levels of activity before and after HLP. Evaluation in two pharmacies only 1 area with service specification change between baseline and evaluation so before and after measures were different
Alcohol Awareness 3 areas	3 areas saw increased in activity and a proportion of at risk drinkers accepting advice on safe drinking		
Medicines Optimisation NMS 3 areas	3 areas saw increased numbers of NMS delivered in HLPs		

Service	Increased activity And improved outcomes (where measured)	No increase in activity or improvement in outcomes	Equivocal results, with no clear effect on activity or outcomes
Medicines Optimisation MUR 4 areas	1 area saw increased numbers of MURs after HLP and in HLPs compared with non-HLPs 2 areas saw increased number of MURs and increased quality measures in HLPs	1 area saw decrease in the numbers of MURs after HLP	
Substance Misuse 1 area	1 area had additional public health content within the service specification so no baseline data was available, but activity reported to meet service specification		
Pivotell™ 1 area	1 area saw increased activity and increased public health advice in consultations following HLP		
Weight management	1 area saw acceptability, delivery and of the service		

The table shows the conclusions of service delivery and whether there was evidence of increased activity, whether there was no discernible improvement or deterioration in activity or whether the data gave equivocal results due to difficulties with the evaluation. The column in the table for increases in activity was shaded green to emphasise the number of services, which showed increases in activity (and/or improvement in outcomes where measured). The numbers were summarised in Chart 12 below.



Across the pathfinder areas that returned data, 33 service evaluations were completed for nine services.

Increased activity and/or improvement in outcomes (where measured) were seen for 26 of 33 evaluations across all services.

Nine services, evaluated in different areas with different service specifications, showed increased activity and where measured, improvements in quality outcomes. These were public health services for prevention: smoking, EHC and weight management; and harm reduction: substance misuse and alcohol awareness; and clinical services in support for self-care: minor ailments; and medicines optimisation: Pivotell™, MURs and NMS.

Implementation of HLP led to increased quality requirements in one service that was evaluated: the substance misuse service in Blackburn with Darwen and East Lancashire, showing that commissioners understood the potential for HLPs to deliver added value to services users. Examining the services, which did not show clear increases in activity and improvements in outcomes, showed that there was very little evidence that implementation of HLP harmed service provision. One service could not be evaluated because the reporting mechanism in the PCT changed and data were not collected for the evaluation period. Another service showed a decrease in activity after the implementation of HLP. This was the only evaluation that showed a clear decrease and amongst the other data appeared to be an outlier, which could be investigated.

Five services gave equivocal results, which may be explained or qualified:

- Three areas saw no change or a decrease in smoking quit rate; however, all had seen an increase in the total number of people setting quit dates and the total number of quits
- Two areas' Stop Smoking services could not be fully evaluated as the data were incomplete
- One area saw a 6% decrease in the number of EHC consultations, but the total number of consultations was high at over 3000
- One area evaluated minor ailments in only 2 pharmacies which showed similar activity before and after HLP implementation
- One area experienced a change to the service specification between collecting the baseline and evaluation data, so a direct comparison could not be made. However, the proportion of consultations provided by counter staff was seen to increase in HLPs and the area reported that the top five pharmacies for activity in the minor ailments services were HLPs.

The strength of the improvements seen was notable as, despite the limitations of the evaluation, gains were seen across different services, with different specifications, in geographically varied areas with different levels of health need and deprivation. The service data suggest that the HLP concept is consistent with increased service delivery, improved quality measures and improved quality in delivery of services outcomes (where measured)

4.1 CHAPTER SUMMARY

The separate survey of contractors sought to understand in more detail information about the public health services being delivered in HLPs, including seeking to identify who is involved in the service delivery, to what extent, and what their respective outputs were. This included looking at the time spent to deliver the average service by different HLP staff members. This survey, and subsequent analysis, was undertaken with an objective to inform how effective, and potentially cost-effective, public health service delivery is within HLPs. Limitations around the available data were identified, and have been considered carefully (e.g. see section 4.2.1).

There is evidence to suggest that the full ranges of staff employed in HLPs are engaged in public health service delivery. This is particularly the case for Weight Management and Alcohol Services. Thus, in line with other evidence presented in this evaluation, this indicates that HLPs are effective in engaging, and making use of, all of the skills available in the pharmacy; i.e. the optimal use of skill mix. Health champions, in particular those who are trained to the Royal Society for Public Health standards, are being creative and innovative in reaching out to people who may not have otherwise received any healthy lifestyle advice.

Using additional data available for Stop Smoking services, these services are often delivered without any input of a pharmacist. Self-reported Stop Smoking quit rates are at least as high when other pharmacy staff deliver Stop Smoking services without input from a pharmacist, compared to when a pharmacist is involved in the service delivery.

Stop Smoking services delivered in a community pharmacy setting have been identified as cost-effective in other studies. Some estimates of staff cost per quit derived from evidence gathered in the contractor survey, for both self-reported and Carbon Monoxide (CO) monitored quit rates, are within the national average cost per quit of £220²³. Thus, when making the link to the reported Stop Smoking quit rates in the contractor survey, there is some evidence to support a view that when making the best use of the available skills, and time, of pharmacy staff in HLPs, these services can be delivered by HLPs in an effective and cost-effective manner.

²³ <https://catalogue.ic.nhs.uk/publications/public-health/smoking/nhs-stop-smok-serv-eng-apr-2011-mar-2012/stat-stop-smok-serv-eng-apr-11-mar-12-rep.pdf> - Noting that the methodologies used for “cost per quit” may not be the same.

4.2 BACKGROUND TO THE CONTRACTOR SURVEY

A separate survey was conducted directly with individual contractors that aimed to gather evidence surrounding the nature of service delivery in HLPs. This was intended to determine the potential cost-effectiveness of HLP service delivery.

The final data set contained 107 observations, of which one was blank. This observation was removed from the analysis data set. The level of response varied by question, and, in light of this, the data was carefully analysed to take into account variable levels of response to individual questions. Whilst one needs to be cautious with a small sample size, there was enough data to undertake some general analysis, as well as some more detailed analysis of Stop Smoking services.

4.2.1 WHAT THE SURVEY CAN AND CANNOT TELL US

The data collected provides some useful information on how services such as Stop Smoking, Chlamydia Screening and Weight Management are being delivered in HLPs. This includes information on the mix of staff employed, the number and range of interactions with individuals receiving the service, and the overall time spent delivering services.

Where data permits, one can estimate staff costs for service delivery. This is an important input for any measurement of cost-effectiveness. There is sufficient data to calculate staff costs for four of the services covered in the survey. However, it is not possible at this stage to undertake a full cost-effectiveness analysis, as there is no data on all of the inputs employed in service delivery, and, most importantly, there is no control group to compare HLP performance.

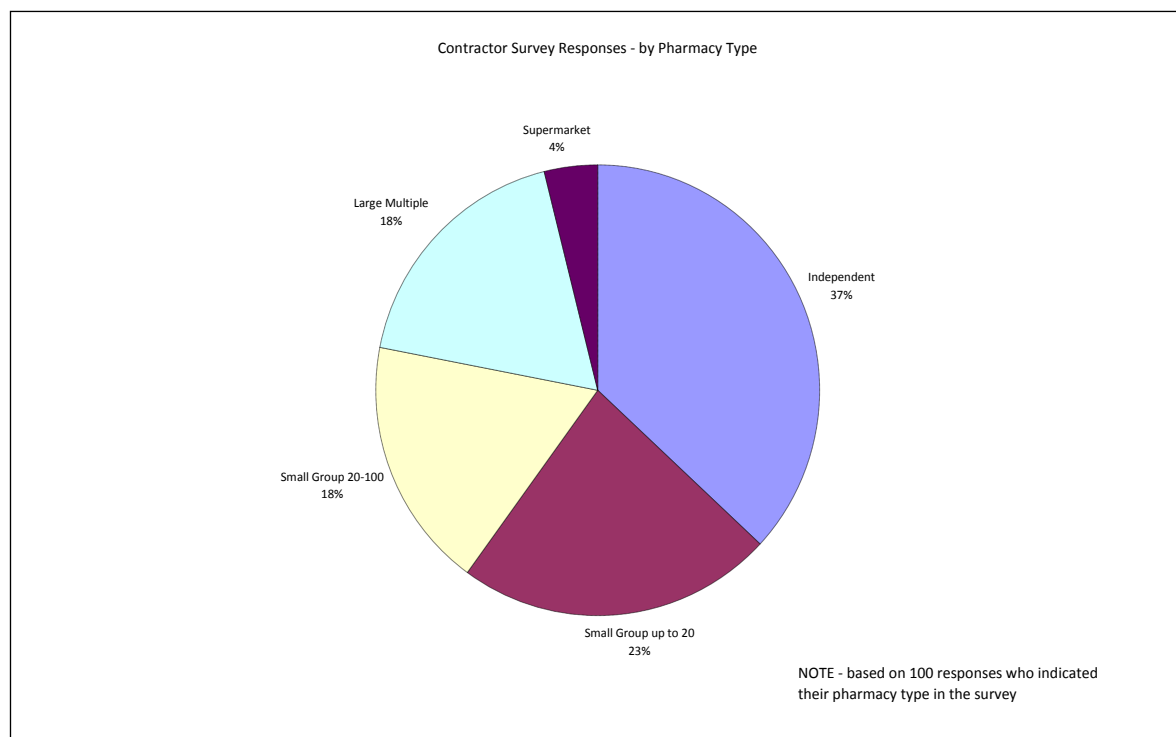
Survey respondents were asked to indicate the date that they became an HLP. In addition, to get a feel for the frequency of service delivery, respondents were asked for the dates covered by their responses to the survey. There would appear to have been a problem with the reporting of dates. Thus, any inference on the frequency of service activity is difficult, as there is no clarity surrounding the periods covered by survey responses.

Yet, despite some evaluation design and reporting limitations, there is some rich data available, which, when combined with the other research, adds further insight to the questions posed for the overall HLP evaluation.

4.2.2 SURVEY RESPONDENTS – PHARMACY TYPE

Just over one-third of the Healthy Living Pharmacies (HLPs) contractor survey respondents were Independents; just under a quarter were small multiples with up to 20 branches; around one-fifth were small multiples with between 20 and 100 branches; another one-fifth were large multiples, and just under five per cent were Supermarkets²⁴.

Chart 13: Survey respondents by pharmacy type



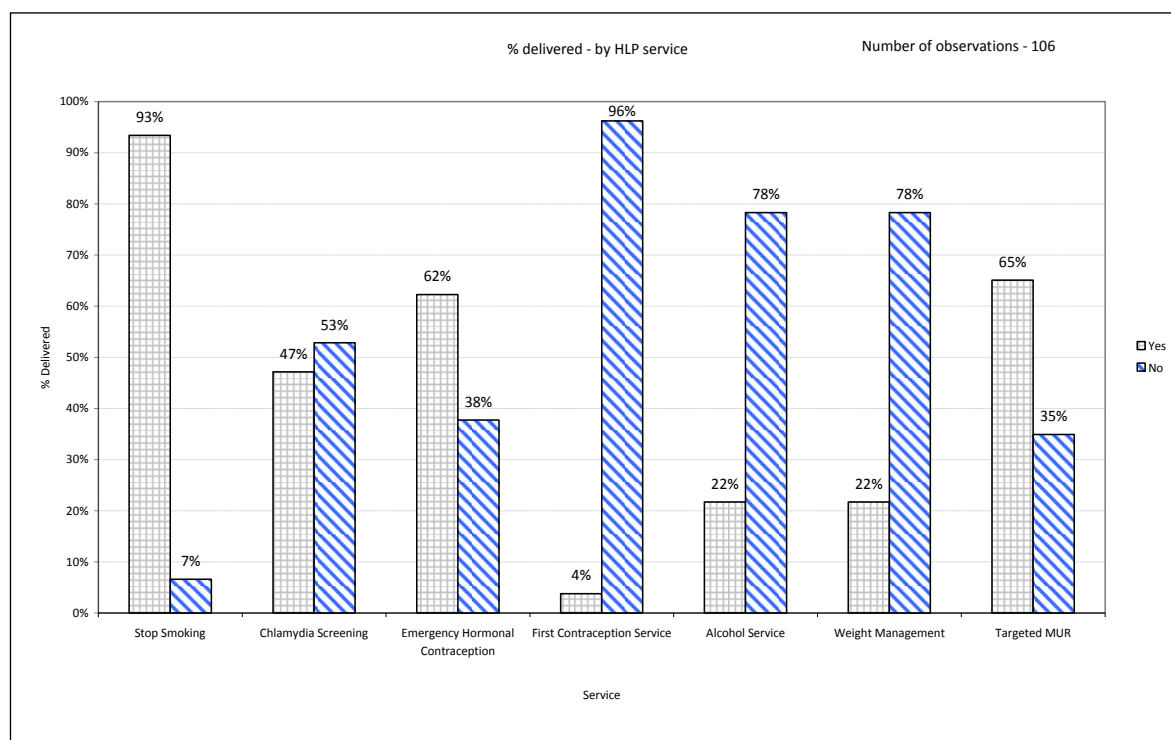
4.3 SERVICES DELIVERED

Most HLPs deliver a Stop Smoking service (99 of 106 responses - 93 per cent) – see Chart 14, below. Around half of the pharmacies in the sample delivered a Chlamydia Screening service. Just less than two-thirds deliver an Emergency Hormonal Contraception (EHC) service, but only four per cent were delivering a First Contraception Service. Just over one-fifth of the pharmacies in the sample were delivering Alcohol and Weight Management services. Finally, two-thirds of the pharmacies in the sample were delivering Targeted Medicine Use Reviews (tMURs)²⁵.

²⁴ If the distribution of contractor survey respondents, in respect of pharmacy type, do not match the distribution of HLPs by pharmacy type across pathfinders, then the data will be naturally biased towards the groups over sampled in the survey.

²⁵ Very little data was collected for Targeted MURs, and this is reflected in the analysis below.

Chart 14: Service delivery in HLPs



4.3.1 STAFF INVOLVEMENT IN SERVICE DELIVERY

The survey asked which staff members were involved in service delivery, before asking the proportion of input made to the service by a specific staff member.

In respect of who was involved in service delivery, pharmacists were reported to be involved in Stop Smoking service delivery in 62 per cent of the pharmacies delivering the service (see Chart 15, below)²⁶. Pharmacy technicians were involved in 52 per cent of the pharmacies, and Dispensing Assistants were involved in 57 per cent. Pharmacy team members, such as pre-registration trainees, counters assistants, or Accuracy Checking Technicians²⁷, were involved in Stop Smoking service delivery in 13 per cent of the pharmacies.

For Chlamydia Screening, in most cases (92 per cent of all pharmacies who delivered the service), the pharmacist delivered part, or all of, the service²⁸. Pharmacy Technicians and

²⁶ Whilst precise figures are presented here, it is worth thinking of the general findings in approximate terms. For example, pharmacists were involved in Stop Smoking service delivery in around six in ten pharmacies.

²⁷ The mix of other staff was identified through an open-ended question (for each relevant service), where a pharmacy used staff other than the pharmacist, pharmacy technicians and pharmacy assistants in the delivery of a service.

²⁸ Although there may be issues with reporting accuracy in the survey, which may suggest that this figure should in fact be 100 per cent.

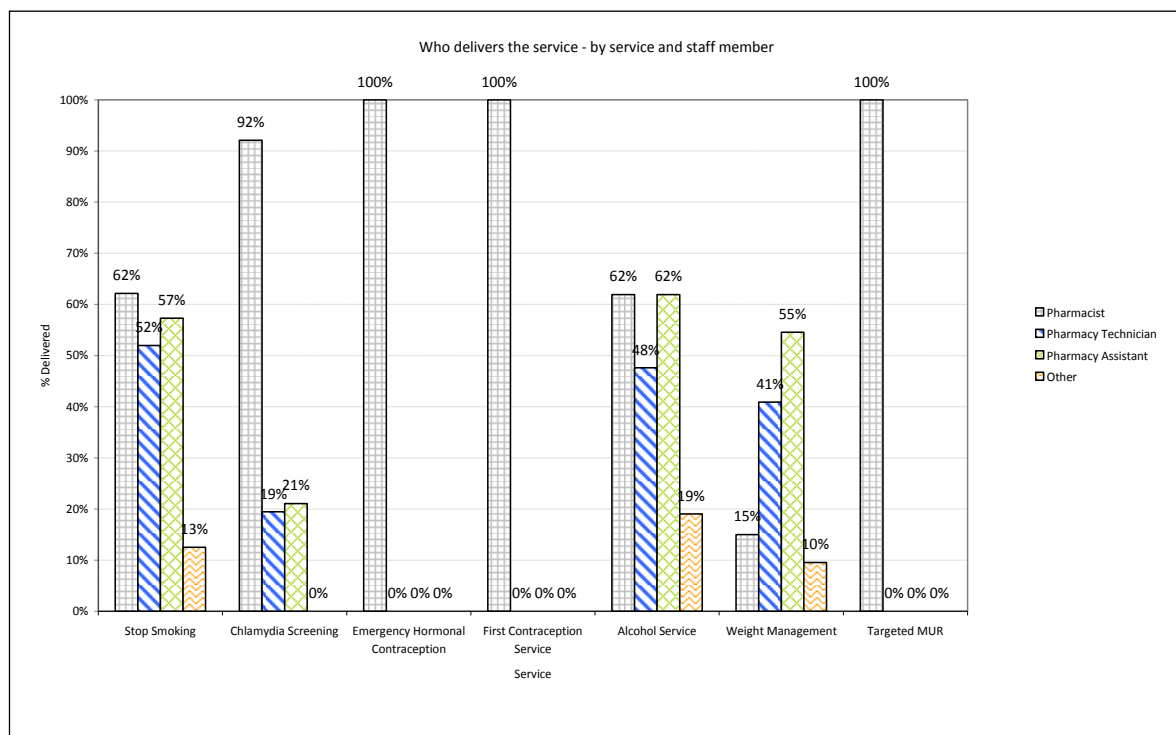
Dispensing Assistants are also involved in the service delivery, in around one-fifth of the pharmacies delivering the service.

The survey did not ask for the same level of detail around staff input for EHC, First Contraception, and Targeted MURs, as it was assumed that in most cases the pharmacist would be the main staff member delivering the service. Other staff members could support the pharmacist, but this was not collected – hence Chart 15 reports 100 per cent pharmacist input for each of these services.

In pharmacies where the Alcohol Service is delivered, two-thirds of pharmacies have pharmacist and pharmacy assistant involvement, and around half of the pharmacies have a pharmacy technician involved in the service delivery. Around one-fifth of pharmacies make use of “other” staff, including dispensers and pre-registration students.

Finally, for pharmacies that deliver a Weight Management service, pharmacists help to deliver the service in only fifteen per cent of the pharmacies, around forty per cent use pharmacy technicians, just over half use pharmacy assistants, and ten per cent use “other” staff, reported as including Health Champions.

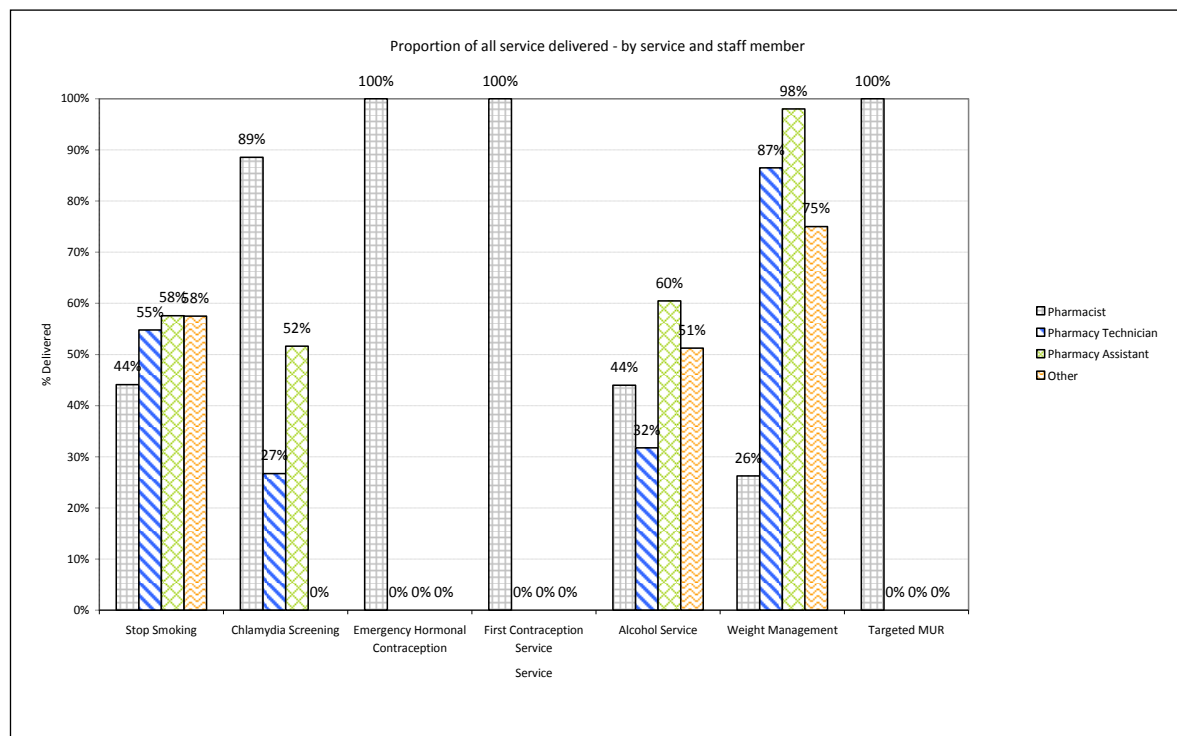
Chart 15: Staff mix in the delivery of HLP services



4.3.2 PROPORTION OF SERVICE DELIVERY BY STAFF MEMBER

Then, based upon the staff mix reported by survey respondents, the survey asked: “What percentage has been undertaken by the respective staff members that you highlighted above?” Here, it may be the case that staff work together at times to deliver a service, which when reported in a survey of this type, could lead to a sum of inputs greater than 100 per cent. In the survey, most responses did add to 100 per cent, however, some responses did indicate figures above 100 per cent. Chart 16, below, shows the mean percentage, by staff member for each service.

Chart 16: Proportion of HLP service delivered by different members of staff



Where a pharmacist is involved in a Stop Smoking service delivery, they contribute to 44 per cent of the service, on average. The other members of the pharmacy team deliver more of the Stop Smoking service, on average, at around sixty per cent of the total service.

In respect of Chlamydia Screening, the pharmacist delivers around 90 per cent of the service on average, and, when involved in the service delivery, a pharmacy technician contributes around one-quarter of the service on average, and pharmacy assistants around one-half of the service on average.

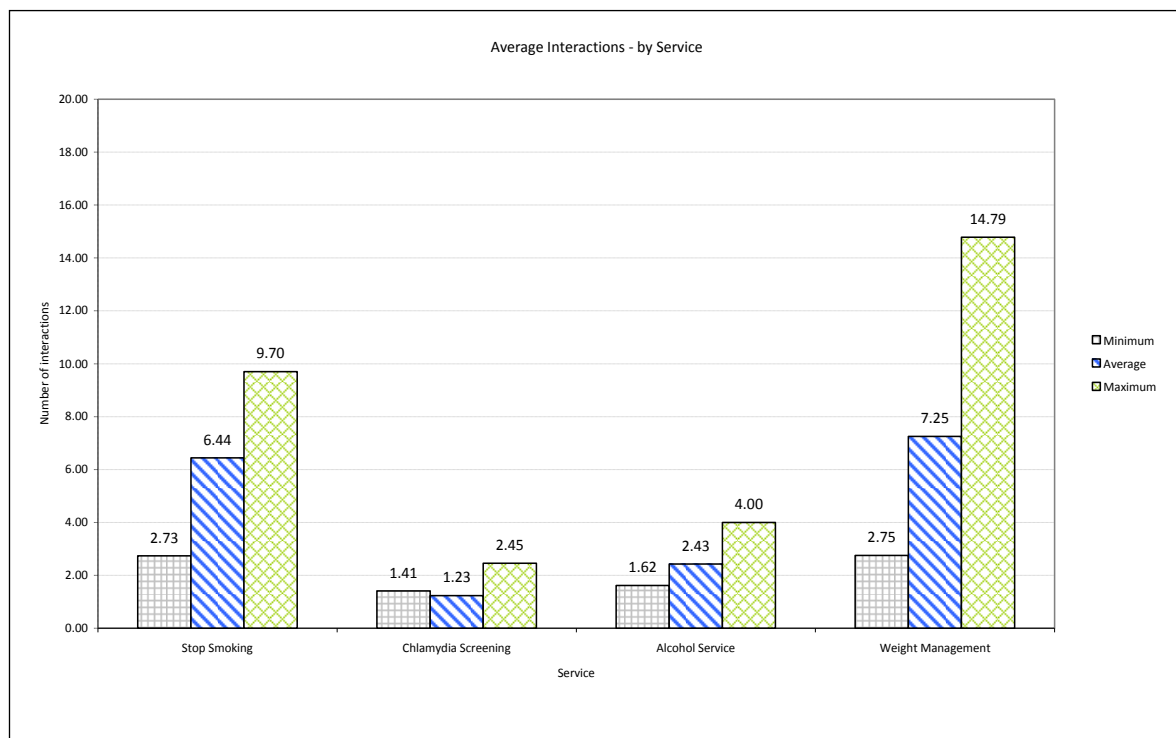
Pharmacy assistants delivered the biggest component of Alcohol Services, with an average of 60 per cent of the service, followed by other staff (51 per cent), pharmacists (44 per cent), and pharmacy technicians (32 per cent of the service).

In contrast, for Weight Management services, one individual typically delivers this service, and this tends to be either a pharmacy technician or a pharmacy assistant²⁹. As per Chart 15, it is assumed that the pharmacist solely delivers EHC, First Contraception and Targeted MURs, but it could be the case that other members of the pharmacy team are involved in service delivery; however, the survey did not ask a specific question to determine this.

4.4 ANALYSIS OF ACTIVITY WHEN DELIVERING SERVICES

The next phase of the analysis looks at how much time is spent in delivering the services, for services where there could be more than one interaction with a person in receipt of the service. This involved collecting data on the average, minimum and maximum number of interactions with a person receiving a service, as well as data on the time spent during the average interaction completed³⁰. The survey collected this data for the Stop Smoking, Chlamydia Screening, Alcohol and Weight Management services.

Chart 17: Average, minimum and maximum interactions per HLP service



²⁹ The graph may be slightly misleading in this context, as when averaging out, the percentages reported naturally dip below 100 per cent as a consequence of a small number of observations where more than one staff member delivers the Weight Management service. There is also an issue around very small numbers in the sample, both from a statistically representative perspective, but also in interpreting the 75 per cent contribution of other staff – this figure relates to only 10 per cent of all pharmacies who deliver this service (i.e. there are 23 overall).

³⁰ Implicitly this is a self-reported indicator.

The average Stop Smoking service is reported to last six (6.44) interactions, the (mean) minimum³¹ number of interactions was three, and the (mean) maximum number of interactions was ten. The average, minimum, and maximum number of interactions for Chlamydia Screening was lower (see chart 17, above), with one interaction on average, and two interactions as a maximum (although in some cases there were more than two interactions, hence the average of 2.45). On average, an Alcohol Service involved two interactions (when rounded down from 2.48), with a (mean) maximum of four interactions. Weight management services were reported to involve more interactions than the other services, with a (mean) minimum of three interactions, an average of seven interactions³², and a (mean) maximum of fifteen interactions with a person receiving the service.

Survey respondents were then asked, in respect of the average service interaction reported for a service, to report the average time spent per interaction.

