Public Health

a practical guide for community pharmacists

PSNC

THE NATIONAL PHARMACEUTICAL ASSOCIATION

Royal Pharmaceutical Society of Great Britain

PharmacyHealthLink
Promoting good health through pharmacy

Public Health

a practical guide
for
community pharmacists

Jointly prepared by

Pharmaceutical Services Negotiating Committee
National Pharmaceutical Association
Royal Pharmaceutical Society of Great Britain
PharmacyHealthLink

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Foreword

It is a pleasure to have been invited to write the foreword for this practical guide for community pharmacists. As the immediate past Chair of PharmacyHealthLink and President of the Faculty of Public Health, I have spent much of my time working alongside pharmacists and have been impressed by their professionalism and dedication to improving the public's health. I'm sure this guide will act as a useful reference for pharmacists. It will help them continue to develop their public health roles that have been identified in so many of the recent Government departments' policy documents.

It is often said that over six million people visit pharmacies every day. Many pharmacy staff work in premises that are sited within local communities and shopping precincts where they provide easy access to the public without the need for an appointment. Visitors to pharmacies come from all sectors of the population and research has shown that local pharmacy services are particularly valued by those without easy access to a car.

Over the past few years there has been increasing recognition of the contribution that community pharmacy can make to improving the public's health and the need to integrate pharmacy into the wider public health workforce in the UK. The *Health Committee Inquiry into Public Health* recommended that *'the Government takes steps for community pharmacists to play a more active role in public health'*.

In England, the policy document *Tackling Health Inequalities: A Programme for Action* highlighted the vital role pharmacists play in improving the public's health and the importance of community settings and services in addressing health inequalities, including community pharmacies. *A Vision for Pharmacy in the New NHS* recognised the contribution that pharmacists can make to the public health agenda and makes a commitment to develop a pharmaceutical public health strategy for England by 2005, which will integrate pharmacy with the wider public health agenda and workforce. *The Vision* also reflects the public health contribution community pharmacy can make in the new pharmacy contract which will be essential to delivering public health services in community pharmacy. Under the new contract essential services provided by all community pharmacies will include the promotion of healthy lifestyles and the promotion of self-care. In addition, there will be arrangements for pharmacies to provide more specialist services in conjunction with primary care organisations.

Scotland Pharmacy for Health: The Way Forward for Pharmaceutical Public Health in Scotland recognises the potential, often untapped, contribution pharmacy can make to improving the public's health and the need to engage all pharmacists in the public health agenda and to utilise their skills and experience to the full. A Pharmaceutical Public Health Service will be one of the four core elements of the new pharmacy contract currently being negotiated in Scotland.

The National Assembly for Wales has a set of guiding principles in the *Plan for Wales*, to act now for the future, reduce poverty and achieve equality. The aim is to improve the health and well-being of people in Wales and to reduce inequalities in health. Improving quality and effectiveness of healthcare and promoting inter-agency working underpins this strategy.

In Northern Ireland, *Making it Better - A Strategy for Pharmacy in the Community* recognises that pharmacy plays an important role within the health services and the community as a whole because of the accessibility of pharmacy and, therefore, its prime position to deliver services that improve the public's health. The strategy aims to build on the traditional roles of pharmacy to make the best use of pharmacists' skills and make pharmacy an integral part of the health and social care team.

Overall the message is clear throughout the UK that pharmacy can make an important contribution to improving the public's health and reduce health inequalities. All four countries are now recognising this untapped resource and the need to engage all pharmacists in the public health agenda. In the future pharmacists will become more recognised as public health practitioners, utilising their skills and experience to the full, and they will become more integrated with the NHS and the wider public health workforce.

As public health practitioners, my colleagues and I look forward to working more closely with pharmacists in order to achieve a better and more co-ordinated primary care service for the benefit of practitioners and the public.