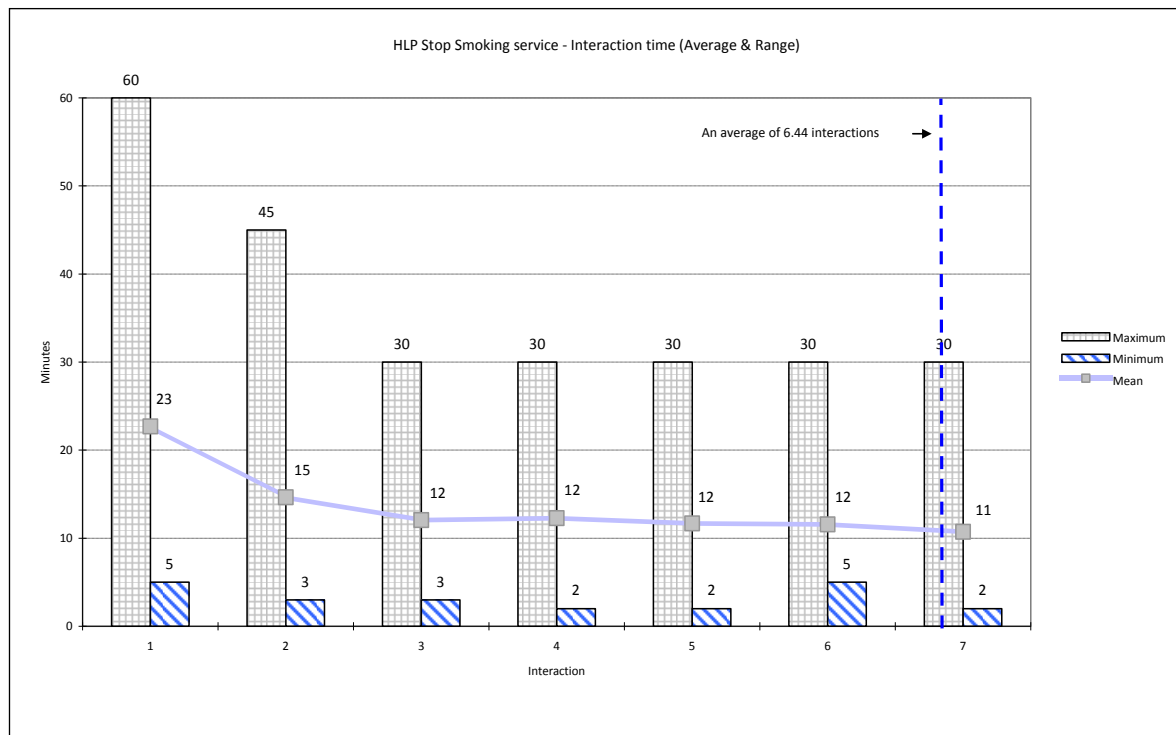
³¹ Put another way, the survey asked each respondent for the minimum number of interactions they have made when delivering a service. This is the mean value of all the minimums reported.

³² This finding may be intuitive in light of the finding during the wider pathfinder evaluation that these services are typically offered in blocks of 12 sessions, and around forty per cent of those engaged in the service complete all twelve sessions.

4.4.1 INTERACTION TIME – STOP SMOKING SERVICE

For the Stop Smoking service, an average of 23 minutes was spent with a person during a first interaction [range: 5 – 60 minutes] – see chart 18, below. The average time fell slightly to fifteen minutes during the second interaction [range: 3 – 45 minutes], and then converged to just over ten minutes for the remaining interactions [range: 2-3 minutes – 30 minutes].

Chart 18: Stop Smoking service interaction time, average and range

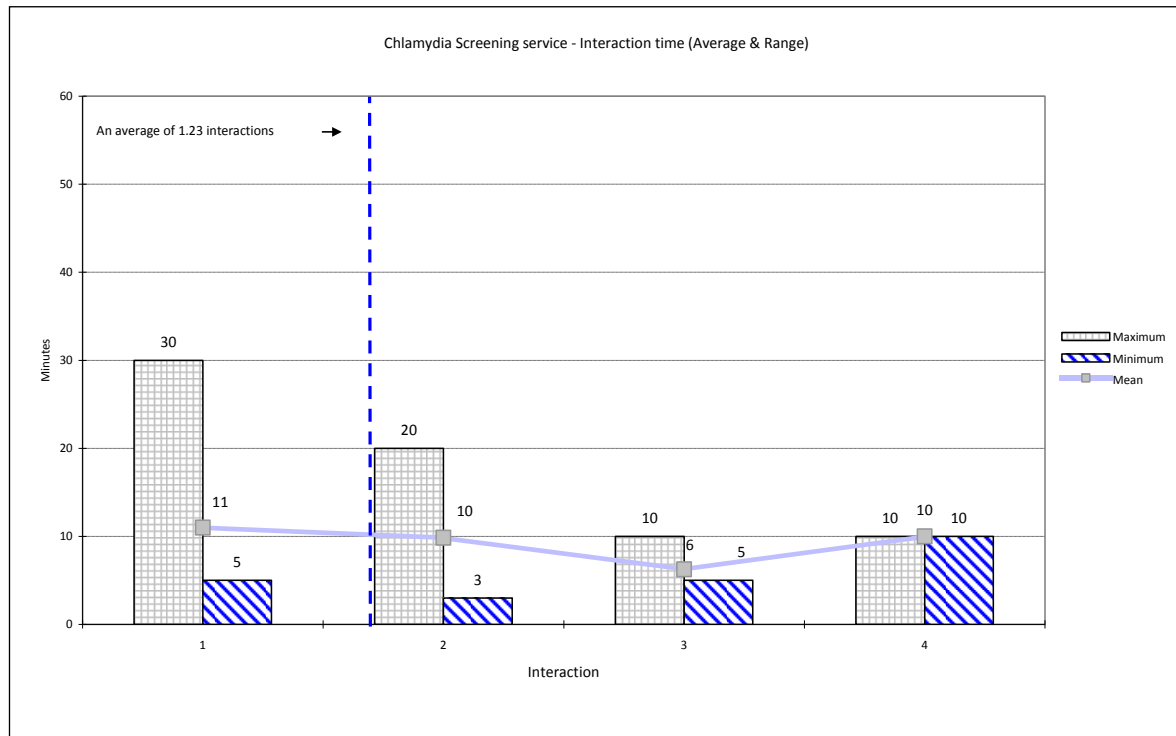


Bringing this information together, one can calculate the total time spent per (average) interaction. This is calculated to be $(23+15+12+12+12+12+ (11*0.44)) =$ **89 minutes** in total.

4.4.2 INTERACTION TIME – STOP SMOKING SERVICE

HLP staff spent an average of eleven minutes during the first Chlamydia Screening interaction [range: 5 – 30 minutes] – see chart 19, below. Where there was a second interaction, this took ten minutes on average [range: 3 – 20 minutes].

Chart 19: Chlamydia screening service interaction time, average and range

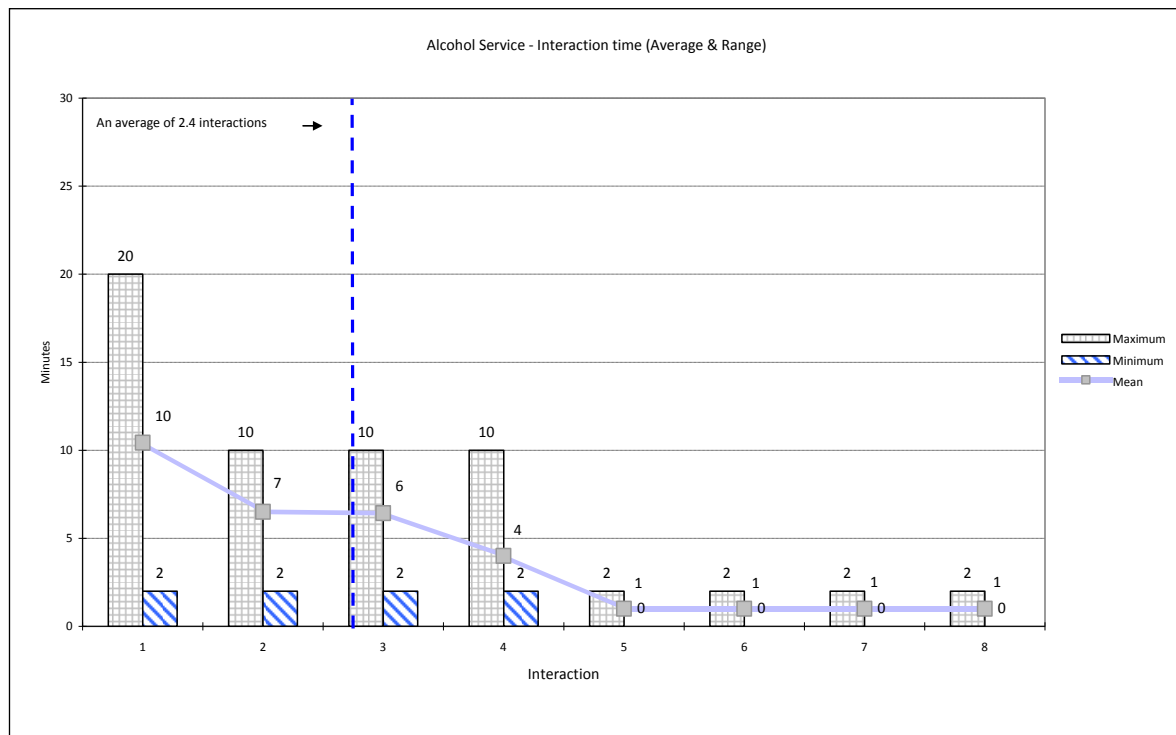


Applying the same approach as the Stop Smoking service to quantify the total time spent delivering an average Chlamydia Screening service, this works out as: $(11 + (10 \times 0.23)) = 13$ **minutes** in total.

4.4.3 INTERACTION TIME – ALCOHOL SERVICE

For the Alcohol Service, HLP staff took ten minutes on average for the first interaction. The second and third interactions took seven and six minutes respectively. The time taken for interactions ranges between two and twenty minutes, but only up to ten minutes for follow-up interactions, see chart 20 below.

Chart 20: Alcohol Service interaction time

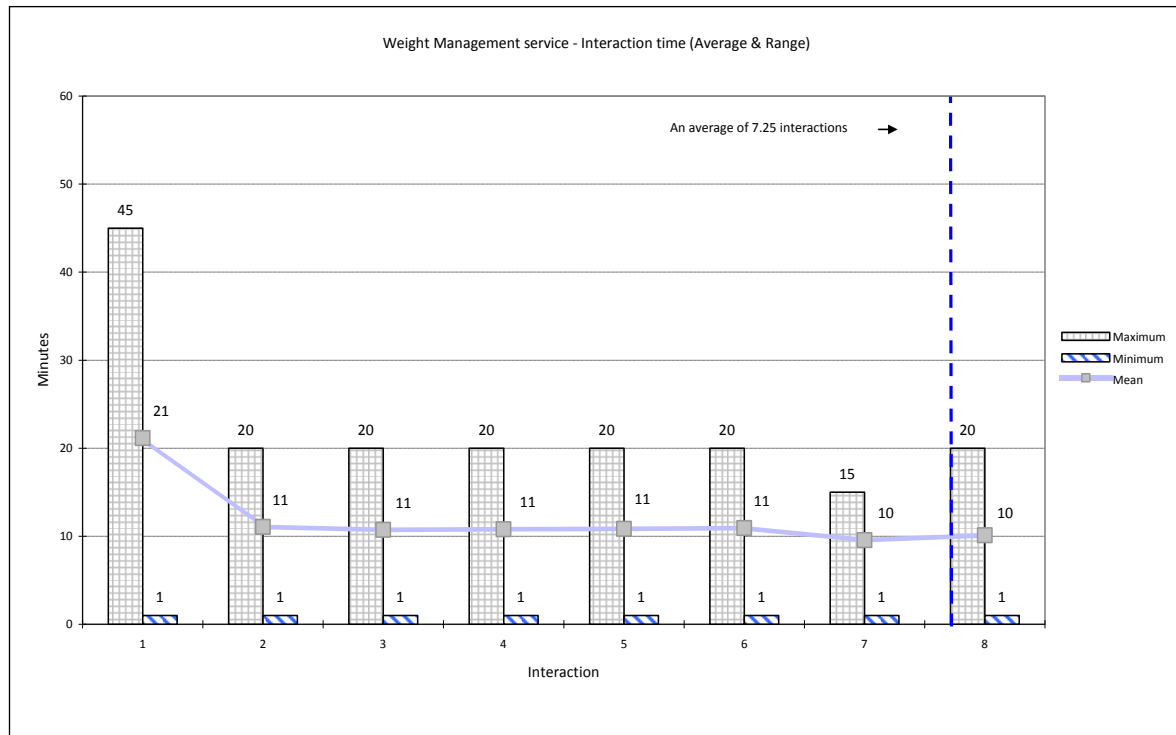


The average Alcohol Service takes $(10 + 7 + (6 \times 0.43)) = 20$ minutes in total.

4.4.4 INTERACTION TIME – WEIGHT MANAGEMENT SERVICE

The Weight Management service has the highest number of interactions of the services analysed. On average, the first interaction takes around twenty minutes, falling to ten minutes for follow-up interactions. The range of time taken for the first interaction was between one and forty-five minutes, and ranged between one and twenty minutes for follow-up interactions, see chart 21, below.

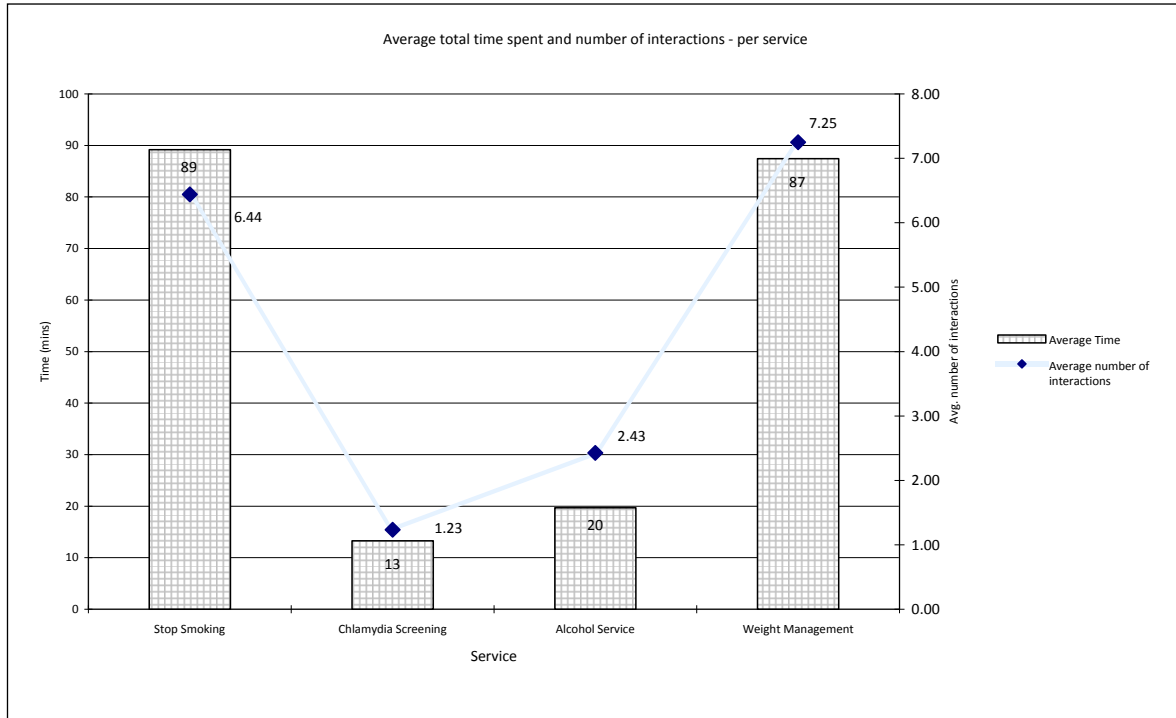
Chart 21: Weight Management interaction time



The average Weight Management service is reported to take $(21 + 11 + 11 + 11 + 11 + 11 + 10 + (10 \times 0.25)) = 87$ minutes in total.

A summary picture across services, covering both the average number of interactions and the total time spent delivering the service, is summarised in chart 22, below.

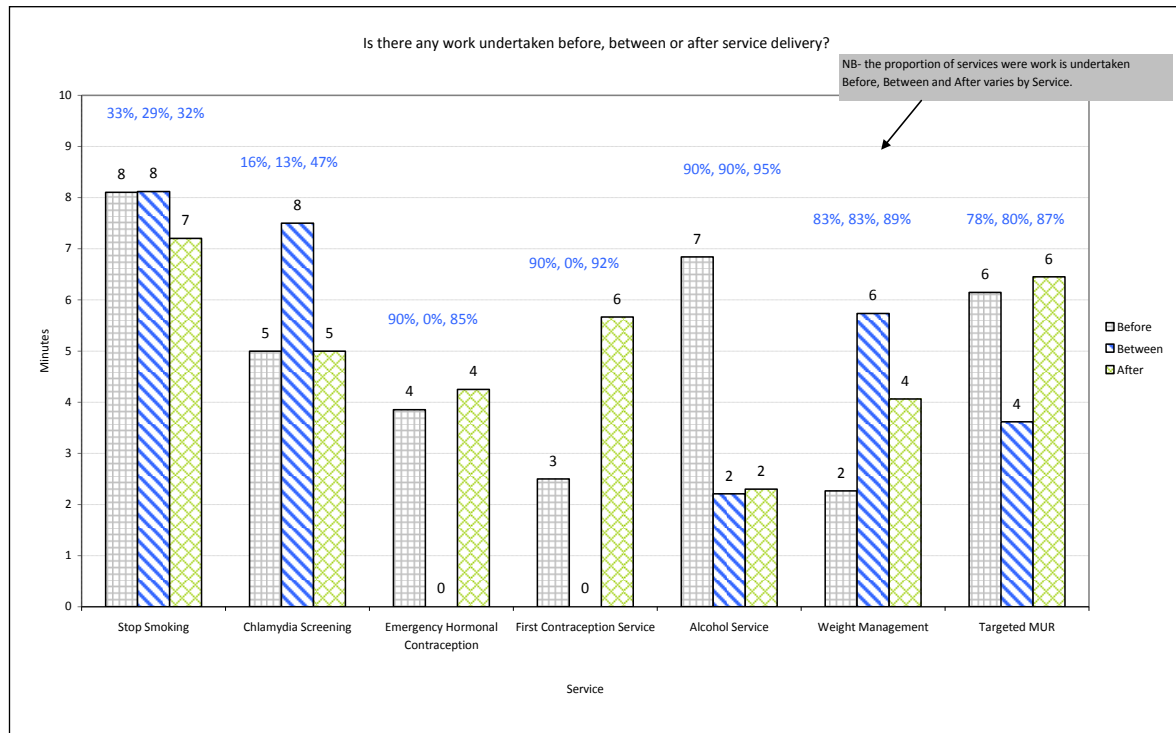
Chart 22: Average total time spent, and average number of interactions by HLP service



4.4.5 INTERACTION TIME – TIME SPENT, BEFORE, BETWEEN AND AFTER SERVICE DELIVERY

In addition, survey respondents were asked whether they needed to do any background work before, between and/or after the full service episode with an individual. This collected information for all services, not just the four services analysed above – see chart 23, below.

Chart 23: Work undertaken before, between and after an HLP service interaction



Despite the comparability in the actual time spent before, between and after a service interaction undertaking some work, the likelihood of doing so varied quite markedly across services (please refer to the percentage figures above the bar graphs in chart 23, above). The survey responses showed that staff were less likely to undertake work before, between or after a Stop Smoking or Chlamydia Screening service, relative to the other services. Where work was undertaken, it ranged between two and eight minutes effort, with an average of around five minutes taken.

4.5 SERVICE DELIVERY COST ANALYSIS

The survey provides some evidence surrounding the range of services being delivered in HLPs, and the way in which HLP staff members are involved in service delivery. This has been broken down into minutes of activity to deliver an overall service. As a further step, one can piece together information to estimate the likely staff costs associated with HLP service delivery.

Salary data has been gathered from the recent pharmacy Cost of Service Inquiry (COSI)³³. This has been converted into a staff cost per minute, to calculate the cost of service delivery, based upon the average service (see table 8, below).

Table 8: Updated salary, on cost, and the calculated cost per minute, by staff member

	Adjusted Salary (12/13)	On Cost	Cost Per Minute
Pharmacist	£49,712	£14,914	£0.68
Pharmacy Technician	£15,770	£4,731	£0.22
Dispensing Assistant	£14,631	£4,389	£0.20
Other	£18,440	£5,532	£0.25

NB – the on cost is assumed to be 30 per cent of the salary level. The cost per minute is calculated based on a 220-day working year, and a 36-hour working week.

Other sector evidence, for example the Chemist and Druggist salary survey, show that pharmacy salaries can vary by not only job type, but also type of business, experience and level of qualifications. For example, pharmacy technician salaries can be well in excess of £20,000 per annum; likewise pharmacy assistant salaries. As is intuitive, relative to the figures presented in Table 8, a staff member on a higher (lower) salary and on cost contribution would have a higher (lower) cost per minute. As an example, using the same methodology, a pharmacy staff member with a salary of £25,000 would have a staff cost per minute of £0.34. This staff cost per minute would be £0.27 for a staff member on a salary of £20,000. For the basis of the analysis below, the data presented in table 8 above is used, but one can easily develop some sensitivity analysis around the findings presented below, in light of the natural variation in salary levels.

With some data available on staff costs, converted into costs per minute, one can look at the variation in service delivery staff cost using some actual examples from the survey responses. The four services where the survey collected additional data are considered in turn.

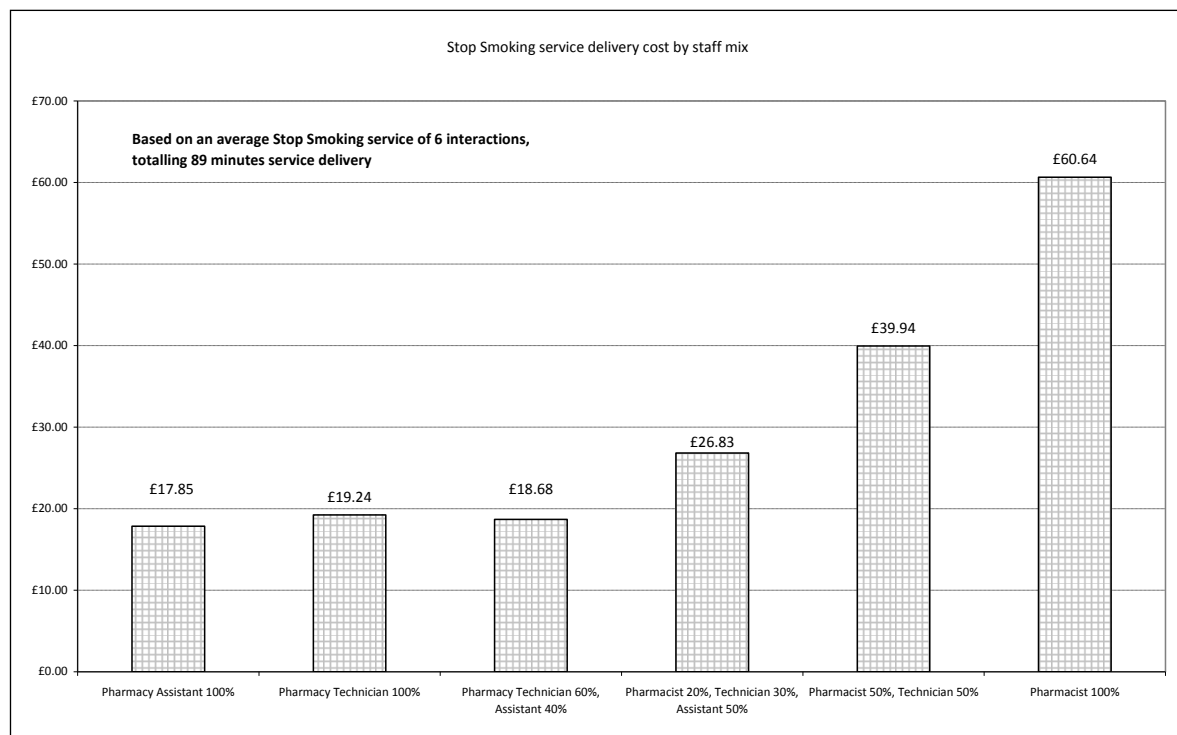
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http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Healthcare/Primarycare/Communitypharmacy/Communitypharmacycontractualframework/DH_128128 COSI data relates to the financial year 2009/10, and the data used can be found in Appendix K (for pharmacy technician and pharmacy assistants), and Appendix N for pharmacists. The figures presented reflect a sub-set of the entire sector, so do not necessarily reflect the sector average. The staff cost per minute for “other” staff are based on the amount paid by the NHS as a training grant for pre-registration students - £18,440. In practice, this salary will vary across community pharmacy businesses. These figures have been updated using the Average Weekly Earnings Index (percentage year on year change) to 2012/13 terms.

4.5.1 SERVICE DELIVERY STAFF COST – STOP SMOKING

For Stop Smoking services, survey responses included situations where the pharmacist, pharmacy technician, and pharmacy assistant delivered the service alone. In some situations, pharmacists, pharmacy technicians and pharmacy assistants worked together to deliver the service, as well as pharmacy technicians and pharmacy assistants collectively without the support of a pharmacist. The results show that when a pharmacist delivers the average Stop Smoking service (of 89 minutes) alone, it incurs a staff cost three times as high as when a pharmacy technician or assistant deliver the service alone, or together³⁴. Depending on the staff mix employed, the range of staff cost for an average Stop Smoking service was calculated to range between £18 and £61, see chart 24³⁵.

Chart 24: Range of staff delivery costs -> Stop Smoking service



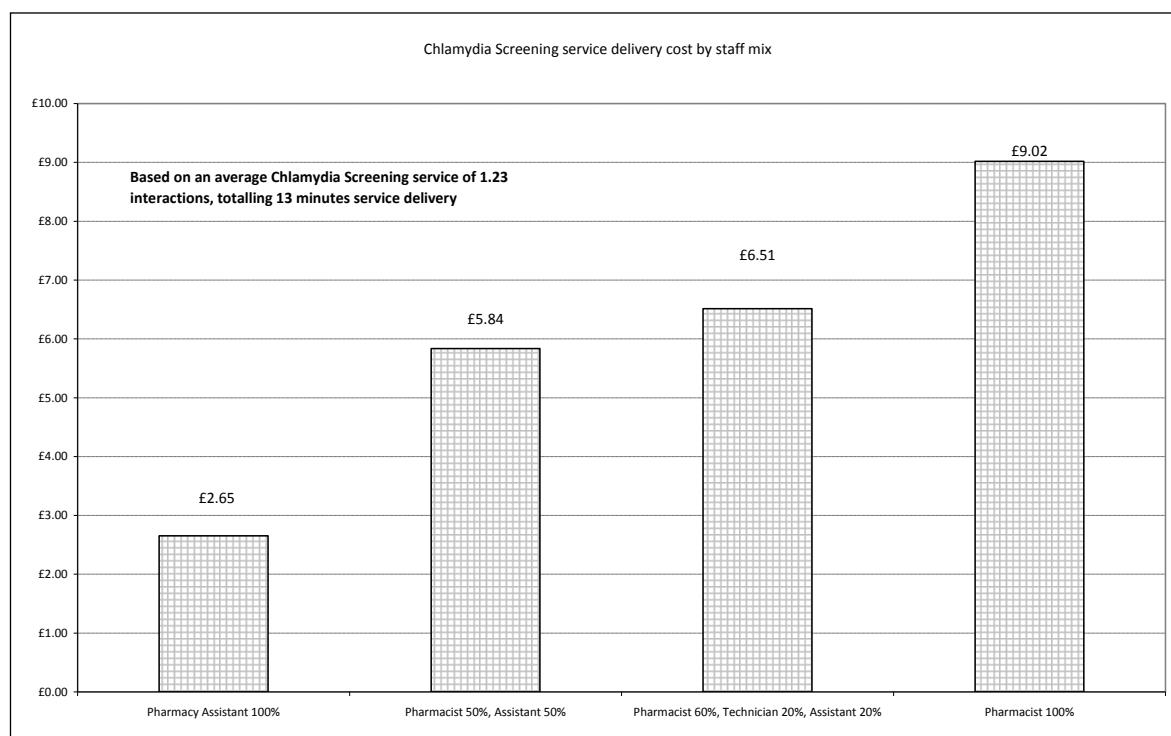
³⁴ These calculations do not include the staff cost of work undertaken before, between, and after.

³⁵ As above, these results could be higher or lower, depending on an individual's salary level relative to the figures used in the analysis.

4.5.2 SERVICE DELIVERY STAFF COST – CHLAMYDIA SCREENING

The Chlamydia Screening service is estimated to take less time than an average Stop Smoking service - thirteen minutes compared to eighty-nine minutes - and this is reflected in staff delivery costs. However, it is worth noting that a pharmacist is more likely to deliver all, or the majority of this Chlamydia Screening service, relative to Stop Smoking (and other services). Therefore, the upper bound of the cost range (approximately £9 per average service of thirteen minutes) is more likely to be borne in practice, see chart 25, below. A small number of responses reported that pharmacy assistants deliver 100 per cent of the Chlamydia Screening service. In this case, the staff cost of service delivery would be in the region of £3.

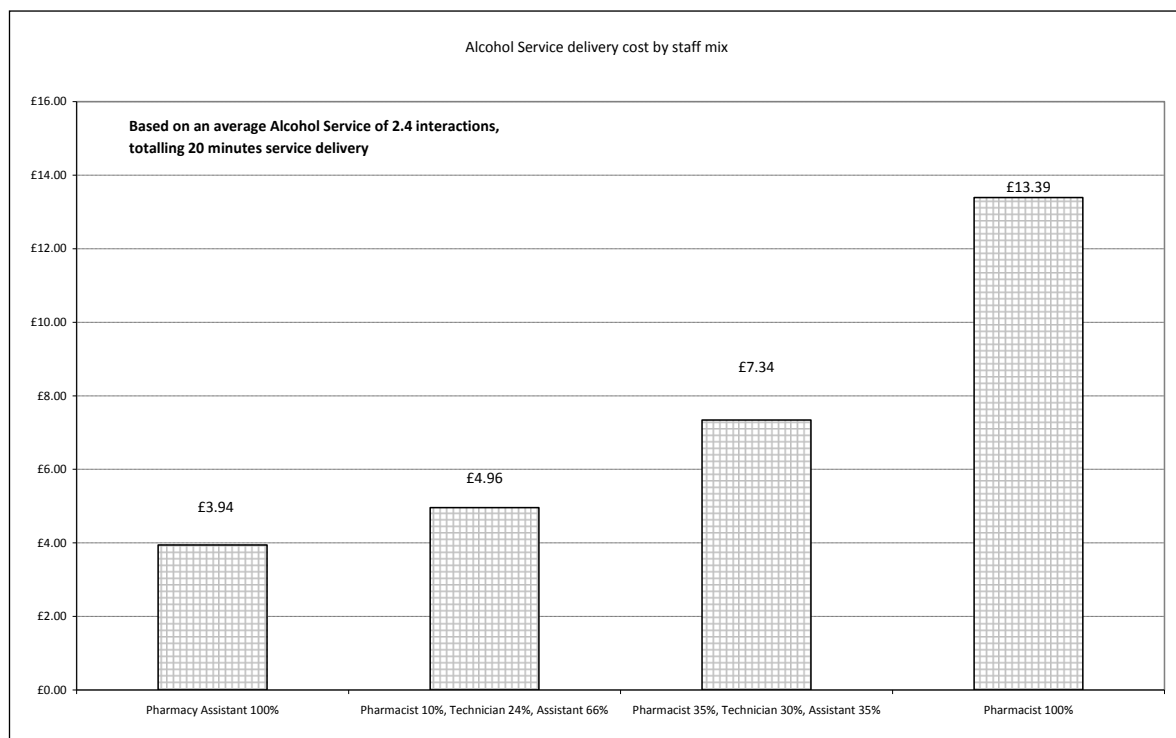
Chart 25: Range of staff delivery costs -> Chlamydia Screening service



4.5.3 SERVICE DELIVERY STAFF COST – ALCOHOL SERVICE

For the Alcohol Service, there is some evidence of service delivery by the full range of pharmacy staff. The data suggest that this is more likely to be the pharmacy assistant than a pharmacy technician. Furthermore, the pharmacy assistant is reported to deliver the majority of an Alcohol Service compared to a pharmacist. The average Alcohol Service takes twenty minutes in total and with a different mix of staff produces a cost range of between £4 and £13. However, in light of the frequent involvement of non-pharmacist staff, the typical staff cost will be closer to the lower end of the cost range presented in chart 26, below.

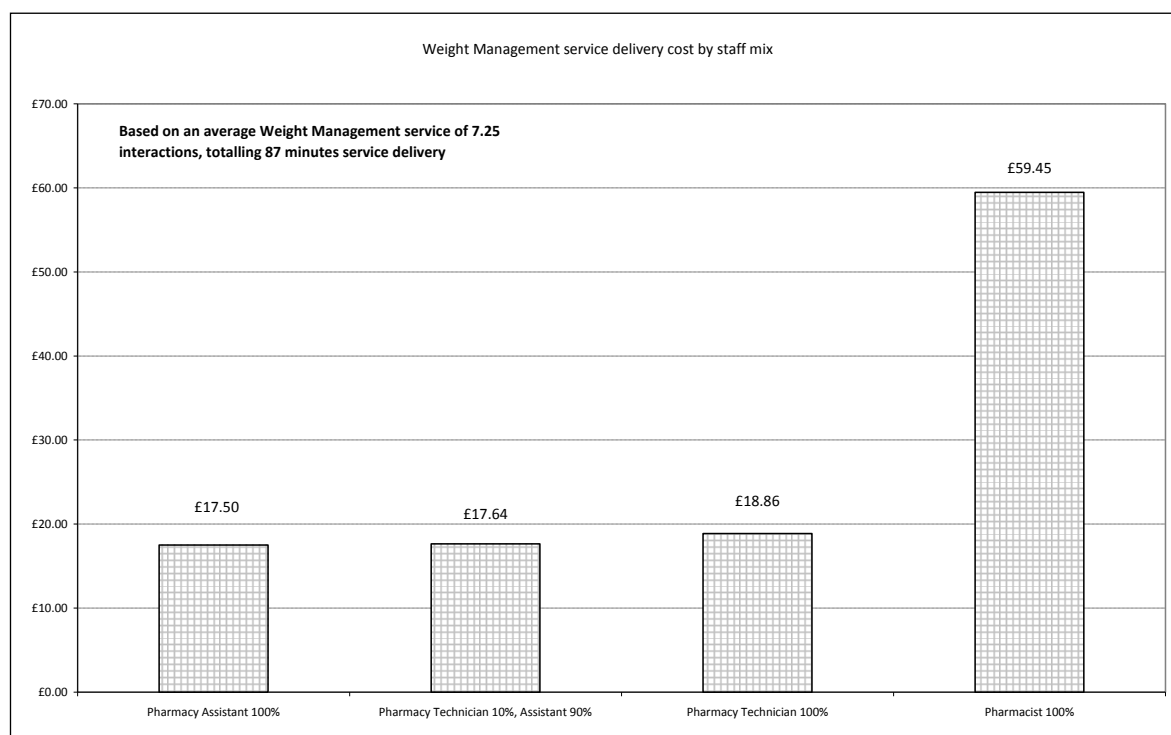
Chart 26: Range of staff delivery costs -> Alcohol Service



4.5.4 SERVICE DELIVERY STAFF COST – WEIGHT MANAGEMENT

The Weight Management service typically lasts the same amount of time as a Stop Smoking service, and requires one more interaction (on average) overall. As discussed above, the pharmacy technician and pharmacy assistant are far more likely to deliver the majority, if not all, of the Weight Management service without little or no input of a pharmacist³⁶, see chart 27, below.

Chart 27: Range of staff delivery costs -> Weight Management service



As with the Stop Smoking service, there is potentially a large difference in the staff cost associated with service delivery, as these services involve many interventions, and around ninety minutes direct input per service. However, in light of the evidence available, a Weight Management service will typically have a staff cost in the region of £20.

³⁶ As per an earlier point, there are very small numbers of observations for this service, however, this finding appears to be conclusive in the small numbers.

4.6 FURTHER EVIDENCE BY HLP SERVICE – WHAT CAN BE SAID ABOUT COST-EFFECTIVENESS?

The survey asked some service specific questions, which were intended to add further colour to the analysis of HLP activity. Clearly, consideration of the cost-effectiveness of HLP service delivery is viewed as important. Based on the breadth and depth of data reported in the survey, the Stop Smoking service offers the potential for deeper analysis.

4.6.1 STOP SMOKING – SERVICE CONTEXT

Academic evidence³⁷ shows that Stop Smoking services are cost-effective. A study commissioned by NICE through the York Health Economics Consortium looked at “the cost-effectiveness of smoking cessation interventions delivered in the workplace, by the NHS and by the mass media.” The study covered a range of delivery settings including through GPs, self-help, clinic visits, and pharmacist consultations (where those undertaking a service were given Nicotine Replacement Therapy for five weeks, as well as five pharmacist consultations). In summary, pharmacist interventions were shown to be cost-effective, relative to no intervention or the provision of brief advice. In addition, Godfrey et al (2005) undertook a survey, collecting evidence on survey data, service configuration, staffing mix, the interventions delivered and development. The authors found that “...smoking cessation services provide a worthwhile investment for health providers compared to many other health-care interventions. Although services’ configurations have been found to vary widely, these differences were not found to be a major influence on the variations in economic performance between services.”

A lack of data (e.g. a non-HLP control group, and further detail on the service inputs) inhibits the ability to undertake a full cost-effectiveness analysis of HLP Stop Smoking services delivered. However, one can make use of a key indicator collected in the survey, the four-week “Quit Rate”, as well as the information provided on staffing mix, the average number of interventions to analyse the staff costs involved; as well as the distribution of staff costs, in the HLP Stop Smoking service delivery. The reported quit rate is assumed a self-reported quit rate. This was defined in the survey questionnaire as the number who quit at 4 weeks/ the total number recruited into the service.

³⁷ For example, 1) NICE - Cost-Effectiveness of Interventions for Smoking Cessation, York Health Economic Consortium, Final Report, January 2007:

<http://www.nice.org.uk/nicemedia/pdf/WorkplaceInterventionsPromoteSmokingCessationEconomicReport1.pdf>, and

2) The cost-effectiveness of the English smoking treatment services: evidence from practice, Godfrey et al, 2005:

<http://onlinelibrary.wiley.com/doi/10.1111/j.1360-0443.2005.01071.x/pdf>

In addition, the survey asked for:

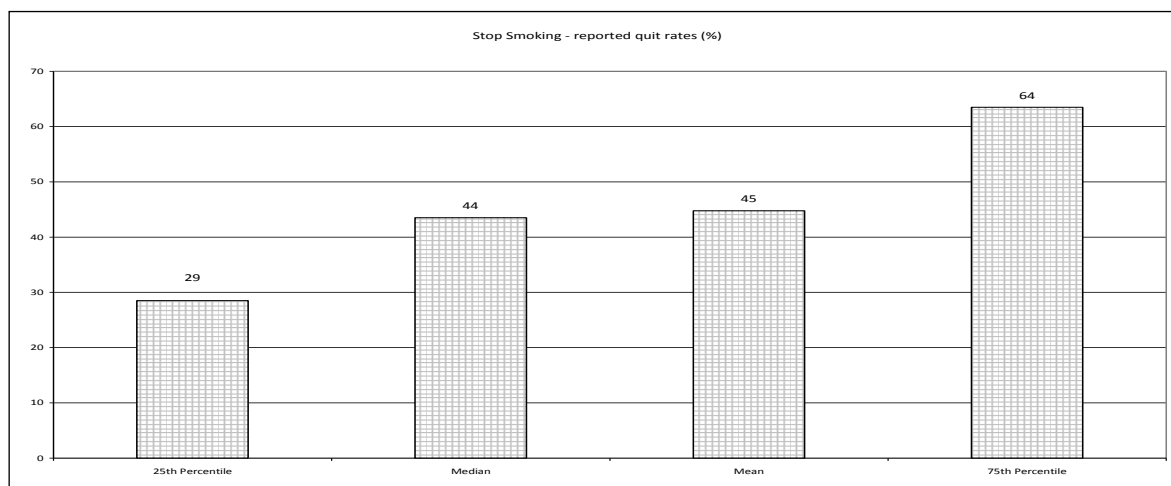
- The numbers of individuals recruited into the service³⁸
- The number of individuals who had tried to quit at least once before
- The number of quitters who had their four-week quit confirmed using a carbon monoxide (CO) monitor, and
- The number of people who failed to quit, but had reduced smoking.

The reported numbers offer some opportunity to calculate quit rates (i.e. number of quitters confirmed by CO monitor/number of recruits)³⁹.

The mean quit rate⁴⁰ in the sample was 45 per cent, with a median of 44 per cent. The national average quit rate, reported by the NHS Information Centre (for 2010/11) was 49 per cent⁴¹. Despite the mean quit rate being slightly lower than the national average, the small sample size (56 responses) may indicate that there is no statistical difference between the numbers. Thus, it would be reasonable to assume that the average HLP is reported quit rate is comparable to the national average Stop Smoking quit rate.

At the 25th percentile, the quit rate was 29 per cent, and at the 75th percentile the quit rate was 64 per cent. The maximum quit rate was 79 per cent in the sample (see chart 28, below).

Chart 28: Range of reported quit rates – Stop Smoking service



³⁸ Problems in interpreting the period covered in the survey responses, by dates entered at the beginning of the survey, have restricted the analysis of activity. However, the wider pathfinder evaluation provides some insight on recruitment levels.

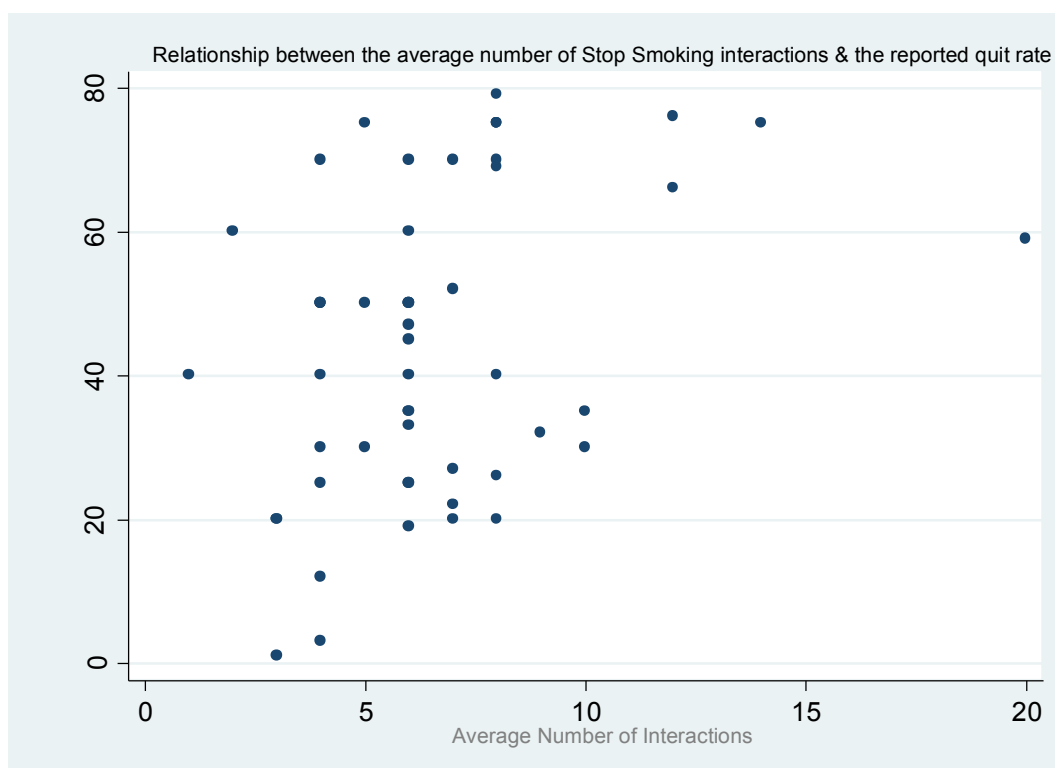
³⁹ Once more flagging the potential issue around the recording of dates in the survey responses.

⁴⁰ Survey respondents were asked to report their overall quit rate. This is assumed to include self-reported quits and any CO monitor quits.

⁴¹ <https://catalogue.ic.nhs.uk/publications/public-health/smoking/nhs-stop-smok-serv-eng-apr-2011-mar-2012/stat-stop-smok-serv-eng-apr-11-mar-12-rep.pdf>

Delving more deeply into the data offers further insight into the Stop Smoking service. One area for investigation is the relationship between the average number of interactions reported, and the reported quit rate. Chart 29, below, is a scatter plot of this relationship. The dispersed nature of the scatter plot could suggest that there is no relationship between the average number of interactions and quit rates. This might be expected, and another means of displaying a normal distribution of quit rates. Another possible interpretation is that the highest quit rates normally result from at least four or more interactions, but not necessarily above-average numbers of interactions, which could be an interesting factor to consider for future service delivery.

Chart 29: Relationship between average Stop Smoking interactions and the reported quit rate



Another avenue for analysis is Stop Smoking service outcomes, in situations with and without pharmacist input into the service delivery. The reported Stop Smoking quit rate was slightly higher (at 49 per cent) when a pharmacist was not involved, compared to a situation where a pharmacist was involved in the service delivery (43 per cent). However, one should treat these results with caution. First, because the sample sizes are small, so they may not be statistically representative, and second, where a pharmacist is involved, they may also receive support from the other pharmacy staff.

The average number of interactions, and the time spent delivering the service, was also analysed with and without pharmacist involvement. The average number of interactions remained virtually the same. However, this analysis shows that where a pharmacist is not

involved in the service delivery, the average delivery time was higher – 100 minutes compared to 83 minutes. This might be expected. The difference in time was found to arise from a few extra minutes being spent, per interaction, from the second interaction onwards. There was no difference in the reported first interaction time.

Table 9: Differences in reported Stop Smoking quit rate, average number of interactions, and the average time spent delivering the service, split by pharmacist and (solely) non-pharmacist input

	Reported Quit Rate	Average Interactions (N)	Average Time Spent (Mins)
Pharmacist involvement	43%	6.4	83
No pharmacist involvement	49%	6.5	100

Despite being cautious around the sample size, there appears to be sufficient evidence to suggest that all HLP pharmacy staff can deliver the Stop Smoking service effectively. Therefore, in light of the demands on pharmacist time for other aspects of pharmaceutical service delivery, and the higher business costs associated with pharmacist input, some HLPs are demonstrating that Stop Smoking services can be delivered in a potentially cost-effective manner – as measured by the 4-week quit rate. Moreover, it also supports a view that other members of staff, who have been appropriately trained, can contribute optimally to effective service delivery. For example, pharmacist’s skills may be necessary in some scenarios, e.g. providing support in the use of medicines, but for other elements of the service the other pharmacy staff can take the lead, without reducing health outcomes.

4.6.2 STOP SMOKING – FURTHER SURVEY EVIDENCE

Using the total number of people recruited, which was reported, and the other Stop Smoking specific questions asked, rates have been calculated for:

- At least one previous quit attempt
- People achieving a 4-week quit based on CO monitoring, and
- Those who did not achieve a 4-week quit but reduced the amount they smoke.

Table 10: Calculated rates - proportion of service users who had tried to quit at least once before, 4-week quits measured by CO monitor, and the rate of those who did not quit but said they had reduced smoking

<i>Stop Smoking - outcome rates</i>	<i>Rate %</i>	<i>N</i>
At least one previous quit attempt	57%	38
4-week quit rate based on CO monitor	28%	49
No quit, but reduced smoking	38%	34

Some caution is required, as the results presented are based on small sample sizes. However, if correct, the results would indicate that 57 per cent of those in the sample who receive a Stop Smoking service had tried to quit at least once before. Perhaps of equal interest is that another 43 per cent were engaged in a quit attempt for the first time. In terms of outcomes, just over a quarter of service recipients were shown to have quit based on CO monitoring after 4 weeks, and another 38 per cent did not quit, but had reduced smoking.

4.6.3 STOP SMOKING – COST PER QUIT ANALYSIS

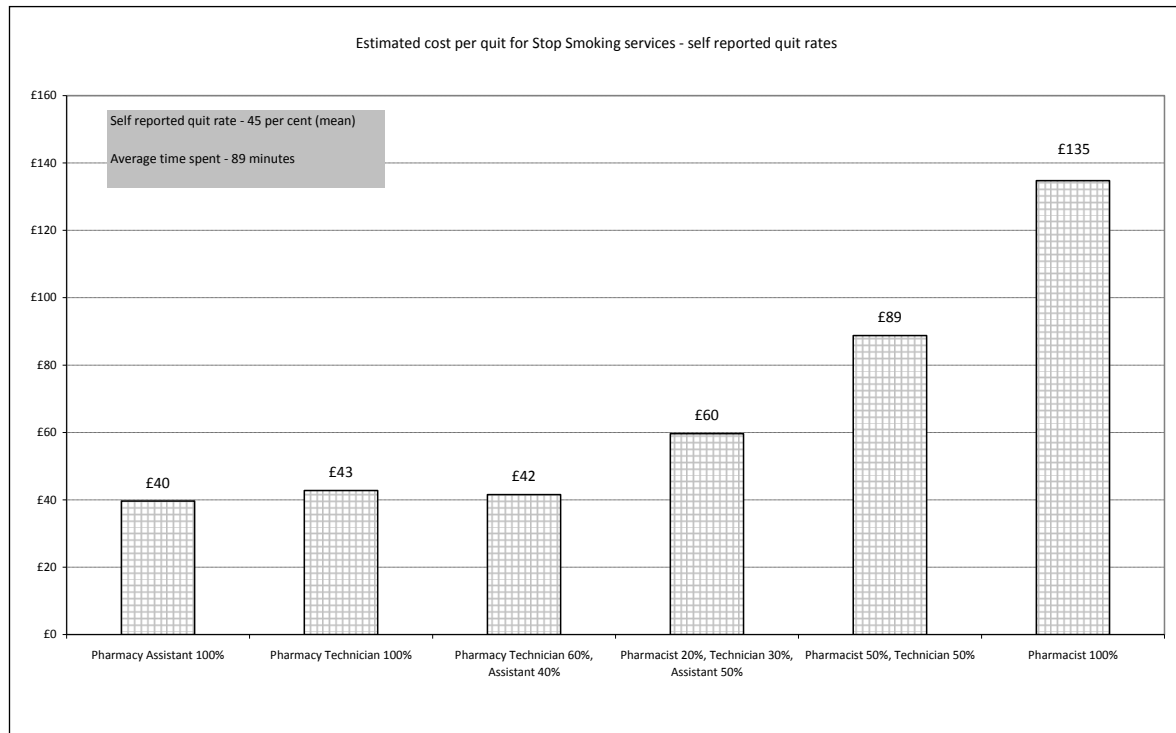
Drawing together some of the evidence presented above, one can calculate a staff cost per quit. This excludes the additional cost of pharmaceuticals, premises, and any other materials used in the process of delivering the service. However, it is assumed that these are likely to be the same inputs for most, if not all, service providers, so they would not be exclusive to this context. To offer some wider context, the NHS Information Centre reported a cost per quitter for NHS Stop Smoking Services of £220 in 2010/11. This figure excludes Nicotine Replacement Therapy (NRT), Bupropion and Varenicline prescriptions.

Assuming that the figures reported in the survey is a fair reflection of HLP Stop Smoking service outcomes, then:

- 45 of every 100 services would deliver a 4-week (self reported) quit, and
- 28 of every 100 services would achieve a 4-week quit based on CO monitoring.

The average service cost varies by the mix of staff involved in service delivery. For Stop Smoking, for the average service of 89 minutes, this ranged from £18 (where a pharmacy assistant delivers the service alone) to £61 (where the pharmacist delivers the service alone). As an example, for every 100 Stop Smoking services, at a pharmacy assistant staff cost of (100 * £17.85=) £1,785, where 45 of the 100 people quit smoking, or 28 of the 100, using the CO monitoring criteria. This leads to an estimated cost per quit of (£1,785/45 =) **£39.67** (rounded to £40 in chart 30, below). This logic has been followed through for each delivery example presented in chart 24. The cost per quit is then calculated from the total cost of service delivery, per 100 services delivered, and the quit rate reported.

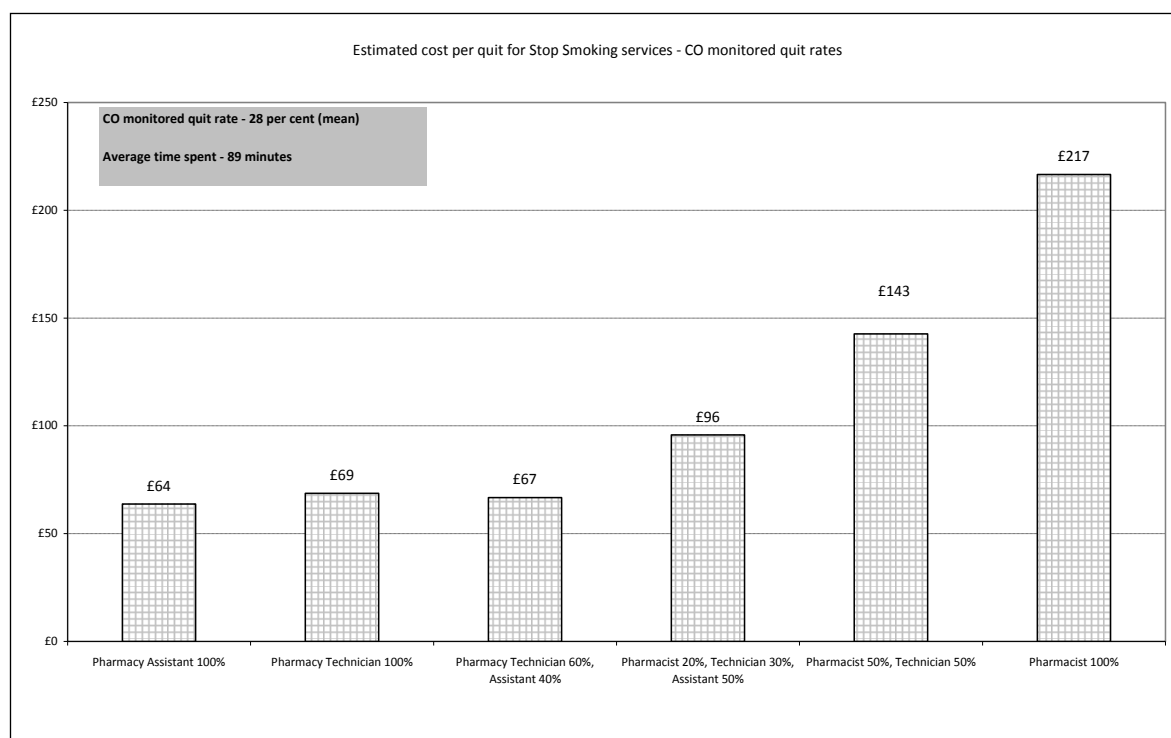
Chart 30: Estimated cost per quit for Stop Smoking services (based on the self-reported quit rate)



The range of cost per quits, as a result of the self-reported quit rates, vary from as low as £40 up to £135, depending on the staff mix employed. As is intuitive, the higher the quit rate achieved, and the less expensive the staff used to deliver these quit rates, the more cost-effective the Stop Smoking service will be.