Professor Sian Griffiths OBE

Introduction

Community pharmacists have always played a role in promoting, maintaining and improving the health of the communities they serve. They are, after all, based in the heart of communities – in rural as well as deprived inner city areas, in town centres and suburbs. Situated on high streets, in shopping centres and on housing estates, they gain a particular understanding of the needs of members of their communities through daily interactions with patients and customers. Community pharmacists are often patients' first point of contact, and for some their only contact, with a healthcare professional. Engaging with communities through day-to-day activities, which might include the provision of advice to parents of young children, the care and support of drug misusers, visits to the homes of older and housebound people and advice on smoking cessation, pharmacists already make a significant contribution to public health.

However, there is a need for community pharmacists to understand the broader concept of public health, which focuses on improving health at a population level. Public health is now firmly on the healthcare agenda and current UK policy offers an unparalleled opportunity for community pharmacists to become more involved in this wider health agenda and to be recognised as part of the public health workforce. In addition, the new contract for community pharmacy will be an important vehicle for delivering public health services in community pharmacy.

This guide explains the broader concept of public health in more detail and outlines the potential contribution that community pharmacists can make to this agenda. It also describes what steps community pharmacists can take to increase their involvement and contribution to public health at a local level in collaboration with other public health colleagues.

Objectives of the Pack

This resource pack will help you to gain a greater understanding of:

- What public health is.
- How public health is linked to community pharmacy.
- Why public health is important to community pharmacy and why community pharmacists should get involved.
- The current policy context.
- How community pharmacists can enhance their contribution to public health.
- How public health is funded.
- How to approach the primary care organisation (PCO)* to deliver a public health service.

The pack also identifies a wide range of further sources of information to ensure you have everything you need to get started.

* In this resource pack the term primary care organisation (PCO) is a generic term that refers to Primary Care Trusts in England, Local Health Boards in Wales, Local Health and Social Care Groups in Northern Ireland, and Local Health Care Co-operatives in Scotland.

What is Public Health?

Introduction

Public health is the study and practice of how best to improve the overall health, and health gain, of populations rather than individuals' health. The most widely used and over-arching definition of public health was coined by Sir Donald Acheson in 1988 as:

> '*the science and art of preventing disease, prolonging life and promoting, protecting and improving health through the organised efforts of society*'.[1]

This definition encompasses a very wide range of activities and emphasises the importance of a strategic approach to public health as well as collaboration between different groups and individuals to achieve these aims.

The Faculty of Public Health (see *Appendix 1*) describes an approach to public health which:

- Emphasises the collective responsibility for improvement in health and on prevention of disease.
- Recognises the key role of the state, linked to a concern for the underlying socio-economic and wider determinants of health, as well as disease.
- Is multidisciplinary, incorporating quantitative as well as qualitative methods.
- Emphasises partnerships with all those who contribute to the health of the population.

Work undertaken in public health principally falls within three key domains *(Table 1)*.

Table 1 Areas covered within the three key domains

Health Protection and Prevention	Health and Social Care	Health Improvement
□ Disease and injury prevention	□ Quality	□ Employment
□ Communicable disease control	□ Clinical effectiveness	□ Housing
□ Environmental health	□ Efficiency	□ Family/community
□ Emergency planning	□ Service planning	□ Education
	□ Audit and evaluation	□ Inequalities/exclusion
	□ Clinical governance	□ Lifestyle advice

Across these three domains the Faculty of Public Health identifies 10 core elements of public health practice, which form the basis of competency standards. These 10 core elements provide an overview of the breadth of skills that all those working in public health need to maximise their contribution to health gain, whatever their area of work:

- Surveying and assessing the population's health and well-being.
- Promoting and protecting the population's health and well-being.
- Developing quality and risk management within an evaluative culture.
- Working collaboratively for health.
- Developing health programmes and services and reducing inequalities.
- Developing and implementing policy and strategy.
- Working with and for communities.
- Strategic leadership.
- Research and development.
- Ethically managing self, people and resources.

More information about these core elements is available on page 28.

Most community pharmacists' everyday practice involves work undertaken in the two domains of health improvement and health and social care. Increasingly community pharmacists are also undertaking work in health protection and prevention[2] and this trend is likely to continue.

The Origins of Public Health

Public health has been recognised as a specialist field of practice in the UK since the middle of the nineteenth century when the foundations of the public health movement were laid by the appointment of the first medical officers of health and the creation of statutory sanitary inspectors.