Using the calculated CO monitored quit rate of 28 per cent, the cost per quit increases, i.e. for every 100 people who undertake a Stop Smoking service, 28 are measured to have quit through the use of a CO monitor. Here, the cost per quit is estimated to range between £64 and £217, depending on the staff mix employed in service delivery, see chart 31, below.

Chart 31: Estimated cost per quit for Stop Smoking services (based on the CO monitored quit rate)



4.7 OTHER INFORMATION GATHERED DURING THE CONTRACTOR SURVEY

The contractor survey gathered some additional information to determine whether HLP contractors collect other information about the public health services being delivered. Table 11, below, summarises this information for each service.

Table 11: Analysis of whether contractors collect information on the different services

Do you collect information for this service?	Yes	No	N
Stop Smoking	60%	40%	82
Chlamydia Screening	29%	71%	42
Emergency Hormonal Contraception	73%	27%	66
Alcohol Service	41%	59%	22
Weight Management	50%	50%	22
Targeted MURs	72%	28%	69

Contractors were found to be more likely to collect information for Emergency Hormonal Contraception, Targeted MURs, Stop Smoking and Weight Management services, respectively, than for the Alcohol Service or Chlamydia Screening.

An open-ended question was asked for each service, where contractors could flag the type of information collected. Table 12, below, summarises the types of information collected by service. The information relates to individual responses, and therefore covers a broad list of information, i.e. it should not be inferred that each pharmacy is collecting all of this

information. For some items of information, there would appear to be a greater probability of collection by an individual contractor, e.g. for age, sex and ethnicity information.

Table 12: Range of information collected by HLPs during service delivery

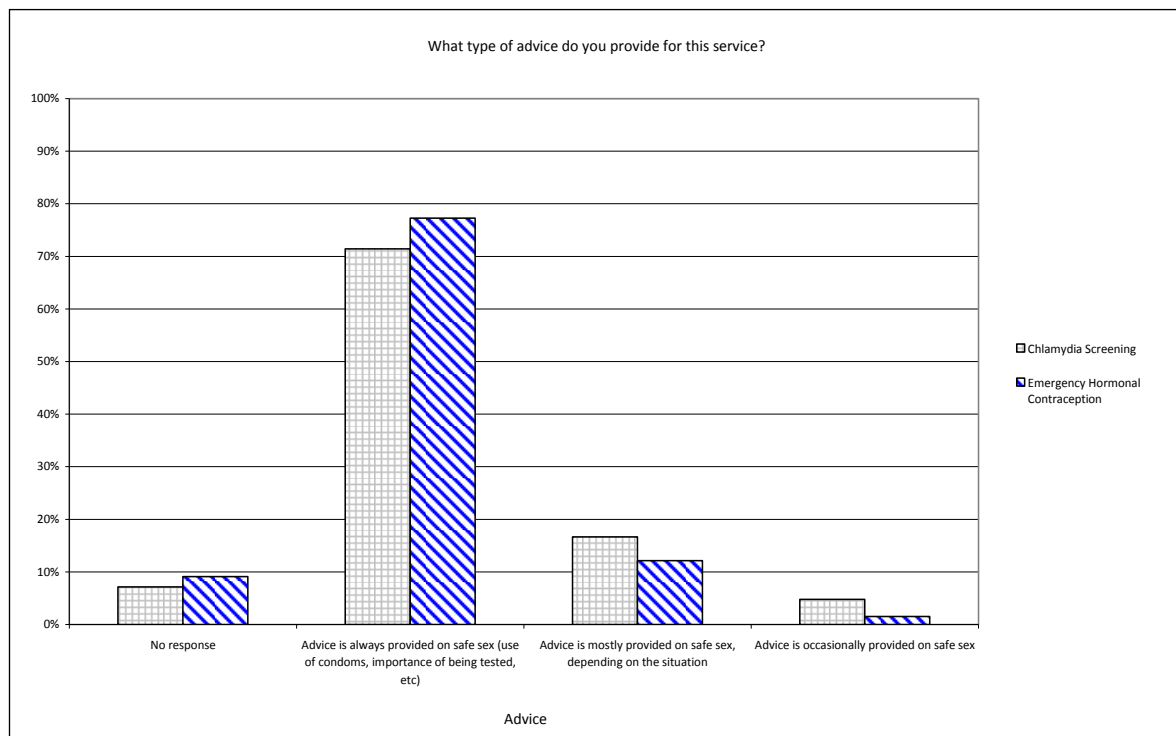
List of information reported as being collected during service delivery

Stop Smoking:	Chlamydia Screening:	Emergency Hormonal Contraception:	Alcohol Service:	Weight Management:	Targeted MUR:
<ul style="list-style-type: none"> • Age • Ethnicity •NRT type •GP surgery • Name •Address •Other medicines •Medical history •Employment status •Occupation, •Children in home under 5 •Whether pregnant •Info based on discussion (diabetic, oral health, hypertension, weight management, level of exercise) •Previous attempts •Registered deaf/blind • Where they heard about service •Post code • Support received from Community Mental Health Team in the last year. 	<ul style="list-style-type: none"> • Age • Sex • Ethnicity • GP Surgery • Address • Post code • Sexual history to trace contacts 	<ul style="list-style-type: none"> •EHC questionnaire • Age • Ethnicity, • Details of contraception usually used/advice given for going forward • Medicines/main medical conditions • Demographic data • Co-morbidities, • Phone number • Address • Post code, • Contraceptive counselling appropriate to the client, • Fraser competence assessment • Date of last cycle 	<ul style="list-style-type: none"> • Age • Medical history • Ethnicity • History of alcohol consumption/habits • family history of alcohol misuse • medicines/medical conditions • Post code • Location • Activity of Alcohol IBA 	<ul style="list-style-type: none"> • Age • Ethnicity • Medicines • Co-morbidities • Address • Telephone number • Health history • BMI • Smoking status • Is the person entitled to free prescriptions 	<ul style="list-style-type: none"> • Age • Follow MUR form • Ethnicity • Co-morbidities • Medicines history • Problems with medicines • OTC medicine • Dose •Side effect • Telephone number • Health history • Action plan • Recommendations • Type of MUR (annual/intervention), Consent obtained (written, verbal) •GP details • NHS number • Lifestyle review/advice • Healthy living advice provided, techniques for appliances •Background information relating to weight, smoking status, exercise, diet

4.7.1 SERVICE SPECIFIC INFORMATION – ADVICE PROVISION & SERVICE FEEDBACK

In respect of additional service specific information, data was collected and analysed surrounding the provision of advice during Chlamydia Screening and Emergency Hormonal Contraception services. In over seventy per cent of cases, advice is always provided on safe sex, see chart 32 below. When adding in the “advice is mostly provided on safe sex, depending on the situation”, the level of advice provision adds up to more than ninety per cent for each service.

Chart 32: Advice provision during Chlamydia Screening and Emergency Hormonal Contraception services

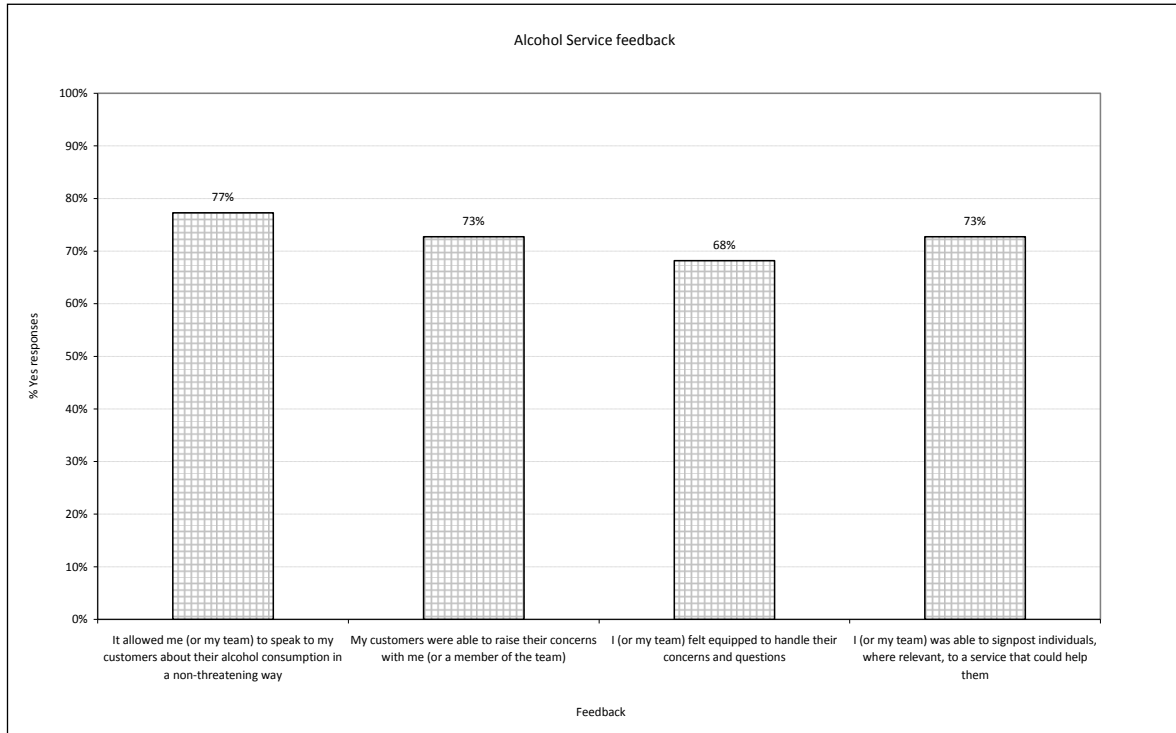


Some specific questions were asked in the Alcohol Service set of questions on feedback from the perspective of staff delivering the service. This covered whether the service –

- “It allowed me (or my team) to speak to my customers about their alcohol consumption in a non-threatening way”
- “My customers were able to raise their concerns with me (or a member of the team)”
- “I (or my team) felt equipped to handle their concerns and questions”, and
- “I (or my team) was able to signpost individuals, where relevant, to a service that could help them”.

Despite a small sample size of 22 responses, the available evidence was very positive for each question, with more than two-thirds of respondents answering yes to each question. Almost eighty per cent of respondents answered yes to the question of whether the service allowed discussions with customers about their alcohol consumption in a non-threatening way. Chart 33, below, summarises the findings.

Chart 33: Feedback to the Alcohol Service



4.8 SUMMARY OF CONTRACTOR SURVEY ANALYSIS

Table 13: SUMMARY OF HLP SERVICE ATTRIBUTES

SUMMARY POINTS	CONTEXT
<p>Stop Smoking, Chlamydia Screening and Emergency Hormonal Contraception were reported to be the most frequent public health services delivered by HLPs. Other services, for example Weight Management and Alcohol Service, are also delivered in HLPs.</p>	<ul style="list-style-type: none"> • More than 90 per cent of HLPs deliver Stop Smoking services • Just under two-thirds deliver Emergency Hormonal Contraception services • Around half of HLPs deliver Chlamydia Screening services. • Around one-fifth of HLPs deliver a Weight Management or Alcohol Service.
<p>Survey data collected on who is involved in service delivery highlights the role of all pharmacy staff in the delivery of services in HLPs.</p>	<ul style="list-style-type: none"> • Pharmacists are typically involved in Chlamydia Screening, Emergency Hormonal Contraception and Stop Smoking service delivery, but their proportion of input varies across pharmacies • The other pharmacy staff are more likely to deliver Weight Management and Alcohol Services.
<p>Stop Smoking and Weight Management services typically involve more interactions, and time spent, with someone receiving the service compared to a Chlamydia Screening or Alcohol Service.</p>	<ul style="list-style-type: none"> • The average Stop Smoking service reported involves six interactions • The average Weight Management reported involves seven interactions • Around 90 minutes in total is spent delivering Stop Smoking and Weight Management services, on average.

Table 13: SUMMARY OF HLP SERVICE ATTRIBUTES

SUMMARY POINTS	CONTEXT
<p>The available data has enabled the calculation of some staff costs per (average) service delivered, for Stop Smoking, Chlamydia Screening, Alcohol, and Weight Management services. Depending on actual salary levels, and staff mix employed, in different pharmacies, these figures could vary.</p>	<ul style="list-style-type: none"> • Estimated staff costs cover both the mix of staff employed in HLP service delivery, and the total length of time delivering a service • Stop Smoking and Weight Management services, which typically take around 90 minutes in total, could have staff costs ranging from £18 to £61. Due to staff mix employed, Weight Management services will typically have a lower staff cost due to a lower likelihood of pharmacist input in service delivery • Alcohol Services last around 20 minutes in total, and the staff cost is estimated to range from £4 to £14 • Chlamydia Screening services last around 13 minutes in total and the staff cost is estimated to range from £3 to £9
<p>Further analysis of Stop Smoking services suggests that the staff cost per Stop Smoking quit is within the boundaries of national-level data on the cost per quit.</p> <p>Moreover, in light of HLPs making use of a range of staff to deliver Stop Smoking services, and the wider evidence base on the cost-effectiveness of Stop Smoking services within the pharmacy context, there is some evidence to suggest that Stop Smoking services are being delivered effectively and cost-effectively in some HLPs</p>	<ul style="list-style-type: none"> • Self-reported quit rates were 45 per cent on average • Non-pharmacist staff were shown to spend slightly more time delivering Stop Smoking services, on average, and • Non-pharmacist staff were also able to perform at least as well as when a pharmacist was involved in the Stop Smoking service delivery – indicating the scope for effective and cost-effective delivery of Stop Smoking services in HLPs
<p>Additional information gathered highlights the broad range of information being collected when delivering services in HLPs. There is evidence that the vast majority of individuals receiving a Chlamydia Screening or Emergency Hormonal Contraception service are receiving important advice on safe sex. Evidence from those delivering the Alcohol Service indicates that the service is well equipped to open dialogue on alcohol use, as well as offering a platform for HLP staff to offer helpful advice.</p>	<ul style="list-style-type: none"> • Information is collected in more than half of the reported Emergency Hormonal Contraception, Targeted MUR, Stop Smoking and Weight Management services. • Advice is always provided on safe sex in more than 70 per cent of Chlamydia Screening and Emergency Hormonal Contraception services • Feedback from the Alcohol Service, from the perspective of those delivering the service, is very positive

4.9 CONCLUSIONS

In conclusion, the contractor survey offers some rich insight into how Public Health services are being delivered in HLPs.

Based on the service information collected in the contractor survey, Stop Smoking is the most common service delivered by most HLPs. A majority of HLPs in the sample also deliver Emergency Hormonal Contraception, Targeted MURs and Chlamydia Screening services. The survey indicates that Alcohol and Weight Management services are delivered in around one-fifth of HLPs.

The survey has also affirmed the important role of non-pharmacist staff in the delivery of public health services in HLPs, notably for Alcohol and Weight Management services. Whilst a pharmacist is involved in the majority of Stop Smoking, Chlamydia Screening and Emergency Hormonal Contraception services, the other pharmacy staff are contributing to service delivery. A full picture surrounding how wider HLP activities has contributed to these outcomes, e.g. promoting the use of health champions, offering training and development opportunities to staff, and leadership training for pharmacists, is not possible from the specific contractor survey, but there could be some inference available in the wider pathfinder analysis. What can be said is that there is clear evidence from the wider evaluation that all pharmacy staff are engaged and enthused by the opportunities being presented to them, and this has the potential to spill over into better service outcomes, with some health champions using innovative and creative models of delivery.

Notably, when making use of the larger sample of Stop Smoking service data, some further analysis has indicated that Stop Smoking services delivered by non-pharmacist staff perform at least as well as when a pharmacist is involved in service delivery. Crucially, this indicates that Stop Smoking services can be delivered more effectively in HLPs, i.e. making best use of each staff member's skills. In addition, in line with the reported Stop Smoking quit rates, this indicates that some HLPs are delivering Stop Smoking services more cost-effectively, i.e. pharmacist's time has a higher business cost.

Making optimal use of each staff member's time, without necessarily risking the ability to generate positive health outcomes, indicates the potential of service delivery in the HLP context.

CHAPTER 5 – PUBLIC REPORTED EXPERIENCES

5.1 CHAPTER SUMMARY

Public reported experiences were evaluated to answer part of Objective 4.

What are the benefits of the HLP concept for the public, commissioner/NHS, contractor, employer and employee?

Data were collected through questionnaires given to clients by the HLPs who had used the services.

The services appeared to be well received, with almost all users comfortable to receive services in the pharmacy setting, happy with how they were treated by the pharmacy staff, and that the pharmacy staff gave them enough information. 98.3% of people surveyed said they would recommend the service to others.

Of the survey respondents, over a fifth of people engaged with health and wellbeing services offered by HLPs, stated that they would otherwise have done nothing. This is an important finding, as they would have not otherwise have benefited from the healthy lifestyle advice or service they were offered. 60% of individuals surveyed would have gone to their GP.

5.2 INTRODUCTION

Recording the public's experience of using the public health services offered by HLPs is an important element of this evaluation. Even if evidence showed that the services provided were fit-for-purpose, with improved health outcomes, safe and cost-effective, if the public were unhappy to receive such services in this setting, or did not feel the service provided was of a high enough quality, then the programme would ultimately fail. This part of the evaluation therefore sought to record public experiences of using each of the services being evaluated, in different areas of the country.

5.3 METHODS

The survey was based on the public reported outcomes assessment card used in the seasonal flu vaccination service provided by community pharmacies in Isle of Wight⁴². Based on local needs and resources, pathfinders decided how to present, format and brand the questionnaire, and how individuals were going to complete them. They were however, instructed not to alter the wording of any of the questions, other than to add the name of

⁴² Available from Hampshire and Isle of Wight Local Pharmaceutical Committee website www.hampshirelpc.org.uk

the service, in order that the data could be collated for the pathfinder work programme evaluation. The 10 questions can be seen in Appendix 5.

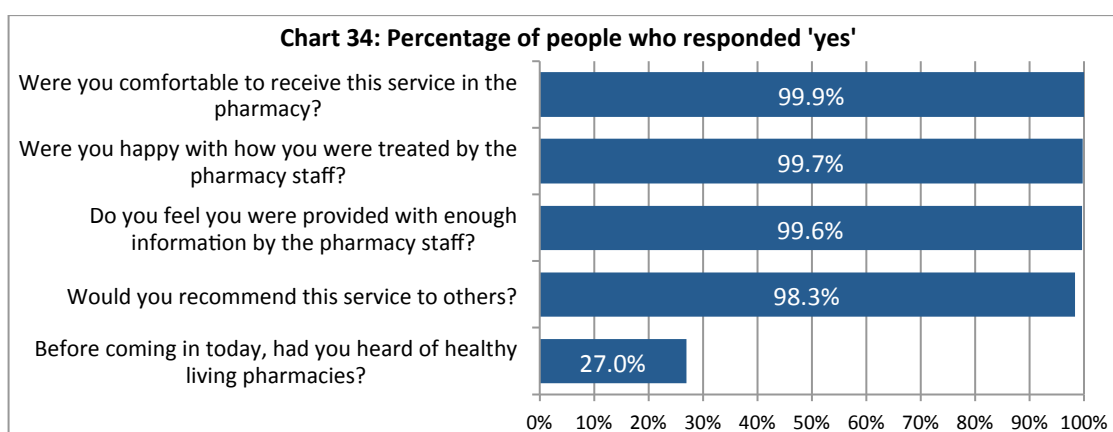
Pathfinders were also given information on different sampling strategies, how to maximise response rates, and how to analyse and present the data (Appendix 6).

5.4 RESULTS AND OUTCOMES OF THE ANALYSIS

Ten pathfinder areas returned public reported experiences of services, which are shown in Table 14 with the number of returned questionnaires:

<i>Table 14: The number of returned public experience questionnaires for each service</i>		
<i>Pathfinder area</i>	<i>Service 1</i>	<i>Service 2</i>
Lambeth	7 Stop Smoking	6 EHC
Brighton and Hove Group	16 Stop Smoking	3 Sexual Health
Stoke-on-Trent	285 pharmacy first	44 EHC
North Staffordshire	54 Pivotell™ pill dispenser	25 EHC
South Staffordshire	45 (ALL SERVICES)	Includes: 9 Stop Smoking 2 EHC
Sheffield	92 Minor Ailments	0
Dudley	58 Stop Smoking	17 Alcohol IBA
Shropshire	126 (ALL SERVICES)	Includes: 48 MUR 24 NMS
Blackburn w Darwen and East Lancashire	238 (ALL SERVICES)	Includes: 67 Stop Smoking 24 Substance Misuse
South Tyne and Wear	15 Stop Smoking	3 EHC

1034 public consultations were evaluated across 10 pathfinder areas and covering 14 different services. The results were overwhelmingly positive as shown below and in Charts 34 and 35.



These results indicated that regardless of the difference in service specifications, demographics, levels of health need, deprivation, urban or rural location, HLPs were well accepted by participants as a location to receive services, where they were happy with the way the staff treated them and the information they received. Additionally, a very high proportion, over 98%, would recommend the service to others, a powerful indicator of acceptance of the community pharmacy as a delivery mechanism for public health services. This would be important in developing the public's willingness to access both 'push' and 'pull' services in a community pharmacy setting, and would lead to increased awareness of the HLP concept.

It was interesting to note that over a quarter of people had heard about HLP before going to the pharmacy. Whilst this does not seem high, it should be recognised that this was done at a time when the HLP concept was still new in all the areas. Some of the pathfinder areas used innovative and creative ways of communicating the HLP concept to the local population.

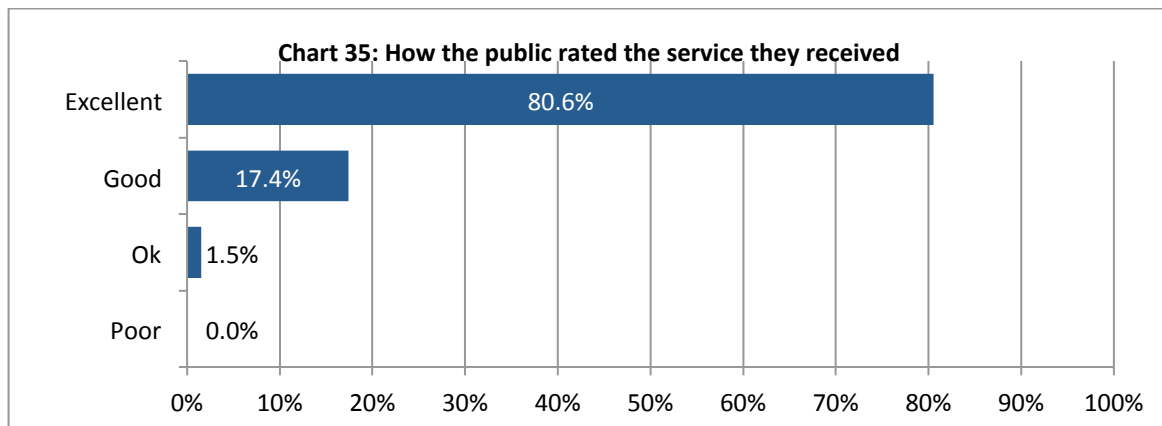
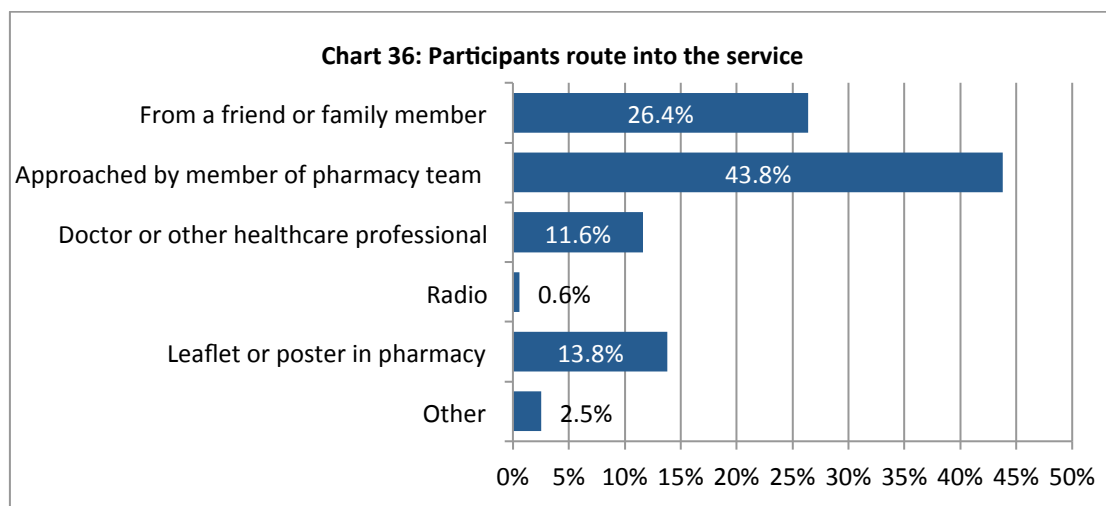
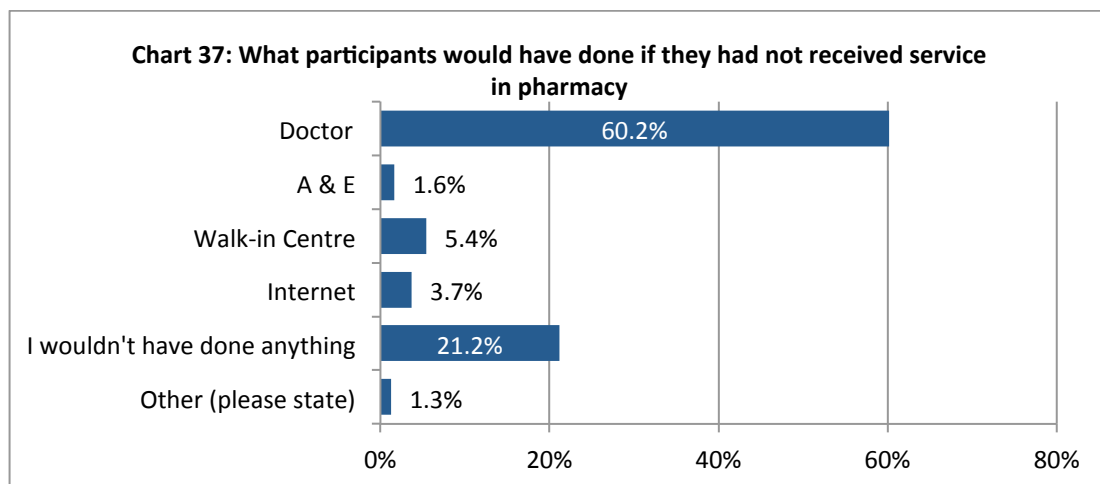


Chart 35 above showed that 98.5% of the participants judged the quality of services as good or excellent. Participants were asked about how they found out about the service. The most common route was through being approached by a member of the pharmacy team, and over a quarter were recommended by family or friend as shown in Chart 36 below:



This chart showed that face-to-face contact and word of mouth were important in building the relationship with participants, which resulted in recruiting members of the public into services. Pharmacy staff were pro-active in engaging with clients, in line with the principles of the HLP concept, and recommendations from family or friends were important. High approval ratings, particularly willingness to recommend the service to a friend, shown in Chart 34 above, positively reinforce the benefits of services delivered and opportunities for health and wellbeing interventions.

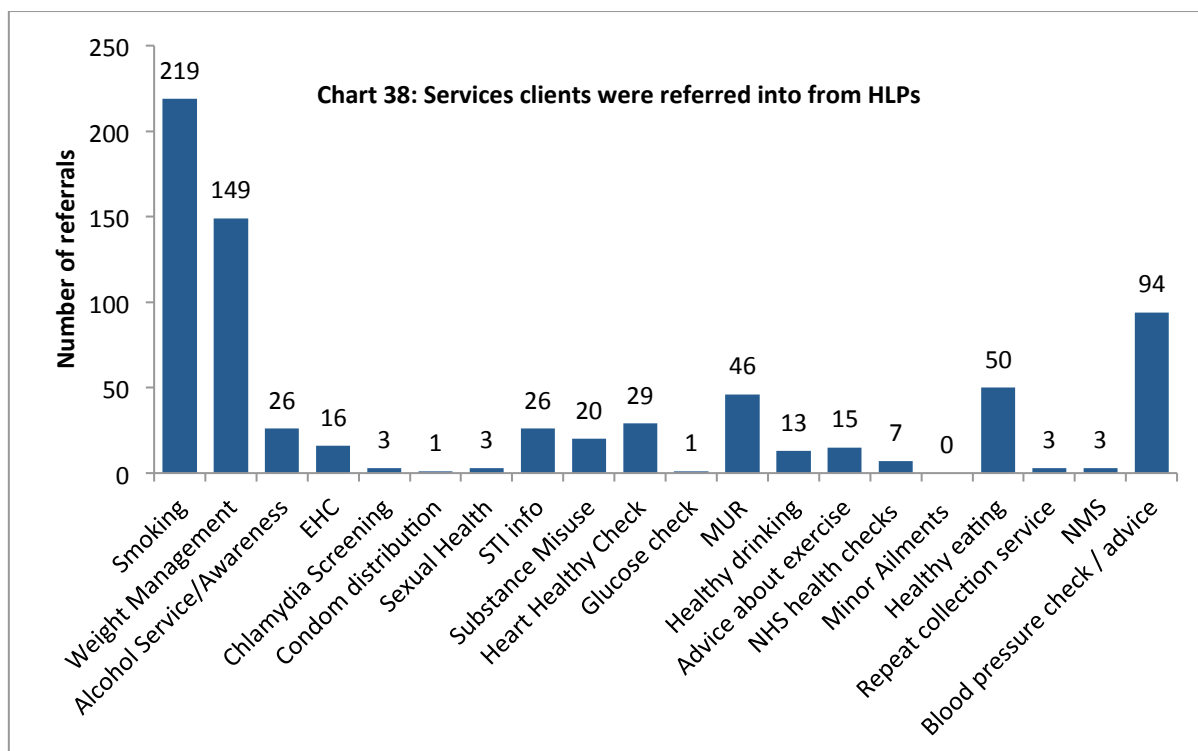
Participants were asked what they would have done if they had not used the pharmacy service and the data showed that over 60% of those asked would have gone to their doctors and over 20% would have done nothing, as shown in Chart 37 below:



This chart shows that over 60% of people in this survey would have used their doctors. As there were 1034 participants, this represents a maximum of 622 appointments at GP surgeries that would have been required to deliver these services and suggests that the HLP concept is effective in helping people receive services they rate highly in an environment they are comfortable with and thereby release capacity in other parts of primary care for more specialist work. Over 20% of people would have done nothing, and would have missed an opportunity to improve their health and wellbeing. From a public health perspective, staff in HLPs were effective in using every interaction as an opportunity for a health promoting intervention, making every contact count.⁴³

The next stage in engagement with clients was to study which services and advice they received. The frequency of service use is shown in Chart 38 below:

⁴³ Making Every Contact Count and Healthy Living Pharmacy. A comparison of competences and knowledge and skills in the Prevention and Lifestyle Behaviour Change: a competence framework and the Healthy Living Pharmacy Framework. A report to NHS Yorkshire and the Humber and the National Pharmacy Association. Shepherd, Payne, Evans, de Normanville and Holden. April 2012.



Most of the services directly support the aims of the Public Health Outcomes Framework for England 2013-2016⁴⁴. The most popular services were Stop Smoking, weight management, healthy eating and blood pressure monitoring. However, pathfinder areas did not evaluate services such as blood pressure monitoring, and the weight management service was evaluated by one area only. From a public health perspective, an important outcome was that members of the public were pro-actively supported to improve their health and well-being.

5.5 LIMITATIONS OF THE PATIENT AND PUBLIC RESPONSES

The results should be viewed as a snapshot rather than a comprehensive survey. Half of the pathfinder areas were either unable to carry out the survey or return responses. It was not possible to calculate an overall response rate as the majority of pathfinder areas did not record how many questionnaires were handed out. Questionnaires were administered by different methods in different pathfinder areas (some completed in store, some returned by post). Similarly, sampling methods and target numbers of responses varied across pathfinder regions.

⁴⁴ Improving outcomes and supporting transparency: A public health outcomes framework for England, 2013-2016. Dept of Health. January 2012.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132559.pdf
 accessed 1 Feb 2013

There was potential for responder bias because the majority of evaluations were completed in store and service users may have felt under pressure to report positively, as the surveys were not anonymised, or may not have completed the survey if they had had a negative experience. Other surveys were to be returned by post and participants may not have returned the survey. In addition, some services were required infrequently so could not achieve high numbers of patient/public experience reports within a relatively short time period.

5.6 CONCLUSIONS AND RECOMMENDATIONS

The survey responses showed that services delivered were well received, with almost all users comfortable to receive services in the pharmacy, happy with how they were treated by the pharmacy staff, and that the pharmacy staff gave them enough information. This was further reflected in the fact that 98.3% would recommend the service to others.

Accessing services in the pharmacy setting has been shown to divert users from visiting other healthcare professionals⁴⁵, and findings from this study support this, with over 60% saying they would otherwise have gone to their doctor. This indicates the potential for community pharmacy to support the health and wellbeing of their local community. HLPs use every intervention as an opportunity to promote health and wellbeing messages or refer people to other services, where appropriate e.g. Stop Smoking, weight management or sexual health services within the pharmacy or signpost to other local providers.

The survey results show that HLPs also engaged with over 20% of people who would otherwise have done nothing, demonstrating the value of HLPs to improve or maintain their health.

Over a quarter of people were aware of HLPs before they went to the pharmacy. The initial Portsmouth HLP project reported from the beginning that raising public awareness was vital to the spread of the programme and to help people use the health and wellbeing opportunities available through HLPs.

Communication of the HLP concept locally was variable due to the resource constraints and rate of spread of HLPs locally.

The underlying principles of the HLP concept were that pharmacy teams were pro-active in engaging with the public for promoting health and wellbeing messages, providing a range of services to a consistently high quality standard, underpinned by the appropriate skill mix with the knowledge to promote health and wellbeing messages. The responses from the public who accessed services from HLPs showed that staff actively engaged with the public.

⁴⁵ Making the case for self care of minor ailments PAGB August 2009

6.1 CHAPTER SUMMARY

The benefits to commissioners, contractors, pharmacists and staff were evaluated to answer part of Objective 4 in section 2.3.

What are the benefits of the HLP concept for the public⁴⁶, commissioners/NHS, contractors, employers and employees?

Assessing the benefits of the HLP concept was important as the success of the programme depends on acceptance of the concept by all the different stakeholders (public, commissioners, contractors and employees), and these groups each have different criteria for success. For example, commissioners require that the services delivered are safe, effective, cost-effective and of a high quality. On the other hand contractors will be looking to deliver services that are financially and operationally sustainable (either directly or indirectly) and helping to improve the health of the local community. The public will be looking for services that are easy to access and acceptable to them in a social context and they would like to see the benefits to their health and well-being. This part of the evaluation therefore seeks to record and assess some of the stakeholder benefits being realised in different areas of the country.

Benefits to the commissioners were derived through thematic analysis of the pathfinder area reports and are presented in section 6.3 below. Benefits to contractors, employers and employees were measured using a structured survey completed by participating contractors and pharmacy staff and the results are presented in section 6.4 below.

The results demonstrate to commissioners the added value that HLPs bring with high quality services, provided by skilled staff in premises that are fit for purpose for promoting health and well-being messages that meet local health needs. In addition, they can be confident that the numbers of people being targeted by HLPs appear to be greater than those targeted by conventional pharmacies. Public health teams have been able to evidence that HLPs are pro-actively engaging in public health initiatives, helping to improve the health of the local population. This knowledge will be important in their new health improvement role in Local Authorities.

The results of the contractor survey showed that the overall effect of the HLP concept was positive for all types of contractors; whilst the benefits experienced varied between different types of pharmacies, there was something in the HLP concept for everyone.

⁴⁶ The benefits to the public are covered in Chapter 6

Three pathfinder areas carried out further evaluation and the conclusions from these projects are shown in section 6.4.3. Portsmouth showed benefits to the pharmacy team for adopting the HLP concept and there was increased activity shown in Plymouth

6.2 INTRODUCTION

The success of the pathfinder programme depended on acceptance of the concept by stakeholders in the health economy, i.e. commissioners in the NHS and public health, contractors, pharmacists and employees, each potentially looking for different outcomes from HLP implementation. For example, commissioners required services to be of a high quality, safe, effective and cost-effective, whereas contractors expected to deliver financially and operationally sustainable services (either directly or indirectly) as well as health improvement for the local population. This part of the evaluation sought to assess stakeholder benefits realised in different areas of the country, although it must be noted that for reasons of commercial confidentiality the financial benefits have to be surmised from the data available.

6.3 BENEFITS TO COMMISSIONERS

6.3.1 METHODS

Commissioners' views were analysed qualitatively from the pathfinder area reports using thematic analysis and NVivo10⁴⁷ to assist interpretation. This process involved analysis of the content of data to categorise recurrent themes from the free text parts of the pathfinder reports. The technique is commonly used in published academic qualitative research and aims to present key points of participants' views. It has been shown to be a useful approach to find out the important issues for particular groups of participants, for example, commissioners or project leaders. Data are studied in the form of the pathfinder sites' written reports to categorise common themes and exceptions, which are useful to illustrate points that may not be important to all participants, but shed light on the implementation process for example. The use of the NVivo10 software is an aid to categorisation, not interpretation, which is carried out by the researcher⁴⁸. Codes were created in NVivo to represent the ideas expressed in the reports, for example the rationale for implementing HLP, or challenges faced. An example of an exception which was helpful in interpretation concerned differences in uptake between pharmacies; an important consideration when considering successful future implementation, but reported by a small number of participants.

⁴⁷ http://www.qsrinternational.com/products_nvivo.aspx accessed 8 February 2013

⁴⁸ Green and Thorogood. *Qualitation Methods for Health Research*. 2nd edition. 2009

6.3.2 RESULTS AND OUTCOMES OF THE ANALYSIS

HLP as a quality mark: commissioners commented that they would focus on HLPs as a vehicle to help them deliver benefits for their local populations, using the quality mark as a proven track record to give them confidence that the services would be delivered to the required quality, standards and volume. For example, one commissioner stated:

“Becoming an HLP will display to commissioners’ pharmacy’s commitment to delivering cost effective and high quality services.” [Birmingham tPCT and Solihull]

A commissioner in one area stressed the importance of continuous service delivery for the population:

“Services must be delivered over the majority of the year e.g. minimum of 10/12 months AND each month to be running at a minimum of 8% annual target. Surely this is only fair for local communities” [Blackburn with Darwen and East Lancashire]

In Portsmouth, where the HLP concept was initiated, commissioners were likely to commission services from HLPs by preference, as they were confident that high quality services would be provided from them and they had the workforce in place to deliver.

“Future commissioning can be targeted and offered to those pharmacies that we know will deliver. So this has become a great organisational tool to target commissioning more cost effectively.” [Portsmouth]

These reports showed that commissioners viewed HLPs as an important delivery mechanism for public health services to meet local health needs consistently, within defined quality criteria, meeting local needs.

HLP as a catalyst for developing working relationships Pathfinder areas reported that HLP had helped them improve and develop working relationships between commissioners and providers. Public health teams were seen as very important players in the forthcoming commissioning structures.

“Since starting the project we have seen greater collaborative working between providers and commissioners and a shared approach to developing pharmacy.... The HLP concept has provided a vehicle for building relationships with elected members of local authorities and the public health teams which are transferring from PCTs to local authorities” [Buckinghamshire and Milton Keynes]

“Public health commissioners see the HLP initiative in a very positive manner, public health teams are now keen to involve community pharmacies and in particular the HLPs in their service developments. They have volunteered to give on-going training to HLCs re information and signposting” [Dudley]

The reports of public health teams' enthusiasm for HLPs were encouraging; HLPs are increasingly demonstrating the added value that they bring for population health with increased numbers of people accessing high quality services, with some impressive outcomes. With public health teams moving to Local Authorities, this could provide the stimulus for recognition of the HLP concept and benefits for local population health.

The impact of the HLP concept on commissioning of new services Three areas reported that services had been either commissioned as a result of being chosen as a pathfinder area – Stop Smoking in Plymouth – or that a service specification had been revised to include new quality outcomes and increased support for clients – substance misuse in Blackburn with Darwen and East Lancashire. NHS Health Checks and Alcohol Intervention and brief advice services have been commissioned in Lambeth following implementation. Plymouth reported that community pharmacies had also been asked to deliver brief interventions for skin cancer, alcohol awareness and diabetes risk, on the basis of becoming a pathfinder. These examples showed the impact of having HLP status for commissioners and subsequently the public; the commissioners in all PCTs had had enough confidence in the evidence from Portsmouth, which resulted in further public health services being commissioned from HLPs.

Dudley reported that alcohol awareness was adopted “recently” and had:

“...shown that community pharmacy is a good place to start and tackle prevention of alcohol related harm ... one of the highest priorities in Dudley” [Dudley]

National accreditation and quality marks One pathfinder area noted that HLP quality marks should be nationally accredited and awarded to avoid local variations and to embed it as part of the NHS:

“National recognition of HLP as an enrichment of the NHS family ... National retention of accreditation measures that are meaningful for the whole team ... National drivers to make it happen – inclusion in National documents/guidance as a specific credible valuable workstream, enhancing PH” [Blackburn with Darwen and East Lancashire]

One report noted the difficulty of local enhanced services requiring specific training delivered by the PCT, and restricting access to training for enhanced services to allow pharmacies to work towards HLP status. A national accreditation programme could use existing training that is nationally provided and potentially accredited with access within the control of contractors and pharmacy teams.

HLP in the future One commissioner was adamant that HLP should be rolled out nationally:

“There is absolutely NO POINT repeating this pilot anywhere else as a pilot. It has already been proved to work with the right support. Neither should it stand still where we are. It

*should be organised / commissioned / developed maybe as a quality framework like QOF”
[Blackburn with Darwen and East Lancashire]*

These reports demonstrate that commissioners value the HLP concept as this could provide a mechanism to increase volume, quality and reliability of community pharmacy services to meet local health needs. Public health teams understood the potential of the HLP concept for local population health and were well placed to take this knowledge with them into local authorities.

6.4 BENEFITS TO CONTRACTORS

6.4.1 METHODS

A short survey was developed to quantitatively assess the benefits (both real and perceived) of the HLP concept for contractors and employers, and for the wider public. The survey was designed to be anonymous, quick to complete, and delivered through an online interface (SurveyMonkey®) to maximise contractor response. The survey can be seen in Appendix 4. Pathfinder leads were requested to disseminate the survey link to their individual HLPs in September 2012 and encourage participation, ideally returning data from a minimum of either 10 or half of their HLPs, whichever was smaller. Completion of the survey was incentivised with entry to a random draw for a Health Champion training distance or e-learning course.

Following a low response rate that would make it difficult to interpret the data, and to ensure all areas of the country were represented, pathfinder leads were sent a reminder encourage a greater response rate (November 2012). An additional question was asked to identify the pathfinder area that the HLP was located in. The survey closed for analysis in December 2012.

A qualitative investigation of the benefits of the HLP concept was carried out in specific pathfinder areas, who had linked into local Universities for academic evaluation:

- Portsmouth: Staff present at 28 pharmacies (a mixture of HLP and non-HLP) were interviewed (face-to-face, semi-structured) to ascertain their perceptions of the HLP concept
- Heart of Birmingham: Interviews were carried out with a range of HLP providers from within the PCT, exploring a number of issues including: motivation for becoming a HLP, experiences around the start of their involvement, current experiences, future plans
- Plymouth: A short survey was carried out to evaluate staff feedback on their delivery of a skin cancer awareness and prevention campaign in HLP and non-HLP pharmacies.

6.4.2 RESULTS AND OUTCOMES OF THE CONTRACTOR SURVEY

The following pathfinder areas were represented in the data returned:

Table 15: Number of responses each pathfinder area from the contractor survey

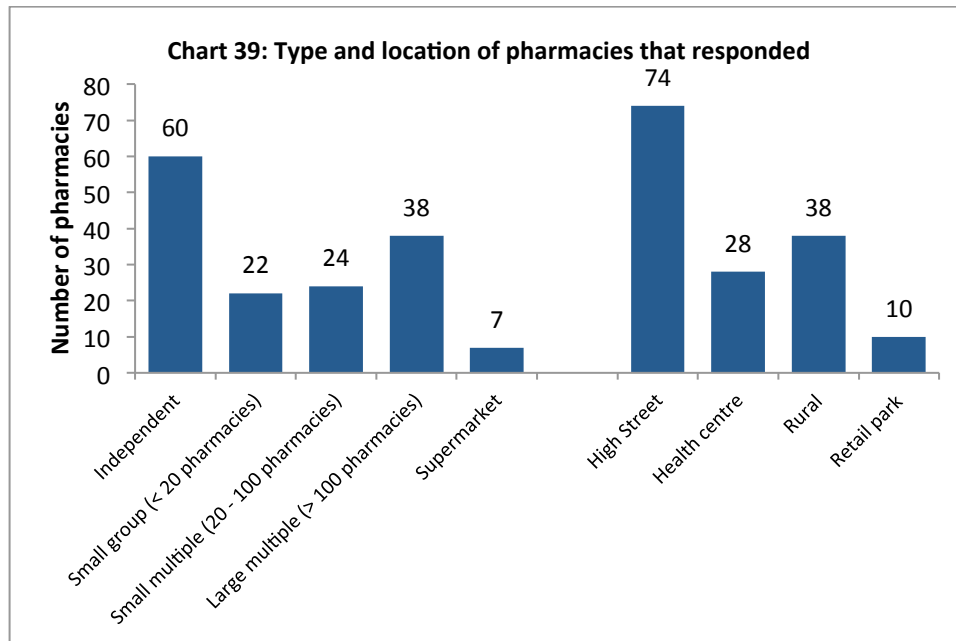
Pathfinder Area	Number of responses
Blackburn with Darwen and East Lancs	17
Buckinghamshire and Milton Keynes	7
Devon	1
Dudley	10
East Sussex	3
Hampshire	2
Heart of Birmingham	5
Lambeth	14
North Staffordshire	6
Portsmouth	5
Sheffield	6
Shropshire	9
South Staffordshire	23
South West Essex	5
Stoke-on-Trent	4
Not identified	36

RESPONSE RATE AND DEMOGRAPHICS

176 surveys were returned, however 23 contained only demographic information and were excluded from analysis. Therefore 153 returned surveys were included in the analysis (December 2012). At the time of closing the survey, there were 402 HLPs within pathfinder areas giving a response rate of 38%. However, these results should be treated with caution as it was not possible to calculate a more accurate response rate as exact dates for achieving HLP status were unknown in each case.

The breakdown of pharmacy type showed that 40% of pharmacies that responded to the survey were Independent pharmacies, with roughly equal numbers (30%) of small pharmacy groups/multiples and large multiples/supermarkets making up the remainder of the responses. In terms of location, approximately half of pharmacies responding were on high

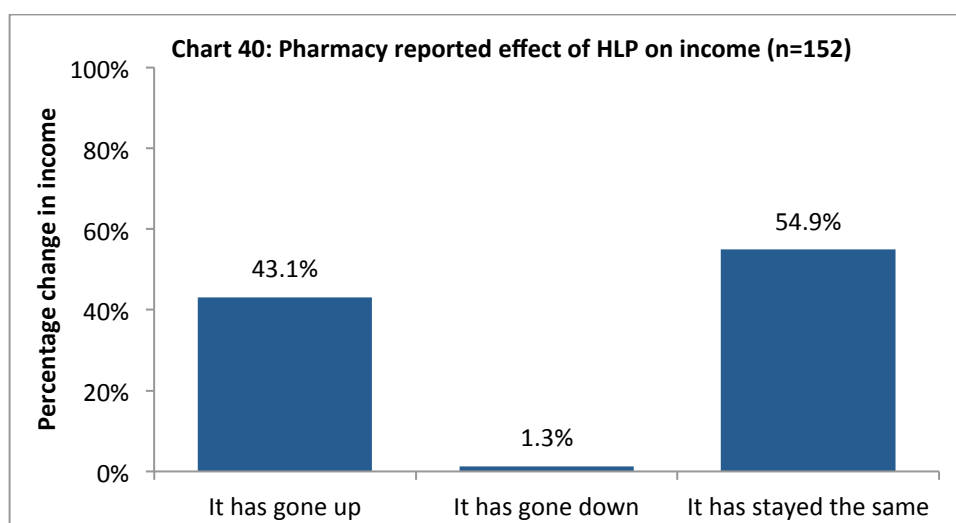
streets (49%), 25% were located in a rural setting, 19% were within health centres, and 7% were on retail parks (see chart 39 below).



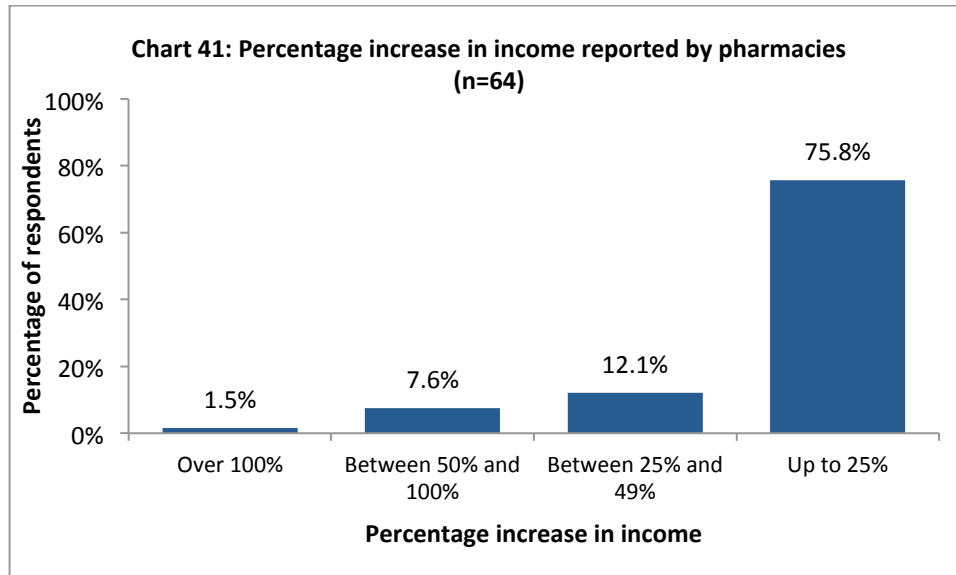
These data show that all types of pharmacies have adopted the HLP concept in different types of location, meeting the differing needs of the local population. In terms of location, public access is served by the variety of location, with the convenience of each location being suitable for different people in different circumstances.

IMPACT OF BECOMING AN HLP ON THE BUSINESS

Participants were asked whether implementation of HLPs had had an effect on their NHS advanced and enhanced service income. 43% of HLPs reported that their income had increased and 55% reported it had stayed the same. Only 2 pharmacies (1.3%) reported that their NHS service income had decreased since becoming a HLP (see Chart 40 below):

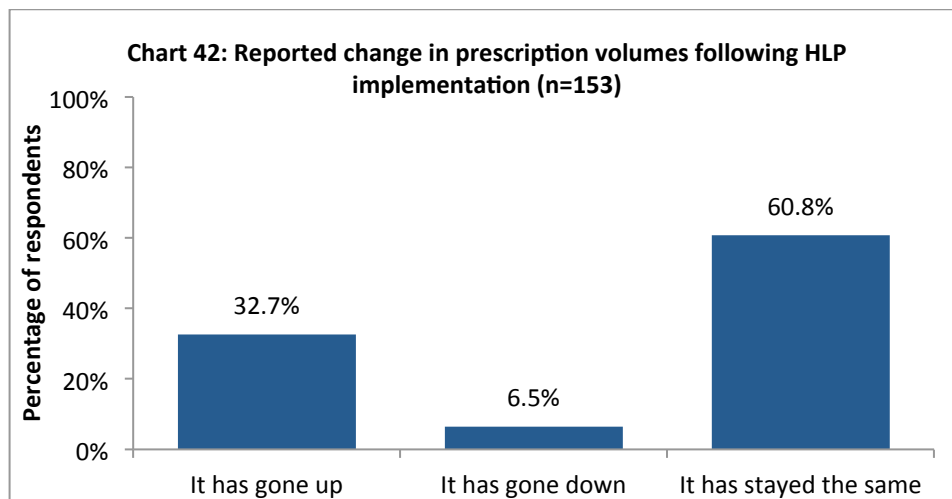


The data show that for over 98% of respondents, implementation of the HLP concept had not adversely affected their income, and over 40% had seen an increase in income. Respondents who reported an increase in income were asked what the increase had been and the results are shown in Chart 41 below:



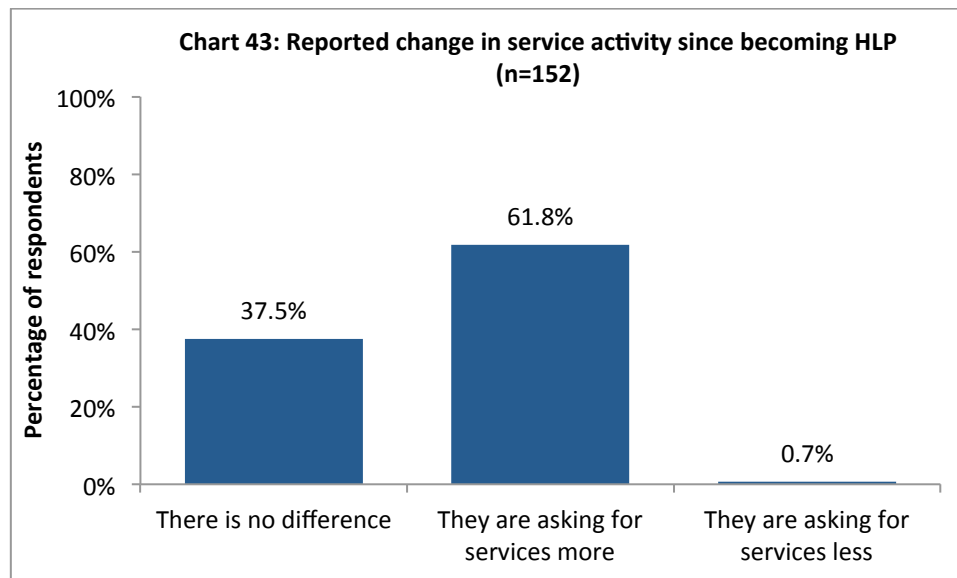
Three quarters of the respondents who reported increased income, said that their income had increased by up to 25% and a quarter by more than 25%.