In 1848, Parliament passed the first Public Health Act as a direct result of Sir Edwin Chadwick's *General Report on the Sanitary Conditions of the Labouring Population of Great Britain.* Chadwick was convinced that socio-economic class was linked to health and demonstrated that the average age at death in Liverpool at that time was 35 years for gentry and professionals, but only 15 years for labourers, mechanics and servants. Chadwick managed to convince Parliament that widespread disease amongst the lower social classes resulted in an enormous cost to society, when taking into account time off for funerals and lost labour. As a result of the Act employers were required to implement measures that would reduce the incidence of disease and ill health at work.

Public Health Today

A modern day public health approach accepts the importance of collective responsibility for improvement in health and on the prevention of disease. There is much greater evidence available on and practice in public health now than in Chadwick's day but the emphasis remains on the State to lead health improvement and set out priorities for action. Today, however, health professionals, industry, public service organisations and, increasingly, individuals themselves play a role in the prevention of disease.

It may be over a century and a half since the first Public Health Act was passed but many of the issues identified by Chadwick are still relevant today, particularly the prevalence and impact of health inequalities. In addition, the primary cause of illness to society is shifting away from communicable (mainly infectious) diseases and accidents at work towards illnesses caused by non-communicable or chronic diseases such as diabetes, coronary heart disease (CHD) and stroke.

Health Inequalities

During the twentieth century there were considerable improvements in the nation's overall health. For example, life expectancy at birth for women is now 80 years compared with 48 in 1900; for men it is 75, compared with 44. Over the same period infant mortality fell from over 1 in 10 to 6 per 1000. Unfortunately these improvements have not always been achieved at a similar rate among all social groups, or in all parts of the UK. In particular, people in lower socio-economic groups tend to be ill more often and to die sooner[3] and suffer more long-standing and limiting illnesses. The death rate in men under 65 years is 1.6 times higher in the North West Region than in the South East. In Manchester, the death rate for people under 65 years is over three times higher than in Kingston and Richmond in the south.[4]

Inequalities begin very early in life, even before conception, and continue throughout life. Health inequalities also cross generations, affecting life chances and quality of life not only of adults, but also of their children and grandchildren.[4] Babies born to poorer families are more likely to be premature, are at greater risk of infant mortality and have a greater likelihood of poverty, impaired development and chronic disease later in life. Babies with fathers in social classes IV and V have a birth-weight that is on average 130 grams lower than that of babies in social classes I and II. Low birth-weight is closely associated with death in infancy, as well as heart disease, diabetes and hypertension in later life.

Because of the importance of addressing health inequalities, there are now numerous health inequalities targets across the NHS (see boxed text).

Health Inequalities Targets:

- Reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy by 2010 (England).[5]
- Reduce the gap in life expectancy between those living in the fifth most deprived electorial wards and the average life expectancy by 50% for both men and women by 2010 (Northern Ireland).[6]
- Health headline targets for the period 1995 to 2010 are, to reduce: premature mortality from CHD by 50%; premature mortality from cancer by 20%; smoking among 12 to 15-year-olds from 14% to 11%; the proportion of women smoking during pregnancy from 29% to 20%; the incidence of men and women exceeding weekly limits from 33% to 29% and 13% to 11% respectively; teenage pregnancy rate among 13 to 15-year-olds by 20%; 60% of 5-year-old children with no experience of dental disease 16 (Scotland).[7]
- In Wales, there are health inequalities targets for cancer, mental health, children, CHD and older people. The aim of these targets is to provide focus and direction for improving health and reducing health inequalities in Wales. For example, the health outcome target for cancer is to reduce cancer deaths in those aged below 75 years by 20% by 2012; and the health outcome target for CHD is to reduce deaths from CHD in 65 to 74-year-olds from 600 per 100,000 in 2002 to 400 per 100,000 by 2012.[8]

Tackling inequalities centres around breaking the cycle of ill health, particularly in focusing on tackling the broader determinants of health and those factors that particularly influence the health of those on low incomes.

The Broader Determinants of Health

An understanding of the broader determinants of health is necessary for any pharmacist who wishes to contribute towards reducing health inequalities.