Respondents were asked whether implementation of HLP had affected their prescription volume, the results are shown in Chart 42 below:



Over 60% of respondents reported that their prescription volume was unchanged. Approximately a third of pharmacies reported that their prescription volume had increased since implementing the HLP concept and a small number of pharmacies (10 pharmacies (7%)) said their prescription volume had fallen.

Respondents were asked about the impact of becoming an HLP on services requested by the public since becoming an HLP; the results are shown in chart 43 below.

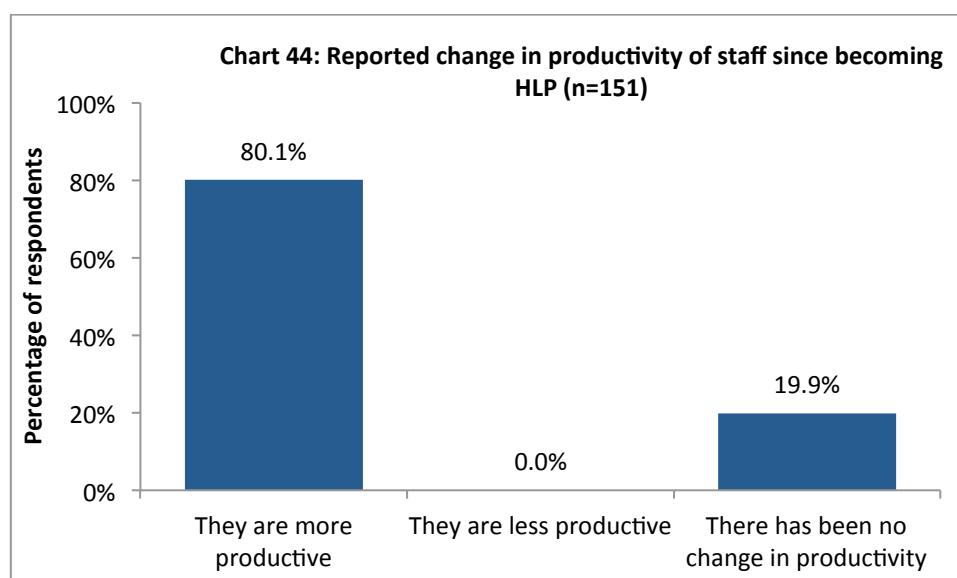


Note to Chart 43, "they" refers to the public

Over 60% of pharmacies reported an increase in the demand for services and apart from one pharmacy the others saw no difference in demand since becoming an HLP. One pharmacy from 152 who responded, reported a drop in demand for services.

IMPACT OF BECOMING AN HLP ON THE PHARMACY TEAM

Pharmacies were asked whether the productivity of staff had changed after becoming an HLP. The results are shown in Chart 44 below:

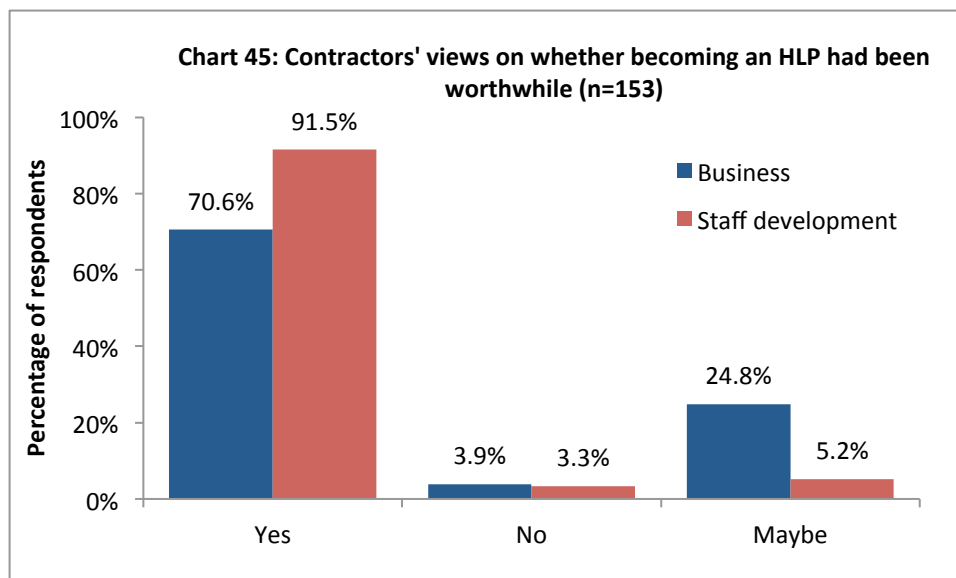


Note to Chart 44, "they" refers to staff

HLP pharmacies reported overwhelmingly that their staff had become more productive since becoming an HLP; 80% of participants reported an increase in output and the remainder reported that there was no change.

In terms of investment to become a HLP, only one in three pharmacies (33%) reported spending money on their premises; however, open comments expanding on this revealed that some pharmacies had not made any specific investments because they had already invested in previous years, or that they would like to invest to drive services but have budget constraints. The most common investments were new consultation rooms, and more generally refitting/upgrading the premises and creating the HLP focus areas/health-promoting zones in the pharmacy. Several pharmacies also reported investing in new signage and posters for their services, as well as staff training (and in some cases additional staff) to deliver these services. Three pharmacies also reported investing in new technologies.

Participants were asked whether the effort required in becoming an HLP had been worthwhile, in terms of business development and staff development. The results are shown below in chart 45.



Considering whether the HLP concept had been worthwhile for the business, 70% of the respondents thought that it had been good for their business, with 25% being uncertain. A small number of pharmacies (6 (4%) felt that it had not been worthwhile. When asked if becoming an HLP had been a worthwhile investment for staff development, 92% of pharmacies said that it had, with 8 (5%) unsure, and only 5 pharmacies (3%) disagreeing.

OTHER FEEDBACK FROM PHARMACIES

Pharmacies were asked if they had any further comments on becoming an HLP. Recurring themes in their responses included:

- Becoming an HLP has been of great benefit to the pharmacy staff, who now have more professional recognition and greater professional satisfaction
- Engaging in the HLP concept had been good to raise the public's awareness of services the community pharmacies offer. However, there was a concern about the lack of awareness that the pharmacy was an HLP and the services being offered.
- HLP will require continued and secured funding on a local scale if it is to be successful
- It is too early to realise actual benefits of becoming an HLP and this should be reassessed in a year's time.
- Being an HLP requires extra work (staff training, delivering more services, reporting data on service usage) and this will have to be remunerated for, if the HLP concept is going to be successful in the long term
- The public/patients who have used services in HLPs have been very satisfied with them.

The following quote summarises several of these themes.

“With proper funding, planning and co-ordination, there is a great opportunity for HLPs to make a real difference to local healthcare. The project is at an early stage in this area and once projects are funded and developed it will be easier to assess impact”

DIFFERENCES BETWEEN PHARMACY TYPES

The responses were reviewed to show whether the responses related to the type of pharmacy.

Service income

- All types of pharmacies reported similar responses of whether they thought their service income had gone up, down or stayed the same
- Those who reported larger increases were from large multiples and supermarkets compared to those reporting increases from independent pharmacies, small groups and small multiples
- On average no change was reported in monthly prescription volume from independent pharmacies, whereas a sizeable proportion of small groups/multiples and large multiples/supermarkets felt their average monthly prescription volume had increased.

Impact on staff

- All types of pharmacy felt that being an HLP had made their staff more productive
- The greatest increase in productivity was seen in independent pharmacies (85%), followed by small multiples (78%), and then large multiples and supermarkets (73%).

Investment In premises to become HLPs

- 45% of independent pharmacies had invested in their premises to become an HLP
- 15% of large multiples and supermarkets had invested in their premises to become an HLP
- 33% of small multiples had invested in their premises to become HLPs.

Worthwhile investment Considering whether becoming an HLP had been a worthwhile investment for their business

- The small groups agreed most strongly with this statement (80%)
- The figure for independent pharmacies and larger multiples/supermarkets was lower at 66%.

Public loyalty Responses to the attitudinal statements were generally very similar between pharmacy types, with the following two exceptions:

- Independent pharmacies were less likely to think that becoming an HLP created public loyalty
- Large multiples and supermarkets were more likely to think HLP led to better financial returns.

It has not been possible to look for statistical differences between the pharmacy types. Response numbers may be too small to make any further interpretation meaningful.

6.4.3 RESULTS OF THE ADDITIONAL QUALITATIVE STUDIES

PORTSMOUTH

From Community Pharmacy to Healthy Living Pharmacy: Early Experiences in Portsmouth

“In Portsmouth, interviews with staff and pharmacists working within HLPs demonstrated that participation in HLPs had generally had a positive impact on the pharmacy team. There was a sense of enthusiasm and belonging for those who were working in HLPs. The introduction of new staff roles with subsequent changes to the skill mix of the team, as well as training and/or accreditation for new responsibilities, all contributed to the success of

becoming an HLP. Existing relationships with members of the public made it easier to promote the HLP concept to them. Managing staff resources appeared to be a challenge; accommodating staff absence for training increased the workload of remaining colleagues with some anxiety that there was no scope for further activities due to other demands within the pharmacy. Encouraging members of the public to take up services was perceived as a barrier, with customer awareness being low despite publicity. Once established, HLP staff detected a noticeable strengthening of relationships with clients; this encouraged existing patients/members of the public to self-refer into available HLP services”.

“A perceived challenge was linking HLP and GP healthy living support services; this was evidenced by the very small number of patients referred to HLPs for weight management services by GPs.”

“The role of the PCT was considered to be important, in HLP support, both in terms of staff education and training, publicity and remuneration”.

“Participants reported increased job satisfaction as a result of working more closely with clients, having a more united team in the pharmacy and acquiring enhanced skills in healthy living support.”⁴⁹

There were some challenges for contractors in allowing for staff participation in training while maintaining their day-to-day workload, and the increased workload as a result of becoming an HLP. However, the contractor survey noted that staff in the pharmacy had become more productive. This could help other contractors to understand the advantages of investing in staff training and development, with staff taking on additional roles and responsibilities that could benefit society and pharmacy.

Public awareness of the HLP concept could be seen as low, at the time of reporting. The pathfinder areas noted that raising public awareness was important and planned for this in their programmes, although many were not able to follow through for various reasons. The importance of public awareness has been recognised from the beginning of HLP implementation. The authors of the Portsmouth review commented that once the public had been engaged, they developed stronger relationships with pharmacy staff. It is suggested that the strengthened relationships and trust between the public and pharmacy teams is used to promote word of mouth and peer-to-peer promotion to the public.

Building relationships between HLPs and GP practices would help to complement each other’s skills with potential population benefits.

⁴⁹ Paul Rutter, Jane Portlock, Zachariah Nazar, Janet Bowhill and David Brown 2012

PLYMOUTH

Know your Skin: Skin Cancer Early Diagnosis Health Promotion project

“Healthy Living Pharmacies reported 87.5% more customer brief advice conversations per pharmacy (30 per HLP vs. 16 per control pharmacy). In total 328 brief advice conversations took place in HLPs (19) and 188 in the control pharmacies (34)”.

“Healthy Living Pharmacies reported that 96% of customer brief advice conversations led to a brief intervention, control pharmacies reported 79%. In total 271 brief awareness interventions took place in HLPs (19) and 137 in the control pharmacies (34)”.

“Healthy Living Pharmacies returned 127% more completed customer brief awareness interventions and customer feedback forms (25 per HLP vs. 11 per control pharmacy)”.

“The Healthy Living Pharmacy model improved the performance of delivery in public health brief advice on skin cancer over the control pharmacies. HLP increases the number of active pharmacies and improved customer engagement in the Know Your Skin Promotion”. [Bird and Stone 2012]

Engaging the public in skin cancer awareness during the summer of 2012 was difficult as the summer was so wet. Despite these challenges, the HLPs demonstrated higher activity and added value through developing interventions into brief interventions.

BIRMINGHAM

To follow in an academic report later in 2013.

6.5 CONCLUSIONS AND RECOMMENDATIONS

Analysis of pathfinder reports showed that the HLP concept was welcomed by commissioners, as they were able to see the benefits that HLPs brought through effective service delivery within defined quality criteria to meet local health needs. Public health teams understood the potential added value that HLPs offered to the public’s health.

The results of the contractor survey showed that the overall effect of the HLP concept was positive for all types of contractor; while the benefits experienced varied between different types of pharmacies, there appeared to be something in investing in the HLP concept for everyone.

The contractor survey demonstrated that implementation of the HLP concept was seen as a worthwhile investment.

For reasons of commercial confidentiality there are no “hard” data on the effect of implementing the HLP concept on the financial impact. However, the uptake of HLP by a

wide range of independent and multiple-owned pharmacies may be evidence in itself of the benefits to the business.

The academic study in Portsmouth⁵⁰ showed that HLPs had a positive effect on the pharmacy team and highlighted issues that may need addressing before considering wider rollout of the concept.

The report from Plymouth of the skin cancer awareness health promotion project showed that HLPs were effective in engaging the public in the intervention.

⁵⁰ Paul Rutter, Jane Portlock, Zachariah Nazar, Janet Bowhill and David Brown 2012

7.1 CHAPTER SUMMARY

It is clear from the HLP pathfinder work programme that community pharmacies have embraced the HLP concept around the country. The target number of 100 HLPs by March 2012 was exceeded, and the number of HLPs continues to increase, with 478 by March 2013. Areas outside the pathfinder programme are also choosing to implement the HLP concept.

The costs reported⁵¹ showed that the median cost of implementation was £26,000 and required about 47 hours of project leader time per month, in addition to the demands on other project team members. These were viewed as one-off costs. When the pathfinder programme was established it was hoped that it would be possible to assess the financial costs and resource required.

Geography, deprivation or type of pharmacy did not appear to impact service delivery, cost effectiveness, benefits to commissioners, benefits to contractors, or public approval. Some pathfinder areas reported some challenges in engaging with and supporting contractors of the large multiples in implementation.

HLPs appeared to demonstrate benefits in meeting the needs of people from deprived communities. Commissioners valued this as it meant that HLPs were meeting local population health needs, confident that services were being delivered to defined quality criteria.

Successful implementation of the HLP concept required considerable commitment over many months, multidisciplinary working, some financial investment and a skilled workforce to proactively deliver health promoting messages and public health services. HLPs have, over time, developed new ways of working, maximising the skill mix within the pharmacy to deliver services to meet local needs. Geography, deprivation, location of pharmacy or type of pharmacy does not seem affect successful implementation.

The impact of effective project management, engagement and leadership to change the culture within community pharmacy to proactively deliver health and wellbeing messages cannot be underestimated. The implementation of HLP requires leadership at all levels.

7.2 PATHFINDER AREA SELECTION AND PARTICIPATION

There were 20 pathfinder areas selected of which fourteen returned reports. All pathfinder areas provided the number of HLPs accredited in their area as well as the number of

⁵¹ See Chapter 7

qualified Health Champions. Three areas, which were not selected as pathfinders but chose to implement HLP in any case, also reported the number of HLPs and Health Champions. Table 16 below shows the total number of known HLPs and Health Champions collated on 29 March 2013.

<i>Table 16: the number of HLPs and Health Champions in pathfinder and non-Finder areas January 2013</i>		
<i>Pathfinder Area</i>	<i>No. HLPs</i>	<i>No. Health Champions</i>
Blackburn and Darwen and East Lancashire	51	78
Brighton and Hove Group	20	20
Buckinghamshire and Milton Keynes	13	75
Dudley	17	58
East Riding and Hull	12	30
Gateshead, Tyneside and Sunderland	31	53
Heart of Birmingham	20	50
Lambeth	21	59
North Staffordshire	23	55
Plymouth	6	40
Portsmouth	20	110
Sheffield	9	12
Shropshire	18	40
South Staffordshire	33	75

No report received		
Ashton Leigh and Wigan	24	24
Dorset	3	27
Essex	12	28
Great Yarmouth and Waveney	8	18
Isle of Wight	4	54
West Kent	17	92
Total in Pathfinder areas	362	995

<i>HLP not in pathfinder programme</i>	<i>No. HLPs</i>	<i>No. Health Champions</i>
Gloucestershire	0	17
Southampton	7	49
West Yorkshire	95	230
Tees	0	42
Worcestershire	10	45
Central Lancashire	4	4
County Durham and Darlington	0	66
National Total	478	1444

The target for the Pathfinder programme was to achieve at least 100 HLPs by the end of March 2012. Table 16 shows that the pathfinder areas have taken up the HLP concept at a

much faster rate than expected, despite all the major changes within the NHS and public health system architecture.

In addition to the number of HLPs, there were over 1300 Health Champions reported across the country.

Six pathfinder areas did not return their reports. This represented 15% of the total number of HLPs in pathfinder areas. It could be assumed that the HLPs in these areas delivered the same mix of services and achieved similar outcomes and outputs, as evidence by HLPs that did report. Similarly, it could be assumed that the public, commissioners and pharmacy teams in these non-reporting pathfinder areas experienced comparable benefits to those reported by the 14 pathfinder areas. It is recommended that future work is carried out to explore the causes of non-reporting by some of the areas, although several reported change in resourcing, NHS changes and delays in full HLP implementation as being reasons for non-completion and have indicated reports to follow in due course.

7.3 IMPLEMENTATION IN THE PATHFINDER AREAS

The 14 pathfinders who reported provided adequate information, however, these responses were not typically in the format set out in the evaluation protocol. Information on project leadership, project team membership, how the HLP concept was implemented locally and the associated costs and funding streams, is presented below to inform the learning from implementation, which could inform further national rollout.

7.3.1 LEADERSHIP AND PROJECT TEAMS

Fourteen areas reported on leadership and project management of the HLP concept with implementation led by people from both the commissioning organisation (PCTs) and LPCs. Within commissioner organisations, leaders were in roles such as Community Pharmacy Development Manager, Pharmaceutical Advisor, or Public Health Consultant. Within LPCs, leads were in roles such as Chief Officers, Service Development Officers and one was also a CPPE Tutor. In one pathfinder area, Dudley, the project lead held a joint post with the PCT and LPC.

The pathfinder areas set up project teams or steering groups comprising LPC members, PCT staff and Public Health team staff, who were at different stages of moving to local authorities or area teams or CCGs. Five areas reported losing members of their project teams during the pathfinder programme, with most not being replaced.

7.3.2 KEY POINTS IN IMPLEMENTATION STRATEGIES

Key points in the strategies selected in pathfinder areas have been extracted from reports to look for differences in the way local project teams implemented the HLP concept and whether there were any linkages to service delivery and outcomes. The key points have been summarised in Table 17 below.

<i>Key points in Strategy</i>	<i>Pathfinder areas and number of HLPs 13 Jan 13</i>	<i>Comments</i>	
All pharmacies invited to take part	Birmingham and Solihull	19	Sheffield had HLP acceptance criteria which interested pharmacies had to demonstrate they met
	Buckinghamshire and Milton Keynes	12	
	Blackburn with Darwen and East Lancashire	47	
	Dudley	17	
	East Riding and Hull	12	
	North Staffordshire	23	
	Portsmouth	20	
	Sheffield	9	
	Stoke-on-Trent	32	
Expression of interest required and/or other documentation	Birmingham and Solihull	19	Brighton and Hove Group deliberately made applications for HLP status challenging to ensure only committed pharmacies applied
	Blackburn with Darwen and East Lancashire	47	
	Brighton and Hove Group	19	
	East Riding and Hull	12	
	Lambeth	21	
	North Staffordshire	23	
	Stoke-on-Trent	32	
Pharmacies selected by project team	Plymouth	6	Plymouth based choice of HLP and non-HLP on smoking prevalence and matched for deprivation, dispensing volume, footfall and type of pharmacy
Self-assessment by pharmacies	Buckinghamshire and Milton Keynes	12	Pharmacies self-assessed prior to review by the project teams
	Blackburn with Darwen and East Lancashire	47	
	Dudley	17	
	Plymouth	6	
	Shropshire	18	

Table 17: Strategy in Pathfinder areas for selecting pharmacies to become HLPs

Key points in Strategy	Pathfinder areas and number of HLPs 13 Jan 13	Comments	
Assessment by project team	Birmingham and Solihull	19	Blackburn with Darwen and East Lancashire selected from interested pharmacies based on locality, deprivation and population size. Lambeth selected first cohort based on current activity, locality, and baseline activity. Sheffield matched applicants with area of greatest health need, and selected a mix of type of pharmacy Shropshire project team set criteria for acceptance
	Brighton and Hove Group	19	
	Buckinghamshire and Milton Keynes	12	
	Blackburn with Darwen and East Lancashire	47	
	Dudley	17	
	East Riding and Hull	12	
	Lambeth	21	
	North Staffordshire	23	
	Sheffield	9	
	Shropshire	18	
	Stoke-on-Trent	32	
Award by project team	Birmingham and Solihull	19	Other areas did not explicitly explain how they awarded quality mark
	Buckinghamshire and Milton Keynes	12	

Table 17 shows that pathfinder areas used a variety of approaches to implement HLPs in their area. The selection methods varied from top-down where the project team selected pharmacies and then recruited them (Plymouth) to bottom-up where all pharmacies were given the opportunity to take part and were expected to work towards HLP status (Buckinghamshire and Milton Keynes, and Portsmouth). Seven areas required an expression of interest to be completed by pharmacies, which was deliberately made demanding by the Brighton and Hove Group to select for committed pharmacies. Pharmacies in five areas were allowed to self-assess their own progress. Project teams in all areas awarded HLP quality marks to pharmacies, which matched their criteria; however, the process was not explicitly described. The data showed that there seemed to be no association between the selection methodology and the accreditation criteria used and the number of HLPs in those areas. It is recommended that more in-depth qualitative work is followed up with areas to explore their methodologies to determine how consistently the HLP concept was applied. This could be an important aspect for informing national rollout.

The use of local project teams and local processes used local methodologies to implement the HLP programme; finding ways to avoid duplication would be helpful.

Supporting the enablers such as local training will have to be found after March 2013, as PCTs provided much of the local training and development to support HLP implementation; alternatives do exist, which some pathfinder areas have used, for example, leadership training from the NPA and CPPE.

7.3.3 FUNDING AND COSTS

Pathfinder sites were asked to report on the costs associated with implementation and specific questions were included in the template report. As noted above, not all the pathfinder sites returned reports. However, the costing data have been extracted and collated as shown in Table 18 below. As the data have been taken from a small group of participating sites, they must be treated with caution but have been included here as pathfinder sites were asked to provide the data because it was expected to add more information about the process of implementation. With these caveats the data give an indication of the costs involved in implementation.

Pathfinders funded the cost of implementation in different ways: from the PCT, LPC, public health and local authority, pharmaceutical company sponsorship and community pharmacy contractors themselves. Both LPCs and PCTs used existing staff to implement HLPs. Two LPCs reported that they funded all the cash costs of implementation.

The implementation costs, funder and the amount of project leadership time were provided by pathfinder areas in their reports and are shown in Table 18 below:

<i>Table 18: Summary of pathfinder costs and funding (note: n=10)</i>				
<i>Pathfinder area</i>	<i>Cost of implementation (excluding staff costs)</i>	<i>Who funded</i>	<i>Project lead time (Hours per month)</i>	<i>Comments</i>
Brighton and Hove Group	£3,000	PCT, LPC drug companies, contractors	Not reported	Costs paid by drug companies not included
Buckinghamshire and Milton Keynes	£30,000	£10,000 LPC £20,000 LPC/contractors	85-100 hours until Apr 12 40 hours Apr 12 to Jul 12	LPC reduced resources from Apr 12 and stopped funding Jul 12
Blackburn with Darwen and East Lancashire	£33,600	~£25,000 joint PCTs and LPC ~£11,000 PCTs	45	
Dudley	£26,000	£1000 PCT/sponsor £25,000 PCT	64 plus admin	
East Riding and Hull	£14,000	£10,000 LPC £1800 PCT/LPC £2200 PCT/LPC/contractors	16 – 24	
Lambeth	£8,000	PCT	64 plus admin	LPC matched funding in kind
Plymouth	£36,000	PCT/LPC/contractors	98	
Portsmouth	£31,000	Not reported	Not reported	
Sheffield	£4,900	£1000 LPC/sponsor/PCT £3,900 PCT	24	
Stoke-on-Trent	£11,600	£5,100 LPC £1,500 LPC/contractors £5000 two LPCs	50	Part funding shared with neighbouring LPC

Table 18 shows that ten areas reported their expenditure on implementation; the figures shown exclude staff costs as most areas used existing staff. One area, Plymouth, analysed staff costs and calculated the set up cost to be £35,000 and the on-going management cost to be £36,000 per year. The amount of cash spent on implementation ranged from £3,000 to £36,000, median value £20,000. Three areas, Brighton and Hove Group, Dudley and Sheffield were able to obtain some pharmaceutical company sponsorship, seven areas had funding from the PCT(s) and LPC and two areas were funded solely by LPCs. The area with

the highest apparent cost of implementation, Plymouth also had three health initiatives commissioned in addition to Stop Smoking.

Five areas reported that their contractors contributed financially to the enabling training to become HLPs. Becoming an HLP encouraged contractors to pro-actively engage in the general principles of the HLP concept.

The amount of time that project leaders were able to devote to implementation ranged from 16 to 100 hours per month, median value 50 hours, showing that there is a significant time investment required, ideally requiring dedicated resources.

Nine of the areas that reported on expenditure also reported increased service delivery. Six of these areas (Blackburn with Darwen and East Lancashire, Buckinghamshire and Milton Keynes, Dudley, East Riding and Hull, Lambeth, Plymouth and Portsmouth) reported benefits for commissioners and improved collaborative working between commissioners, public health and providers. Contractor and public approval was high across all areas that reported.

7.3.4 LEARNING FROM IMPLEMENTATION TO INFORM ROLL-OUT

Pathfinder areas reported on the challenges they faced and what they would do differently if they were to implement HLPs again and their comments have been analysed⁵². Themes that emerged are shown below:

Project Management Participating areas were concerned about the sustainability of the HLP concept following the pathfinder programme. Participants noted the importance of support for project management as an important aspect of the drive for further roll out.

“The main constraining factor to achieving more successful outcomes has been down to the lack of any funding to project manage the HLP programme and widely promote the HLP concept and the services an HLP in the area provides” [Brighton and Hove Group]

The need for continued support was explained by one pathfinder area:

“Sustained managerial support for the project is essential to maintain regular contact with pharmacies for one to one mentoring, support, problem-solving, encouragement, to overcome their isolation and day to day workload taking priority.” [Buckinghamshire and Milton Keynes]

Any change management programme requires sustained support to ensure that it becomes embedded as standard practice and areas reported that they did not know what would

⁵² NVivo 10 QSR as before

happen to project management in the future, and some had lost key people or time resources for HLP implementation, which had not been replaced.

One area reported that the implementation of HLP in one of its areas had been dependent on one person in the PCT who acted as the interface and champion for HLP implementation in the organisation. When she left the continuity of implementation was damaged:

“... she was effectively the gatekeeper to HLP for the PCT and did much of the work herself, as there was considerable reorganisation in other departments and people were not available to share the workload. This individual left abruptly during the reorganisation and left a tremendous gap; her work was taken on by one person covering the whole cluster who had not been involved in HLP earlier and although convinced of its value and with a wish to roll it out across the cluster, had very limited time to devote to HLP.” [Buckinghamshire and Milton Keynes]

Areas reported on the importance of the steering group or project team to increase robustness of the programme.