The broader determinants of health (see *Figure 1*) reflect the environment in which people live that influence their health beliefs, expectations and their health choices. These determinants, and their effects on inequalities, are comprehensively outlined in the report *Independent Inquiry into Inequalities in Health* chaired by Sir Donald Acheson[9]. This report made 39 recommendations, underpinned by a broad analysis of the social, economic and environmental determinants of health inequalities, which served as the basis for a number of successive UK government strategy documents to tackle inequalities. Further information on the broader determinants of health and priorities for tackling inequalities is available from each of the UK government strategies.

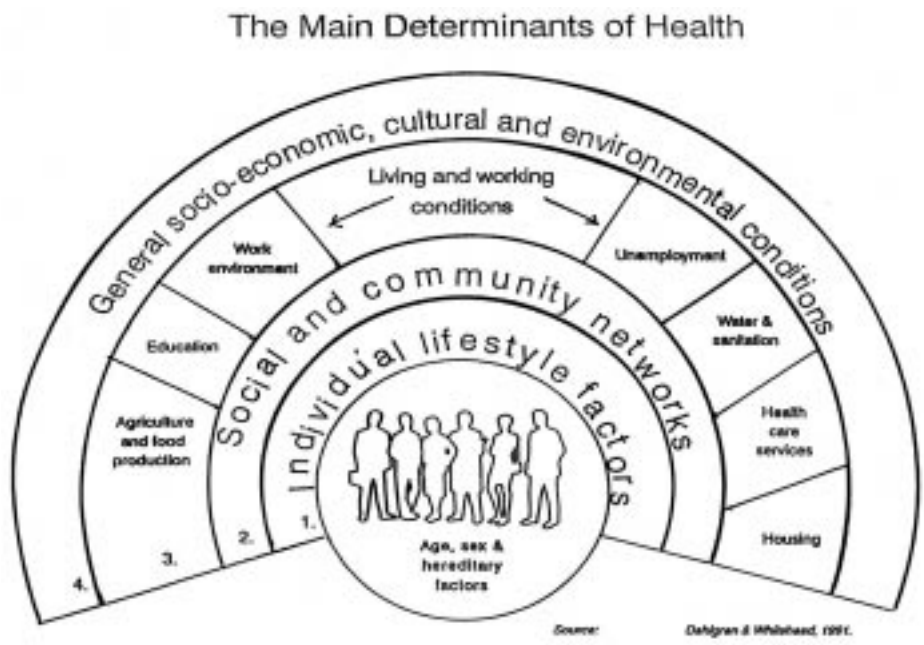

Figure 1. Dahlgren and Whitehead (1991)[10] pictorially illustrated the main determinants of health.

The report concluded that the root causes of ill health were so varied, they could not be dealt with by focusing on 'health' or the health services alone. The main conclusions of the report were:

- The weight of scientific evidence supports a socio-economic explanation of health inequalities. This traces the roots of ill health to such determinants as income, education and employment as well as to the material environment and lifestyle.
- Action to tackle health inequalities thus reaches far beyond the remit of the Department of Health. Some relate to the whole government while others relate to particular departments.

The key areas for future policy development were identified as:

- financial – poverty, employment, income, tax and benefits;
- education;
- environmental – housing, mobility, transport and pollution;
- nutrition and the common agricultural policy.

It was felt that a high priority should be given to the health of families with children, and that further steps should be taken to reduce income inequalities and improve the living standards of poor households.

Who are the Public Health Workforce?

In line with the key findings of the *Independent Inquiry into Inequalities in Health*[9] there are many employees (including voluntary workers) who contribute to improving the public's health and thus become part of the public health workforce.

The Report of the Chief Medical Officer's Project to Strengthen the Public Health Function[11] provided a framework for assessing the contribution of the broader public health workforce to the public health function. In particular the document referred to three main categories of employees:

(1) wider contributors
(2) practitioners
(3) specialists.

In addition there are also many others working in public health such as researchers, academics, government departments, regional and local authorities and members of the public, but the bulk of the employed public health workforce is covered by these three main categories.