“Required significant amount of time from the steering group in and out of meetings to make it happen...this should not be underestimated.” [Blackburn with Darwen and East Lancashire]

The concurrent reorganisation of the NHS, Public Health and social care system had an impact on project management and implementation; one pathfinder summed up the effect on the HLP programme:

“The eight months that followed the submission of the application to become a pathfinder saw the implementation of a major structural re-organisation within the NHS and it became increasingly apparent that some of the original stakeholders who had supported the HLP project had different priorities, that meant the LPC had to lead on the project more than it had originally envisaged.” [East Riding and Hull]

Some of the pathfinders commented on the time scale of the pathfinder programme and found it difficult to implement and report within the time allowed; this could explain why some of the reports were incomplete and why some areas did not report.

Participants needed to ensure that they planned for and set clear objectives, and defined key performance indicators. Some of the learning and the experience of the pathfinders could be helpful in informing national rollout. It is recommended that more work is carried out with pathfinder areas to explore their learning about these issues.

Contractor and Pharmacy Engagement Some areas reported that they found it difficult to help pharmacies from the large multiples implement the HLP concept. They reported that the objectives of the organisation were not lined up with their stated commitment to HLP status for example:

“... how to influence companies not actively backing HLP implementation to support branch involvement. Despite being ‘put forward’ for participation, we have found enthusiastic branches have had conflict with their companies in order to create public health areas, display HLP material, even put an HLP poster in the store window.” [Sheffield]

Another area observed that where pharmacies from large multiples were successful in developing HLPs there appeared to be a key person in the organisation that could link up the organisation’s strategy and enthusiasm for HLP with the branches’ enthusiasm for HLP and help make it happen.

“We started with good engagement of area and regional managers in multiples, however two things happened: one was that some of the multiples were restructured and new people came in or priorities changed and the other was that there was an implementation gap between the high commitment of local area managers and some of the pharmacies” [Buckinghamshire and Milton Keynes]

One pathfinder found that when pharmacy teams had completed their training, had the IT system for recording data and been briefed on what was expected of them, they seemed to be waiting for permission from the project team to work towards their HLP quality mark. In this instance there appeared to be an implementation gap where pharmacies had not gained the confidence to take responsibility for working towards their quality mark.

These difficulties could be overcome; in Portsmouth where HLP concept had been established longest, a commissioner participant noted that HLPs had helped community pharmacies work more cohesively:

“The HLP project appears to have made a positive impact on community pharmacy services in Portsmouth. It has produced a strong community of participating pharmacies and the public and patients are beginning to benefit from the services provided” [Portsmouth]

These observations demonstrated that time and continued work to build a network of community pharmacies was worthwhile as pharmacies were being perceived as health professionals providing public health services with the public benefiting from the commissioned services.

Enablers Implementation of the pathfinder work programme at the time of the reorganisation of the NHS and public health resulted in difficulties for pathfinder areas. This included obtaining data and accessing local training for potential HLPs within their areas as staff left PCTs, or individuals were redeployed, or took on extra work or were moved to other areas when PCTs clustered. Additionally, information systems were changed, or superseded when PCTs clustered. In some areas, which had seen a commitment initially, the key individuals had moved e.g. East Riding and Hull.

Pathfinders recommended that contractors should be able to access nationally available sources of enablement to achieve HLP rather than rely on local provision, potentially provided by national pharmacy organisations.

“National accreditation measures retained that are meaningful for the whole team” [Blackburn with Darwen and East Lancashire]

Some pathfinder areas used leadership training from national providers (e.g. NPA and CPPE) and a variety of providers for the Health Champion training (RSPH Understanding Health Improvement Level 2 award). Some pathfinders had local training facilities available; this kind of local training may be more sustainable but would lead to challenges on consistency and quality assurance.

The difficulty of capturing data made it more difficult for pathfinders to report data in a consistent manner.

“It has been recognised that there is a lack of consistency nationally and locally in IT support systems, resulting in numerous difficulties for data capture” [Plymouth]

At least two areas (Blackburn with Darwen and East Lancashire, and Buckinghamshire and Milton Keynes) used ESMAQ (a web-based system for Enhanced Services Monitoring and Quality) to record their HLP data. Portsmouth and the Isle of Wight also used ESMAQ as the system. These areas were able to provide detailed information about service delivery, which was reported in Chapter 3. Another pathfinder suggested linking data capture with integrated care records and a quality outcomes framework to support commissioning (Blackburn with Darwen and East Lancashire).

One pathfinder area recommended that the HLP concept be recognised and standardised nationally to raise awareness of the HLP concept with commissioners, encourage implementation and increase robustness:

“National recognition of HLP as an enrichment of the NHS family ... National absolute standards for HLP ... National retention of accreditation measures [as seen with current HLP Quality Criteria] ... more services to be commissioned (maybe Direct Enhanced Services) ... inclusion in national documents/guidance as a specific credible valuable workshop, enhanced public health ... HLP direction and support from national level” [Blackburn with Darwen and East Lancashire]

National standardisation to ensure consistency and quality of public health services delivered through community pharmacies for the public would not be consistent with local flexibility to commission services according to local health need. However there may be benefits to having national criteria for enables and HLP status.

Public Awareness - pathfinder areas recognised the importance of raising public awareness of the HLP concept and some areas had allocated funding to publicity campaigns. However due to financial constraints, the funding was subsequently withdrawn or suspended.

The results from the public survey in Chapter 5 showed that before going to the pharmacy 27% of the public were aware of the HLP concept. This is an encouraging figure taking into account that the HLP concept has not been around for long. However there is a need to increase public awareness locally, particularly as the public's willingness to recommend the service to others was 98%.

7.3.5 SUMMARY OF IMPLEMENTATION EXPERIENCE

Commissioners, Public Health teams and community pharmacies, have embraced the HLP concept; the number of HLPs and Health Champions has demonstrated this. The target number of HLPs by March 2012 was exceeded, the number of HLPs continues to increase and by the end of March 2013 there were 478 HLPs including areas outside the pathfinder work programme choosing to implement the HLP concept. Pathfinder areas reported some challenges to implementation due to NHS and public health system architecture changes. Despite this, implementation of HLPs continues to progress at a good rate. Some pathfinder areas have made constructive recommendations to inform spread of implementation. HLP implementation was successful with pathfinders using different strategies to implement HLP in their areas with good support from their PCTs and LPCs.

7.4 IMPACT OF GEOGRAPHY, DEPRIVATION AND TYPE OF CONTRACTOR

The impact of geography and deprivation were considered in terms of:

1. Service delivery
2. Benefits to Commissioners
3. Benefits to Contractors and Pharmacy Teams
4. Public reported experiences
5. Approaches to implementation in the pathfinder areas

And through the parameters of:

1. Differences in deprivation
2. Differences in health need
3. Urban or rural environments
4. Different types of contractor

It should be noted that there are limitations in the interpretation of this data and this would be worthy of future investigation.

7.4.1 SERVICES

The services evaluated and discussed in Chapter 3 were reviewed in the context of the parameters listed above.

1. Differences in deprivation – for example Stop Smoking services were evaluated in Birmingham and Buckinghamshire. Birmingham had the highest deprivation (ranked 13 of 326) of any of the pathfinder areas and Buckinghamshire had a district with the lowest deprivation (312 of 326) of any of the pathfinder areas. Both areas reported increased numbers of people setting quit dates, achieving a quit and increased quit rate after HLP implementation.
2. Differences in health need – for example, Stop Smoking services were evaluated in Portsmouth and Buckinghamshire. The prevalence of adults smoking in Portsmouth was 26% (significantly higher than the England average) and in Buckinghamshire was 16% (significantly lower than the England average)⁵³. Both areas showed increased number of people setting quit dates and achieving quits in HLPs than in non-HLPs or before HLP implementation, even though in some cases, the differences may be low
3. Urban or rural environments – most of the service evaluations returned were from mainly city or urban environments. However, two areas contained rural areas: East Lancashire and Buckinghamshire which both reported improvements in access to EHC and associated condom distribution, in line with the findings in Portsmouth and Stoke-on-Trent, which are densely populated urban environments. Further evaluation of more rural areas is required
4. Different types of pharmacy contractor – pathfinders reported very little effect of type of contractor, although one suggested that activity was greater in independent pharmacies and independent multiples. The same area reported high activity in a large multiple for one service.

7.4.2 BENEFITS TO COMMISSIONERS

- Differences in deprivation - commissioners noted the importance of commissioning HLPs in areas where there were differences in deprivation
- Differences in health need as a positive commissioning tool. Commissioners were confident that HLPs would deliver services to meet local need, within defined quality criteria
- Urban or rural environments – no differences were seen in responses from pathfinder areas from urban and/or rural environments, although more work may be needed to confirm service delivery within rural environments

⁵³ Data taken from Health Profiles 2012

- Different types of pharmacy contractor – commissioners appeared to distinguish only between HLPs and non-HLPs and did not consider the different kind of contractors in their choice of HLPs.

7.4.3 PUBLIC REPORTED EXPERIENCES

Questionnaires were returned from 10 areas, including one, which had not returned service data. The areas included variation of deprivation and health need and urban and rural locations.

1. Differences in deprivation – no differences seen in responses
2. Differences in health need – no differences seen in responses
3. Urban or rural environments – no differences seen in responses
4. Different types of pharmacy contractor – no differences seen in responses.

The absence of differences between responses show that services delivered through community pharmacies were acceptable to the public and service users, regardless of the location or type of pharmacy.

7.4.4 BENEFITS TO CONTRACTORS AND PHARMACY TEAMS

Questionnaires were returned from 15 areas, including one, which had not returned service data or a report. The areas included variation of deprivation and health need and urban and rural locations.

- Differences in deprivation – no differences seen in responses
- Differences in health need – no differences seen in responses
- Urban or rural environments – no differences seen in responses
- Different types of pharmacy contractor – all types of contractors reported increased service income (large multiples and supermarkets reported the greatest increase), increase in productivity of staff (independents and small multiples reported the greatest increase), investment in the premises to implement the HLP concept (independent pharmacies were the largest group that invested in the premises), that they felt that investment in HLP was worthwhile (small multiples reported the highest agreement) and increased customer loyalty (large multiples and supermarkets). This indicates that HLP has benefits for all types of contractors, in different ways.

7.4.5 APPROACHES TO IMPLEMENTATION IN PATHFINDER AREAS

1. Differences in deprivation – no differences seen in responses
2. Differences in health need – no differences seen in responses
3. Urban or rural environments – no difference seen in responses
4. Different types of pharmacy contractor – some challenges were highlighted with implementation with pharmacies owned by large multiples.

7.4.6 CONCLUSIONS

There appeared to be no negative effects of geography, deprivation or type of pharmacy reported in terms of service delivery, benefits to commissioners, benefits to contractors, or public approval. This is encouraging as factors such as geography, deprivation, location of pharmacy and type of contractor would be unalterable to achieve successful implementation.

Commissioners in some areas decided to selectively commission HLPs from some community pharmacies in areas of high health needs..

There were different results for different types of contractor, with each type of contractor reporting benefits to implementing the HLP concept for their pharmacy business, and staff, showing that HLP could be suitable for all types of contractors.

The public did not appear to distinguish between different types of pharmacy and approval rating was high for all, and in all localities and for all services evaluated, showing that commissioners' ambitions to use HLPs to meet local health needs would be acceptable to the public.

7.5 SERVICE DELIVERY WITHIN DEFINED QUALITY CRITERIA

One of the underlying principles of the HLP concept was that HLPs would consistently deliver a wide range of services within defined quality criteria with appropriately trained workforce in premises fit for promoting health and wellbeing and delivering services. The pathfinder programme indicated that despite the limitations of the service evaluation (see section 2.4), there was consistent delivery of a range of public health services within defined quality criteria, delivered locally for most areas. This was not evidenced by all pathfinder areas; some pathfinder areas did not return data and others reported that some pharmacies in their areas did not report. It is important to recognise that the pathfinder programme did take place against a background of considerable change to the NHS and public health commissioning structures. However, a change management programme such as HLP implementation would have to be sustainable against a challenging background because it would be operating in the real world where the environment could not be expected to be static.

Commissioners recognised the benefit of commissioning services from HLPs and either commissioned new services, or revised service specifications for existing services on the strength and quality of the services delivered by HLPs; examples include Plymouth, Blackburn with Darwen and East Lancashire and Lambeth.

7.6 COMMISSIONED SERVICES

There was considerable variation in service specifications for the same services with a similar purpose, with different measures and outcome requirements in different localities. Similar services were commissioned in many areas, for example, Stop Smoking and EHC. Others were focused on particular health needs in the area, for example, alcohol awareness or substance misuse. The development of national illustrative specifications for services, which are universally commissioned, may be helpful, especially as some pharmacies rely on locums for service delivery. This would be consistent with the pathfinders' recommendations about some form of national accreditation criteria to support reliability, consistency and high quality provision. In this way, similar services may be delivered regardless of the location, based on local health need, increasing equity for the public. With consistent data capture and evidence gathering, the evidence base for pharmacy's contribution to public health could be strengthened.

7.7 FACTORS ASSOCIATED WITH SUCCESSFUL HLP IMPLEMENTATION

The factors that appeared to be associated with successful implementation taken from section 7.3 were:

- **Dedicated project manager and commitment of project team/steering group** The median amount of time required for project management was 50 hours per month. The need for a dedicated project manager, project team and/or steering group was considered important
- **Funding for implementation and maintenance of HLP** It is considered important to ensure that access to funding to facilitate the support required for HLP implementation is made available. The current financial climate provides challenges for additional funding for development
- **Regular contact between pathfinder leads and pharmacies** Regular contact between the project team with implementing pharmacies was important to help focus pharmacy teams on achieving HLP status, successful delivery of services and supporting staff development and motivation
- **Stakeholder engagement** Collaborative multidisciplinary working to implement the HLP concept has been fundamental to successful delivery. Stakeholders include commissioners, public health teams, health and social care professionals, contractors and pharmacy teams. Commitment of the management teams within the medium to large multiples was also an important factor
- **Proactive pharmacy teams** In order to deliver the HLP concept effectively, pharmacy teams need management support. This includes the confidence to delegate effectively, allowing Health Champions to lead on health promotion activities
- **Targeting implementation** There was some evidence that pharmacies that demonstrated the HLP ethos before implementation of HLPs were likely to become effective as HLPs and that some pathfinder areas targeted pharmacies to become HLPs. Given the benefits seen to local communities, the question of whether to target or not should be further considered. The Pharmacy and Public Health Forum HLP Task Group has indicated that all pharmacies should have the opportunity to become HLPs, and that this should not be limited. However, it may be appropriate in certain situations to commission certain services from identified community pharmacies, based on local demography and need.

This *before and after* evaluation tells a positive story about HLP implementation. The results indicate that the concept could be replicated in other areas with different geography and demographics. The individual stories from Health Champions and HLPs, too numerous to capture in this report, have been inspiring. The public has reported that they like the location of a community pharmacy to access services and the majority would recommend the service available from HLPs to others. Importantly this evaluation has shown that over 20% of people would have done nothing to access health and wellbeing advice or services if they had not received it within the pharmacy. There are however a number of questions that have not been answered. A further review or robust academic research, including further health economic data, may be needed to address some of the limitations of this evaluation, mentioned earlier.

A number of challenges exist which threaten the continued momentum that has already been generated to implement HLPs around the country. It is important to not lose the momentum especially during the transition to the new NHS and public health system architecture. Issues that impact on the continued momentum of HLP implementation include:

- New mechanisms to commission public health enhanced services from a range of providers
- Change in personnel who have been leading the implementation of the HLP concept at a local level
- Lack of information and engagement from contractors; general uncertainty about continuity of funding and return on investment
- Concerns around funding to support further development
- New commissioners to build knowledge, relationships and trust with contractors
- Raising public awareness.

Throughout the pathfinder programme there have been a number of lessons learnt:

- Importance of continued national and local leadership
- Consistent monitoring and on-going evaluation
- Need for a clear case for investment for contractors and employees
- Adequate access to resources
- A local pharmacy public health lead
- Area team ownership
- Local Professional Network ownership
- Continued support from national pharmacy and public health bodies
- On-going learning and networking opportunity
- Public engagement and promotional campaigns.

The following recommendations are suggested to sustain the momentum achieved with implementation of the HLP concept and to accelerate the rollout, ensuring scalability:

- National support and leadership from NHS England, Public Health England and DH
- Potential support for the achievement of the HLP Quality Criteria and enablers within the community pharmacy contractual framework
- Local recognition of HLP status by Local Authorities, Directors of Public Health, Health and Wellbeing Boards and Clinical Commissioning Groups, to enable future confidence and investment in the concept
- National consistency for quality assurance purposes to ensure the public can expect the same standard of service delivery from HLPs regardless of location
- Consideration needs to be given to the establishment of a national awarding body for the HLP quality mark
- Consideration needs to be given for developing a national data collection set, which can be used locally
- Development of national, illustrative 'HLP' service specifications for some of the universal services to ensure consistency in delivery and measurement
- Consideration needs to be given to develop some common performance measures including developing further public reported experience measures
- Continued leadership and support from the national pharmacy and public health bodies
- Continued leadership and support locally.
- Resources to support contractors from for example, Local Education and Training Boards, Local Pharmaceutical Committees, commissioners
- Consideration needs to be given to using Making Every Contact Count Prevention and Lifestyle Behaviour competences framework to further develop the HLP workforce development framework through the workforce development task group of the Pharmacy and PH Forum
- Consideration for further development of the Health Champions for HLP levels 2 and 3
- Consideration for further development of HLP leadership competencies linked to the RPS Leadership Competency Framework
- Consideration for extending the role of HLPs, based on the success in improving access, to include, for example, support for dementia and early detection of cancers.

8.1 COMMISSIONER ENGAGEMENT

There has been good recognition of the HLP concept with support seen across the health system. However as we move into a new NHS and Public Health system, with NHS pharmaceutical services commissioned through the NHS England and public health services through the Local Authorities, it is important that momentum is not lost during the transition. Raising awareness of the benefits that HLPs are bringing to the local community with Health and wellbeing Boards, Clinical Commissioning Groups, Directors of Public Health and local councillors could go some way to embedding the HLP concept in local service delivery.

8.2 NATIONAL CONSISTENCY

Several pathfinder areas have reported the need for national consistency in awarding criteria for the HLP quality mark. This will ensure that the public, walking into an HLP in any area of the country will be able to recognise the characteristics of an HLP and be confident in the quality of public health services delivered through HLPs. Further work is required to identify what mechanism is needed for awarding the quality mark, its awarding body, the quality criteria used to define an HLP. Further work is currently being undertaken by the Pharmacy and Public Health Forum task group for acceleration of roll out of HLPs and within the task group charged with workforce development to consider how best to achieve this.

8.3 EVALUATION

The limitations of this evaluation, which were identified frankly, highlight a potential need for more detailed research. However, some areas have been happy to proceed with implementation without any further research. Analysis of HLP performance over a longer timescale to understand sustainability would be of interest to a range of stakeholders. The full evaluation of Portsmouth has demonstrated continued and sustainable performance.

A core requirement of any future research is the consistent collection, reporting and analysis of data across all HLPs and non-HLPs, ideally web-based, by clients and in real-time.

For example, in order to undertake a full cost-effectiveness analysis of HLP service delivery, one would consider a number of factors, including:

- Identifying a control group, such as a cohort of non-HLPs, to allow detailed analysis of the differences in outputs and outcomes between HLPs and non-HLPs
- Collecting additional data, for example in the context of Stop Smoking services, data on age, sex, and demography, as well as on the type of support provided, for example: was it 1:1 support with a pharmacist, a Health Champion, or another pharmacy staff member?

- In addition, collecting data on whether the person receiving the service made use of pharmacotherapy to support their quit attempt. This can assist in answering a number of other detailed questions, and can support drawing out any variation in performance across pharmacy type, and type of intervention made
- Develop methodologies to capture similarly rich data for some of the other public health services, especially for those where there may be gaps in the literature around the potential cost-effectiveness of an intervention
- Capturing all business costs (or use of existing assets) associated with service delivery, which can be fed, for example, into calculating the cost per quit.

Clearly, such a study, or studies, would require significant resources, because of the specialist knowledge that would be needed. However, such research could add significant value to the wider public health literature, as well as to commissioners, businesses with an interest in the HLP concept, and the public.

8.4 LEADERSHIP AND PROJECT MANAGEMENT

The original principle that drove implementation in Portsmouth was to ensure leadership at all levels including developing the pharmacists and non-pharmacy managers as leaders. Every HLP should have an identified individual in a leadership role that has undertaken leadership and change management training. A possible path could be the development of leadership competencies, potentially linked to the RPS Leadership Competency Framework, [which in turn links to the NHS Leadership Framework] and an understanding of how this varies at each level of the HLP framework.

8.5 ENGAGEMENT WITH POTENTIAL HLPS

The HLP Task Group recommends that all pharmacies should have the potential to be an HLP. However, it is recognised that in certain situations, it may be appropriate to commission services from identified pharmacies. This would be driven by local health needs.

When commissioning services, commissioners may need to consider whether to focus on a defined number of quality-marked pharmacies or whether to aim for universal delivery and therefore universal access, although not all pharmacies may wish to become an HLP. Whilst there are likely to be certain efficiencies that can be gained by redirecting service delivery to a defined number of quality-marked locations, a far greater benefit may be realised by increasing numbers of HLPs.

GLOSSARY OF TERMS USED IN THE REPORT

<i>ABBREVIATION</i>	<i>FULL NAME</i>
AQP	Any Qualified Provider
CPPE	Centre for Pharmacy Postgraduate Education
DES	Directed Enhanced Service
EHC	Emergency Hormonal Contraception “the morning-after pill”
ESMAQ	Enhanced Services Monitoring and Quality web-based reported system
HLP	Healthy Living Pharmacy
IMD	Index of Multiple Deprivation
LPC	Local Pharmaceutical Committee
MUR	Medicines Use Review (Advanced service in community pharmacy contractual framework)
NMS	New Medicine Service (Advanced service in community pharmacy contractual framework)
NPA	National Pharmacy Association
PCT	NHS Primary Care Trust
PSNC	Pharmaceutical Services Negotiating Committee
PH	Public Health
RPS	Royal Pharmaceutical Society

APPENDIX 1: HEALTHY LIVING PHARMACY FRAMEWORK⁵⁴

LOCAL HEALTH NEED				
HEALTHY LIVING PHARMACY FRAMEWORK PUBLIC HEALTH MODEL				
NEED	CORE	LEVEL 1 <i>Promotion</i>	LEVEL 2 <i>Prevention</i>	LEVEL 3 <i>Protection</i>
Smoking	Health promotion, self care, signposting, OTC supply	Pro-active health promotion. Brief advice, assess willingness, signpost to services	NHS stop smoking service, cancer awareness, Health Check	COPD and cancer risk assessment with referral. Prescriber for stop smoking service.
Obesity	Health promotion, self care, signposting, OTC supply	Pro-active health promotion. Brief advice, assess willingness, signpost to services	NHS weight management service, cancer awareness, Health Check	Prescriber e.g. obesity, CVD, diabetes. Cancer risk assessment
Alcohol	Health promotion, self care, signposting	Pro-active health promotion. Brief advice, assess willingness, signpost to services	NHS alcohol intervention service, cancer awareness, Health Check	Structured care planned alcohol service. Cancer risk assessment
Physical Activity	Health promotion, self care, signposting	Pro-active health promotion. Brief advice, assess willingness, signpost to services	NHS Health Checks, healthy lifestyle consultation service	Structured physical activity plans, activity prescriptions
Sexual Health	Health promotion, self care, signposting, OTC supply	Pro-active health promotion. Brief advice, signpost to services	NHS EHC & chlamydia screen and treat PGD service	Assessment, support, contraception & vaccination
Men's Health	Health promotion, self care, signposting	Pro-active health promotion. Brief advice, signpost to services	NHS Health Check. PGD Treatment. Cancer awareness.	PwSI/Prescriber in men's health
Substance Misuse	Health promotion, self care, signposting	Supervised consumption, needle & syringe exchange	Harm reduction Hep B & C screening	Client assessment, support and prescribing. Hep B vaccination
Other	Health promotion, self care, signposting	Oral health, travel health, sun & mental health awareness	Cancer early detection and treatment adherence support, vaccination	Prescriber for travel health and immunisation and vaccination
Minor Ailments	Health promotion, self care, OTC supply, signposting	NHS service (advice and treatment with P & GSL medicines)	NHS service (PGD treatment)	NHS service (prescribed POMs)
Long-term Conditions	Health promotion, self care, signposting, dispensing supply, risk management	Medicines optimisation (New Medicine Service and targeted Medicine Use Reviews)	Parameter monitoring, clinical review and management	Prescriber/PwSI for LTCs
ENABLERS - QUALITY CRITERIA				
Workforce Development	Core capabilities	Healthy Living Champion Leadership skills	Behavioural change skills Leadership skills	PwSI/Prescriber Leadership skills
Environment	GPhC standards	Advanced IT and premises	Enhanced IT and premises	Enhanced IT and premises
Engagement	Operational	Primary Care	Community	Public Health & Clinical leadership
PHARMACY CAPABILITY				

⁵⁴ Ratified by the Pharmacy and Public Health Leadership Forum in January 2010

APPENDIX 2: PRE QUALIFICATION SELECTION CRITERIA FOR PATHFINDER AREAS

Requirement	Details
Commissioner commitment to support HLP until April 2012 minimum	<ul style="list-style-type: none"> a) Who is the local commissioner of pharmacy services? b) What agreement have they given to implement HLP? c) Name of board level sponsor: d) Name of commissioner lead for HLP: e) Has the commissioner defined the services that HLPs will need to deliver at level 1 HLP? f) Has the commissioner committed to supporting HLP and the services commissioned through to April 2012? g) What funding, if any, has the commissioner committed to HLP implementation (outside of service payment)? h) Will the commissioner put the resource behind awarding the quality mark to HLPs and on-going monitoring? i) What is emerging in your local area regarding commissioning of health and wellbeing services?
LPC support and leadership	<ul style="list-style-type: none"> a) Name of LPC: b) Name of LPC member lead for HLP: c) What commitment has the LPC given to supporting HLP? d) What funding, if any, has the LPC committed to HLP implementation? e) How will the LPC support on-going implementation of HLP? f) What other pharmacy networks might support these activities in your area e.g. LLPs, LPF?
An HLP implementation plan including identified funding to support the enablers and public communications campaign	<ul style="list-style-type: none"> a) Is there an HLP implementation plan outlining activities, responsibilities and timings? b) Has an engagement event(s) to involve local contractors and their teams been planned and if so, on what date? c) Has a training provider been identified for RSPH Level 2 Health Improvement Award for Healthy Living Champions? d) If so, who is the provider and when will this go ahead? e) Has a training provider been identified for pharmacy leadership development? f) If so, who is the provider and when will this go ahead? g) Have you identified a stakeholder group and if so, whom does this include (role required not name)? h) Is there a plan for public communication? i) If so, what does this involve (brief outline)? j) Who is the communication lead supporting the project? k) What other plans do you have that would be useful for us to know about? l) Will you be prepared to provide the Pathfinder Support group with an update on progress against your action plan every

	quarter?
A minimum of 2 enhanced services should be commissioned from potential HLPs so that a range of services can be provided	<ul style="list-style-type: none"> a) Which locally enhanced services will be a requirement of level 1 HLP? b) Are you defining a specific number of MURs/targeted MURs as part of level 1 HLP? If so, provide details? c) Are these commissioned from all contractors in the area? d) If not, how do you expect to manage this? e) Have you defined services at level 2 HLP? f) Would you be happy to share the Service Level Agreements and fee paid (not essential)? g) What other requirements will pharmacies have to demonstrate to achieve their HLP quality mark?
Provide specific data to ensure consistency in evaluation using the data collection methodology and mechanism agreed by the Pathfinder Support Group	<p>NB: final details will be made available as soon as possible but are still in development; the group aims to keep the measures consistent, outcome-focussed and simple</p> <ul style="list-style-type: none"> a) How do contractors provide evidence currently of delivery of locally enhanced services? b) What data collection methods are being used in your area to collate data on pharmacy services? c) We require pathfinders to provide data of service delivery using a data collection platform and mechanism yet to be decided. Would your area be prepared, in principle, to provide the relevant data as required? d) What potential barriers or issues do you see in collating the data? e) How do you think these can be reduced?
A Healthy Living Champion (HLC) is a requirement of all HLPs (Royal Society of Public Health Level 2 Health Improvement Award)	<ul style="list-style-type: none"> a) How many HLCs do you plan to have in your area (minimum of one per pharmacy)? b) How will support be given to HLCs throughout HLP implementation? c) Will your HLCs link into a local Health trainer service?
HLPs should as a minimum, satisfy the Quality Criteria recommended by the HLP National Reference Group	<ul style="list-style-type: none"> a) Do you plan to use the Quality Criteria (as developed by the National Reference Group) as part of the HLP Quality Mark requirements? b) Will you be prepared to provide feedback on the quality criteria as part of the on-going and final evaluation? c) Are you considering amending these criteria to include anything else? If so, please provide a brief outline of what these might be.
Pathfinder areas should plan to	<ul style="list-style-type: none"> a) When do you expect to have awarded your first HLPs with their quality mark?

award their first HLPs by end March 2012	<ul style="list-style-type: none"> b) How many HLPs are you expecting to have by end March 2012? c) How many contractors are there in your area?
Health challenges and any other information	<ul style="list-style-type: none"> a) What are the top five issues faced by your area that you believe HLP might help to address? b) Briefly describe the demography of your area c) Briefly describe anything that we might find of interest concerning your area that will contribute positively to the development of HLP

Please note: this template has been copied in plain text and empty lines removed to save space. The version provided to pathfinders was in a user-friendly format

HLP Pathfinder Area report

Name of Pathfinder Area

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1. Background

Pathfinder area team

Local health needs and challenges

Description of your area: geographical size and description, population size and description, main health challenges in this area, who commissions services and a short overview of the commissioning process (flow chart?)