Wider Contributors

Wider contributors are professionals, who have an impact on public health as part of their work, but who may not recognise this as such, for example, teachers and social services employees. This part of the workforce is important because they can reach people who are not in contact with the health service and refer them on to sources of advice and support. In terms of their development they '*need to adopt a public health "mindset", with a greater appreciation of how their work can make a difference to health and well-being and where more specialist support can be obtained locally'.*

This definition also applies to community pharmacy support staff who advise the public on the safe use of medicines, minor ailments and healthy lifestyles.

Practitioners

Practitioners are a smaller number of professionals who *'spend a major part, or all of their time, in public health practice. These professionals have in-depth knowledge and skills in their specific areas and are a vital part of the workforce'.*

Community pharmacists are 'public health practitioners' when they advise the public on safe use of medicines, the treatment of minor ailments and on healthy lifestyle choices. They may also provide specific public health interventions as part of a broader NHS service, for example, weight-loss clinics, specialist smoking cessation advice or drug misuse services.

Specialists

Specialist advisors in public health are usually *'Public health consultants and specialists working at a strategic or senior management level'*. They play a role in developing public health programmes and often have specific scientific expertise.

Pharmacists working in strategic advisory positions in health commissioning organisations such as Strategic Health Authorities may be considered as 'specialists' in pharmaceutical public health. Work is currently ongoing to investigate the potential for pharmacy specialists to be formally recognised, for example, by inclusion on the Voluntary Public Health Register held by the Royal Institute of Public Health. More information on this initiative is available at www.publichealthregister.org.uk

How Effective is Public Health?

The Evidence Base for Public Health

In an attempt to improve the evidence base, PharmacyHealthLink (PHLink), previously known as the Pharmacy Healthcare Scheme, and the Royal Pharmaceutical Society of Great Britain (RPSGB) have published two reports, which demonstrate what community pharmacists can contribute to health development (i.e. public health and health promotion).

The first report is a systematic literature review of the *published* evidence relating to the contribution of community pharmacy to health development, both in the UK and internationally from 1900-2001.[12]

The review of the published evidence covered 35 trials or experimental studies reported in 40 papers. Of these, 18 were UK studies, 14 were from the US or Canada and 8 from Europe. There were also 34 descriptive studies, of which 14 were from the UK, 12 were from the US or Canada and 8 from Europe.

The second report is a review of *non-peer reviewed* literature and *unpublished* work (i.e. the grey literature). It includes masters and doctoral research at schools of pharmacy, reports to Government bodies and presentations at conferences.[13]

The review of this grey literature included 37 studies.

The aim of these reviews was to determine which health development activities are most likely to be effective in a community pharmacy setting, how they might best be provided, and to identify areas for further research.

Almost all of the evidence identified for both reviews was from a community setting, i.e. activities either taking place in community pharmacies or carried out by community pharmacists in settings such as nursing homes or general medical practice. The researchers looked for evidence involving community pharmacists in the:

- promotion of health and well being;
- prevention of illness;
- identification of ill health;
- maintenance of health for those with chronic or potentially long-term conditions.

The reviews did not cover pharmacists' advice on the treatment of minor illnesses or prescribing and prescription reviews.

The key service areas covered across the two reviews were:

- Smoking cessation.
- CHD: lipid management, identifying risk factors for CHD, secondary prevention with aspirin, anticoagulation, obesity and weight reduction.
- Skin cancer prevention.
- Drug misuse.
- Sexual health (including emergency hormonal contraception).
- Immunisation.
- Head lice management.
- Oral health.
- Mental health.
- Accidental injury prevention.
- Folic acid and pregnancy.
- Asthma.
- Diabetes.
- Nutrition and physical activity.
- Multi-topic health promotion programmes.

The reviews concluded that the literature clearly demonstrates the potential of community pharmacists to contribute to health development (i.e. public health and health promotion).

The following section describes some of the evidence base covered by these reviews in more detail, and the conclusions that were drawn. It also describes useful additional studies that were not included in the PHLink/RPSGB reviews.

Smoking Cessation

Smoking cessation is an obvious area for community pharmacist involvement. Indeed, a recent UK survey of current activities showed that smoking cessation services are the most common health development activity in community pharmacies at present. Many pharmacists are working as part of the wider primary healthcare team and with the NHS smoking cessation services to provide specialist advice. Some of these schemes were set up to be health authority-wide (where all pharmacists were invited to take part), while others were targeted in Health Action Zone (HAZ) areas or localities less well-covered by other smoking cessation services and at low income clients.