Motivations for HLP programme

Why you wanted to be involved in HLP? Where are you coming from / what (if any) HLP-type activities were you already undertaking? What additional benefits did you hope/envisage HLP would deliver?

Description of service 1

What need does the service meet/why is it offered, what happens in pharmacy, what data is collected, what metrics are requested by commissioner, who is commissioner, what have they defined as 'success'/payment milestones for service

Description of service 2

What need does the service meet/why is it offered, what happens in pharmacy, what data is collected, what metrics are requested by commissioner, who is commissioner, what have they defined as 'success'/payment milestones for service)

Description of any other services offered

(details as above) and whether they will be evaluated in this report or not

2. HLP Implementation Programme

Pharmacies involved

Defining pharmacy type

Rural

High street

Retail park

Health centre (incl GP surgery)

Defining pharmacy size:

Independents (1-5 branches),

Smaller Multiples (6+ branches),

Non-retail-driven Large Multiples (branches from the 6 largest entities which focus on NHS services – as defined by the entities themselves), need to state which are the six largest entities - Boots, Lloyds, Coop, Rowlands, Tesco, Sainsburys

Retail-driven Large Multiples (branches from the 6 largest entities which focus on retail services – as defined by the entities themselves) and

Supermarkets (in-store pharmacies)

Deprivation score – please leave blank – we will complete this for you and send back.

Pharmacy selection

How were premises chosen to be HLPs? Brief description of application process and selection criteria.

Implementation timeline

Timeline of HLP journey in your area

Local promotion and engagement

How has HLP been promoted to the public in your area?

3. Service 1 (Stop Smoking): Uptake and delivery of service compared to baseline

Data collection

Copy of data recording sheet/screenshot if collected online

Description of data collection process (including staff training in data collection) and of data transcription process.

Baseline data

Define the data you are using for comparison (likely to be historical data from same premises before HLP status, but may be non-HLPs at same time), and where this has been accessed from.

Results

Our targets

Minimum reporting outcomes

as defined at Feb masterclass (number recruited, 4 week quits and quit rate, % lost to follow up, pharmacy postcode, cost/quit).

Enhanced reporting outcomes

ethnicity, sex, age, patient postcode, HLP status, smoking behaviour, previous quits, CO validation, plan to quit, level of support provided, how the user entered the service, and any other metrics you have recorded.

Sub-group analysis

Do you see any interesting differences in outcomes based on: pharmacy type, size, deprivation score, patient demographics etc? Please present data here but leave any speculation about reasons why for the discussion section.

Comparison to baseline

Compare where appropriate to baseline data. State any limitations/assumptions in the comparison.

Baseline data

Define the data you are using for comparison (likely to be historical data from same premises before HLP status, but may be non-HLPs at same time), and where this has been accessed from.

Results

Our targets

Minimum reporting outcomes

as defined at Feb masterclass (number recruited, 4 week quits and quit rate, % lost to follow up, pharmacy postcode, cost/quit).

Enhanced reporting outcomes

ethnicity, sex, age, patient postcode, HLP status, smoking behaviour, previous quits, CO validation, plan to quit, level of support provided, how the user entered the service, and any other metrics you have recorded.

Sub-group analysis

Do you see any interesting differences in outcomes based on: pharmacy type, size, deprivation score, patient demographics etc? Please present data here but leave any speculation about reasons why for the discussion section.

Comparison to baseline

Compare where appropriate to baseline data. State any limitations/assumptions in the comparison.

4. Public reported experience of service

Service 1 (Stop smoking) :

Methods

(If applicable) Describe your sampling strategy and reasoning behind this.

Include a copy of the questionnaire you used.

Describe the data collection dates and process (including staff training in data collection) and the data entry process.

Results

Number of questionnaires given out, number completed and response rate.

Table for yes/no questions - given actual number and %s,

Charts for questions 1 – 9.

Paragraph to describe the types of response given to Q10. Mention any recurring themes, and if possible illustrate these with some direct quotes.

5. Service 2: Uptake and delivery of service compared to baseline

Data collection

Copy of data recording sheet/screenshot if collected online

Description of data collection process (including staff training in data collection) and of data transcription process.

Baseline data

Define the data you are using for comparison (likely to be historical data from same premises before HLP status, but may be non-HLPs at same time), and where this has been accessed from.

Results

Minimum reporting outcomes

Enhanced reporting outcomes

Sub-group analysis

Do you see any interesting differences in outcomes based on: pharmacy type, size, deprivation score, patient demographics etc? Please present data here but leave any speculation about reasons why for the discussion section.

Comparison to baseline

Compare where appropriate to baseline data. State any limitations/assumptions in the comparison.

Minimum Reporting Outcomes

Enhanced Outcomes

Results

Comparison to Baseline

6. Service 2 : Public reported experience of service

See Section 4 above.

Methods

(If applicable) Describe your sampling strategy and reasoning behind this.

Include a copy of the questionnaire you used.

Describe the data collection dates and process (including staff training in data collection) and the data entry process.

Results

Number of questionnaires given out, number completed and response rate.

Table for yes/no questions - give actual number and %s,

Charts for questions 1 – 9.

Paragraph to describe the types of response given to Q10. Mention any recurring themes, and if possible illustrate these with some direct quotes.

7. Costs incurred

Setting up Healthy Living Pharmacy

Project Management

How many hours on average per month has it taken to project manage and support HLP in your area?

How much has this cost in the first year of HLP (estimate if within someone's existing role, or real costs if commissioned)?

Was project management undertaken as part of an existing employee's role? If so, what impact did this have, if any, on other services?

If a new role was created, who funded project management? If jointly funded, please indicate who paid what?

Engagement meeting(s)

How much has been spent on the initial engagement event(s) with contractors and their teams?

Were there any backfill costs? And if so, how much?

Who paid backfill costs? If jointly funded, please indicate who paid what.

How many pharmacies did this event cover?

How many of these have gone on to become HLPs or are working towards their HLP status (at the point of completing this question)?

Who paid for the event(s)?

Leadership training

How much has been spent on the HLP leadership course(s)?

How long was this training course(s)?

Were there any backfill costs? And if so, how much?

Who paid backfill costs? If jointly funded, please indicate who paid what.

How many individuals have been trained on leadership as part of the HLP programme?

How many of these leaders have developed their practices into HLPs or are working towards their HLP status (at the point of completing this question)?

Who paid for the training? If jointly funded please indicate who paid what.

Health Champions (Healthy Living Champions)

How much has been spent on the Health Champions RSPH Understanding Health Improvement Level 2 Award in total?

How long was this training course (approximate hours per Health Champion)?

Was it distance learning or face to face (or a combination)?

Were there any backfill costs? And if so, how much?

How many individuals have been trained?

How many of these individuals gained their qualification (at the point of completing this question)?

Who paid for the training? If jointly funded please indicate who paid what.

Public Promotion

How much has your area spent or plans to spend on public promotional activity in the first year of HLP?

Who has paid for this? If jointly funded please indicate how paid what.

Premises enhancement

Did the PCT or LPC provide any support for premises enhancement to enable HLP implementation?

If so, what was supported?

And how much did this cost in total? Per pharmacy?

What other equipment have pharmacies or commissioners invested in as part of the HLP programme e.g. health information screens

Running Healthy Living Pharmacy

Enhanced service payments

Service one (define what service):

Payment to the pharmacy (enhanced service element only) per service activity or outcome e.g. £ per activity, any bonus payments, successful outcome, etc.

Whether, per pharmacy, you have paid out more, the same or less to HLPs when compared with non-HLPs. If you have these figures then please provide.

In total (HLPs and non-HLPs) how much did you spend on this enhanced service prior to HLP implementation? How has this changed post-HLP implementation? Have you seen more, less or the same amount of service activity across all pharmacies in the area (we want to know whether HLP shifts service delivery to HLPs or whether an uplift is seen across the whole area)

Service two (define what service – where HLPs are given a choice of commissioned services then choose an appropriate service to provide data):

Payment to the pharmacy (enhanced service element only) per service activity or outcome e.g. £ per activity, any bonus payments, successful outcome, etc

Whether, per pharmacy, you have paid out more, the same or less to HLPs when compared with non-HLPs. If you have these figures then please provide.

In total (HLPs and non-HLPs) how much did you spend on this enhanced service prior to HLP implementation? How has this changed post-HLP implementation? Have you seen more, less or the same amount of service activity across all pharmacies in the area (we want to know whether HLP shifts service delivery to HLPs or whether an uplift is seen across the whole area)

On-going maintenance costs

How much do you predict will be required to support HLP on an on-going basis? Please provide an estimated annual cost for:

Project management

Engagement events

Training

Public promotion

Anything else

Summary

In the light of the total investment that you have made as a pathfinder (detailed above), do you feel the HLP programme has been value for money?

If you are evaluating cost effectiveness locally please provide a brief description of how this is measured, i.e. what are you comparing with what

Who funded HLP development in your area?

The PCT

Public Health

Local Authority

The LPC

The contractor

A combination of two or more of the above (please state)

How much was spent on the programme – would be good to get a pharmacy by pharmacy cost:

8. Discussion and Conclusions

Service 1 (Stop Smoking)

Comparison to baseline data

Describe any differences in performance observed. Acknowledge any limitations to the comparison

Differences in sub-groups

Describe any differences observed, and suggest reasons why

Patient reported experiences

Give a broad overview of the findings – were patients generally happy/unhappy with the service they received?

Achievement of success measures

Did you achieve the success measures described in section 1? Have you improved service provision to help meet a local need?

(If applicable) How do you compare to any other providers of this service in your area?

How did you compare to national performance standards?

Service 2

Comparison to baseline data

Describe any differences in performance observed. Acknowledge any limitations to the comparison

Differences in sub-groups

Describe any differences observed, and suggest reasons why

Patient reported experiences

Give a broad overview of the findings – were patients generally happy/unhappy with the service they received?

Achievement of success measures

Did you achieve the success measures described in section 1? Have you improved service provision to help meet a local need?

(If applicable) How do you compare to any other providers of this service in your area?

How did you compare to national performance standards?

Overall HLP assessment

Have you achieved any of the additional benefits you described in the section 1?

If you were to repeat this process, would you do anything differently?

Learning points

APPENDIX 4: CONTRACTOR BENEFITS SURVEY

<p>10. DO YOU FEEL THAT BECOMING AN HLP HAS BEEN A WORTHWHILE INVESTMENT FOR YOUR BUSINESS?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Maybe</p> <p>11. DO YOU FEEL THAT BECOMING AN HLP HAS BEEN A WORTHWHILE INVESTMENT FOR YOUR STAFF'S DEVELOPMENT?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Maybe</p> <p>12. HOW HAS BECOMING AN HLP AFFECTED YOU AND YOUR BUSINESS? PLEASE RATE YOUR AGREEMENT WITH THE FOLLOWING STATEMENTS</p> <table border="1"> <thead> <tr> <th></th> <th>Strongly agree</th> <th>Agree</th> <th>Neither agree nor disagree</th> <th>Disagree</th> <th>Strongly disagree</th> </tr> </thead> <tbody> <tr> <td>Increases Professional satisfaction</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>Promotes Team engagement</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>Creates Public loyalty</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>Develops better relationships with other healthcare professionals</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>Develops better relationships with commissioners of services</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>Increases motivation</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>Leads to better financial return</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>Increases development</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>Other (please state)</td> <td colspan="5"><input type="text"/></td> </tr> </tbody> </table> <p>13. DO YOU HAVE ANY OTHER COMMENTS ABOUT BECOMING AN HLP?</p> <input type="text"/>		Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Increases Professional satisfaction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Promotes Team engagement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Creates Public loyalty	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Develops better relationships with other healthcare professionals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Develops better relationships with commissioners of services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Increases motivation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Leads to better financial return	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Increases development	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Other (please state)	<input type="text"/>					<p>INSTRUCTIONS</p> <p>In this quick survey, which should take no longer than a few minutes, we would like you to provide us with an overview of your experience since starting on your HLP journey. The answers of this survey will not be shared with anyone other than the researcher and have been kept non-specific to protect any commercial sensitivities. Your answers are so very important to the national HLP Task Group and we look forward to receiving them. Surveys received with an email address will be entered into a random draw for a prize – a Healthy Living Champion (distance or e-learning course) provided by the NFA for one of your team.</p> <p>1. HOW WOULD YOU DESCRIBE YOUR PHARMACY?</p> <p><input type="radio"/> Independent <input type="radio"/> Supermarket <input type="radio"/> Small group (up to and including 20 pharmacies) <input type="radio"/> Small multiple (between 20 and 100 pharmacies) <input type="radio"/> Large multiple (more than 100 pharmacies)</p> <p>2. HOW WOULD YOU DESCRIBE THE LOCATION OF YOUR PHARMACY?</p> <p><input type="radio"/> Rural <input type="radio"/> High Street <input type="radio"/> Retail park <input type="radio"/> Health centre</p> <p>3. IN WHICH PATHFINDER AREA IS YOUR PHARMACY?</p> <input type="text"/>
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<p>COMMERCIAL IMPACTS OF HLP</p> <p>4. GENERALLY WHAT IMPACT DO YOU THINK HLP HAS HAD ON YOUR OVERALL NHS SERVICE (ADVANCED AND ENHANCED SERVICES) INCOME?</p> <p><input type="radio"/> It has gone up <input type="radio"/> It has gone down <input type="radio"/> It has stayed the same</p> <p>5. IF YOUR NHS SERVICE INCOME HAS GONE UP, PLEASE ESTIMATE BY HOW MUCH</p> <p><input type="radio"/> Over 100% <input type="radio"/> Between 50% and 100% <input type="radio"/> Between 25% and 49% <input type="radio"/> Up to 25% <input type="radio"/> (NA - Service income has not gone up)</p> <p>6. SINCE IMPLEMENTING HLP, WHAT HAS HAPPENED TO YOUR AVERAGE MONTHLY PRESCRIPTION VOLUME?</p> <p><input type="radio"/> It has gone up <input type="radio"/> It has gone down <input type="radio"/> It has stayed the same</p> <p>7. SINCE BECOMING AN HLP, HOW WOULD YOU DESCRIBE THE PUBLIC'S DEMAND FOR SERVICES?</p> <p><input type="radio"/> There is no difference <input type="radio"/> They are asking for services more <input type="radio"/> They are asking for services less</p> <p>8. WHAT IMPACT HAS BECOMING AN HLP MADE ON YOUR STAFF?</p> <p><input type="radio"/> They are more productive <input type="radio"/> They are less productive <input type="radio"/> There has been no change in productivity</p> <p>9. HAVE YOU HAD TO INVEST IN YOUR PREMISES TO BECOME AN HLP?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>If yes, please provide a brief description</p> <input type="text"/>	<p>THANKYOU</p> <p>Thankyou for your very important involvement in the future of HLPs. We would like you to participate in a more comprehensive survey to inform the cost of providing the service. An assessment of the cost effectiveness of HLP is vital to the future development of this programme. Please indicate in the box below if you DO NOT wish to participate.</p> <p>This second survey will be entirely anonymous and will be your opportunity to influence the national agenda.</p> <p>14. Please check this box if you DO NOT wish to participate in a follow up survey</p> <p><input type="checkbox"/> I do not wish to be involved in a follow up survey</p> <p>15. Please provide your email address so that we can contact you for the next survey and/or draw</p> <input type="text"/>																																																												

APPENDIX 5: PUBLIC QUESTIONNAIRE

[NAME OF SERVICE]

17. Were you comfortable to receive this service in the pharmacy?

Yes No

2. Were you happy with how you were treated by the pharmacy staff?

Yes No

3. Do you feel you were provided with enough information by the pharmacy staff?

Yes No

4. Before coming in today, had you heard of healthy living pharmacies?

Yes No

17. How did you hear about this service?

From a friend or family member Radio
 Approached by member of pharmacy team Leaflet or poster in pharmacy
 Doctor or other healthcare professional Other (please state) _____

17. Were you directed to any other services offered by the pharmacy (tick all that apply)?

[List all appropriate]

.....

.....

No

17. If you had not received this service or advice from the pharmacy, where would you have gone?

- | | |
|---|--|
| <input type="checkbox"/> Doctor | <input type="checkbox"/> Internet |
| <input type="checkbox"/> A & E | <input type="checkbox"/> I wouldn't have done anything |
| <input type="checkbox"/> Walk-in centre | <input type="checkbox"/> Other (please state) _____ |

17. How would you rate the service provided?

- | | | | |
|-------------------------------|-----------------------------|-------------------------------|------------------------------------|
| <input type="checkbox"/> Poor | <input type="checkbox"/> OK | <input type="checkbox"/> Good | <input type="checkbox"/> Excellent |
|-------------------------------|-----------------------------|-------------------------------|------------------------------------|

17. Would you recommend this service to others?

- | | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

10. Is there anything else you want to tell us about using [this service] today?

Public reported experiences – Patient feedback questionnaire

10 questions have been developed which can be applied to all of the services you are implementing and can be quickly answered by public/patients/clients. Pathfinders can individually decide on how to present these questions (e.g. page formatting/local branding) and how they should complete them (in pharmacy/postal return) etc.

Resource requirements:

- Time to design questionnaire form, decide on the sampling process and timelines
- Communicate data collection exercise sampling process to pharmacy staff
- Print questionnaires and distribute to pharmacies
- Pens/clipboards/boxes in pharmacy
- Data entry – either by each pharmacy or by pathfinder lead
- Data analysis and presentation – reasonably quick using provided spreadsheet

If you have absolutely no resource to assess public experiences in this way, then you can present relevant findings from your CPPQ results however we must stress that this will not be comparable to the above data, nor does it assess anything specifically to do with HLP and therefore we view this very much as a backup option.

Guidelines/tips for administering the questionnaire

We recommend that this is carried out as an audit and run for 1 week at a time (e.g. every month/quarter as appropriate). You can choose whether to evaluate all your services in the same week, or during different weeks.

Please include the title of your service at the top of the questionnaire so that individuals know which service they are evaluating. Please add in the 'other services' options in Q7 depending on what is offered by your pharmacy/in your area. You could also adapt the questionnaire for use with Health Champion interventions if you would like to evaluate this as well.

In the first instance we would recommend giving the questionnaire out to every patient during your 'audit period', and recording how many you give out and how many are

completed. If you have particularly busy services then feel free to implement your own sampling strategy (e.g. form given to every 3rd patient/x patients per day) as appropriate. You will need to describe your sampling strategy in your report and record the response rate (how many forms did you give out vs. how many were filled in and returned).

It is likely that you will have the best response rate if you ask patients to complete the form whilst in the pharmacy (provide pens and clipboards). If you have budget available you could consider using a freepost return option, otherwise they can simply be left at the pharmacy for collation by the team.

Explain that the questionnaire is entirely anonymous and that the results will be used to help you improve the services that you offer. Perhaps provide a box for them to put completed questionnaires in so that anonymity is maintained.

The questionnaire should take about 2 minutes to complete – printing it on 1 side of paper/on a small size of paper will reinforce that this will only take a short amount of time to complete.

This questionnaire assumes basic literacy in English; if you think that this will cause problems for a proportion of your patients/clients, then you need to consider alternative ways of administering the questionnaire (and describe this in your report).

Guidelines/tips for analysing and presenting the data

Individual pharmacies or pathfinder leads should transcribe the data (pathfinder to decide) into the provided spreadsheet. Please use a new spreadsheet for each service. Each record should correspond to one column on the 'raw data' sheet, and it is good data entry practice to assign each paper questionnaire a unique identifier number and mark the sheet in some way when you have entered it on the system. If possible hold onto the returned questionnaires so that accuracy of data entry can be checked if necessary.

Having entered all the questionnaires on the raw data sheet, count up the totals for each row and enter these in the red cells on the 'chart output' sheet. This *should (!)* automatically produce your output charts and tables.

If you have additional time you could look at how different pharmacy premises / types / sizes / deprivation scores affect the results; this should be possible as long as you record which premises each questionnaire was filled out in. If you would like some advice on statistics for this data please get in touch with me directly (Erika.kennington@rpharms.com).

If possible, I am hoping to collate all this data for some national analysis so please make sure you keep a copy of the excel spreadsheet. Finally, in order to collate data for national analysis, it is very important that you do not change the wording of any of the questions (other than to insert the name of your service).

APPENDIX 7: STOP SMOKING SERVICES: THE METHODS USED FOR EVALUATION IN THE INDIVIDUAL PATHFINDER AREAS

<i>Pathfinder area</i>	<i>No. of pharmacies used in evaluation</i>	<i>Comparison</i>	<i>Other comments</i>
Birmingham	7	Before and after award of HLP quality mark, three months data	Baseline data of one year to allow for seasonality; reporting dates varied between pharmacies
Blackburn with Darwen and East Lancashire	21 non-HLPs 15 HLPs	Non-HLPs and HLPs	Comparison over the same time period of financial year broken down by quarter showing increase in all measures for Q4 (Jan-Mar)
Buckinghamshire	40	Before and after implementation of HLP	Baseline data Jan – June. Report data Jan – Mar
Dudley	16	Before and after implementation	Comparison of three month data before and after over same quarter
Lambeth	22	Before and after implementation	Comparison of whole year
Milton Keynes	12	Before and after implementation of HLP	Baseline data Jan – June. Report data Jan – Mar
Portsmouth	19 non-HLPs 17 HLPs	Non-HLPs and HLPs	Comparison of the same time period of financial year Quit rates in non-HLPs and HLPs compared statistically and found to be significant at $p < 0.001$
Sheffield	6	Before and after implementation	Comparison of three month data before and after over same quarter
South Staffordshire	30	Before and after implementation of HLP, six months data	Baseline data 6 months. Risk of bias in 'after' data as it included high quit months of Jan – Mar

APPENDIX 8: EMERGENCY HORMONAL CONTRACEPTION SERVICES: THE METHODS USED FOR EVALUATION IN THE INDIVIDUAL PATHFINDER AREAS

<i>Pathfinder area</i>	<i>No. of pharmacies used in evaluation</i>	<i>Comparison</i>	<i>Other comments</i>
Buckinghamshire		Before and after implementation of HLP	Baseline Apr- Sep 2011 After Apr-Jun 2012
East Riding and Hull	15 HLP 106 non-HLP	Non-HLP and HLP	Data compared for the same six month time period Apr-Sep 2011
Lambeth	22	Before and after implementation of HLP	Baseline data full year 2010/11 compared with full year after 2011/12 for individual pharmacies
Milton Keynes		Before and after implementation of HLP	NHS MK changed data collection methods Jan 12 and useful data could not be obtained
Portsmouth	16 non-HLP 17 HLP	Non-HLP and HLP	Data compared for the same financial year in Year 2001/12 Comparison with before HLP 2008/9
Stoke-on-Trent		Before and after implementation of HLP	Baseline data full year 2011 compared with full year after 2012

APPENDIX 9: MINOR AILMENTS SERVICES: THE METHODS USED FOR EVALUATION
IN THE INDIVIDUAL PATHFINDER AREAS

Pathfinder area	No. of pharmacies used in evaluation	Comparison	Other comments
Birmingham and Solihull	2	Before and after implementation of HLP	Baseline three months Jan-Mar 2011 before, then during and after receiving quality mark
Sheffield	10	Before and after implementation of HLP	Baseline three months Jan-Mar 2011 compared to three months Jan-Mar 2012
Stoke-on-Trent	Not reported	Before and after implementation of HLP	Baseline data five months Apr-Aug 2010 compared with five months Apr-Aug 2012 Service specification changed between baseline and evaluation period to reduce inappropriate use of the service

APPENDIX 10: ALCOHOL AWARENESS: THE METHODS USED FOR EVALUATION IN THE INDIVIDUAL PATHFINDER AREAS

<i>Pathfinder area</i>	<i>No. of pharmacies used in evaluation</i>	<i>Comparison</i>	<i>Other comments</i>
Dudley	16	Before and after implementation of HLP	Baseline three months Apr-Jun 2011/12. Evaluation Apr-Jun 2012/13
Buckinghamshire & Milton Keynes	22 non-HLP 11 working towards HLP 9 HLP	Non-HLP, working towards HLP and HLP	Six months from start of alcohol awareness campaign, Nov 11 to Apr 12
Portsmouth	8 non-HLP 12 HLP	Non-HLP and HLP	Financial year 2011/12

APPENDIX 11: MEDICINES OPTIMISATION: THE METHODS USED FOR EVALUATION
IN THE INDIVIDUAL PATHFINDER AREAS

<i>Pathfinder area</i>	<i>No. of pharmacies used in evaluation</i>	<i>Comparison</i>	<i>Other comments</i>
Blackburn with Darwen and Lancashire	25 HLP 79 non-HLP	Before and after implementation of HLP and non-HLP vs. HLP	Baseline data Oct 10 to Mar 11 Evaluation period Oct 11 to Mar 12
Buckinghamshire	4 HLP 23 working towards HLP		
Milton Keynes	15 non-HLP 9 HLP 13 working towards HLP 7 non-HLP	Non-HLP, working towards HLP and HLP	May 2011 to Dec 2012
East Riding and Hull	15 HLP 115 non-HLP	Non-HLP and HLP	Data collected monthly from Oct 2011 to July 2012
Portsmouth	12 HLP 13 non-HLP	Non-HLP and HLP	Financial year 2011/12
Shropshire	19 HLP 31 non-HLP	Before and after implementation of HLP and non-HLP vs. HLP	Data collected monthly for one year Baseline for HLPs May-Jul 2011 and compared with May-Jul 2012