What is the evidence that such services are effective? Two UK randomised controlled trials (RCTs), one conducted in Scotland[14] and the other in Northern Ireland,[15] demonstrate that there is good clinical and cost-effectiveness evidence from the peer-reviewed literature. Abstinence rates in the Scottish trial were 12% for the intervention and 7% for the controls at nine months, and in the Northern Ireland trial, 14.3% for the intervention and 2.7% for the controls at one year *(P<0.001)*. A health economic analysis of the Scottish trial showed that the cost of producing one successful attempt to quit smoking by using intensive rather than standard pharmaceutical support was £300, or £83 for each life saved.[16] In a health economic evaluation of a pilot study prior to the Northern Ireland trial the cost per life year saved in the intervention arm ranged from £196.76 to £351.45 for men and £181.35 to £722 for women.[17]

These RCTs and other studies in the published literature indicate that community pharmacists trained in behaviour change methods are effective agents in helping clients to stop smoking.[12] The non peer-reviewed literature confirms that training increases knowledge, self-confidence and positive attitudes of pharmacists and their staff in relation to smoking cessation. The grey literature also shows the potential benefit of the involvement of pharmacy staff in the training and provision of the service.[13]

Additional studies in this area include:

- A study evaluated the Pro-Change adult smokers programme in one community pharmacy and three GP practices in Northumberland. The programme was particularly aimed at low income and unemployed smokers. The Pro-Change programme involved an interactive multimedia computer program, self-help material and support from trained health professionals. The programme was found to reach the target audience of low income smokers, and self-reported quit rates were comparable to other reported studies. Siting the programme in the community pharmacy widened access compared with provision in general practices alone – of the 258 people who accessed the programme over the six-month pilot, 159 did so in the *one* community pharmacy compared to 99 in the *three* general practices.[18]

Coronary Heart Disease

CHD is seen as a high priority by the government, and community pharmacists have a unique opportunity to demonstrate their skills and knowledge in dealing with this client group. The potential contribution of pharmacists in CHD is to:

- Provide sound information, advice and support on stopping smoking, healthy eating and physical activity.
- Get involved in smoking cessation services:
  - establish and record smoking status;
  - smoking cessation clinics;
  - patient group directions (PGDs) for nicotine replacement therapy (NRT);
  - training on use of NRT for pharmacy staff and other health professionals;
  - distribution of free NRT.
- Provide medicines management services to support people on medication (and their carers) for the prevention or treatment of CHD and stroke.
- Provide information on local screening services and the need for regular checks of, for example, blood pressure and blood lipid levels.
- Participate in initiatives to identify people at high risk of CHD and stroke.
- Provide warfarin monitoring to reduce the incidence of second heart attacks and stroke.
- Help with the implementation of the National Service Framework (NSF) for CHD.
- Get involved in healthy schools or workplace initiatives (e.g. giving talks on the benefits of stopping smoking).
- Provide a smoke-free environment in the pharmacy.
- Learn to recognise a heart attack and what to do (including resuscitation skills).
- Educate the public about the symptoms of a heart attack and what action to take.

And in deprived areas for pharmacists also to:

- Provide information on maximising welfare benefits for low income families.
- Participate in healthy living centre initiatives.
- Work with shopkeepers/local authorities to improve affordable access to healthy foods (especially fruit and vegetables).
- Provide information on exercise on prescription.
- Participate in NRT voucher schemes.

What is the evidence that community pharmacists can be effective in providing CHD-related services?

The PHLink/RPSGB review covered several areas including:

- Lipid management.
- Identifying risk factors for CHD.
- Secondary prevention with aspirin.
- Anticoagulation.
- Obesity and weight reduction.

Lipid management

Evidence from US and Canadian RCTs in lipid management in the prevention of heart disease showed that lipid management services provided by community pharmacists are effective in:[19-22]

- Helping clients to achieve target lipid levels.
- Enhancing prescribing and use of lipid-regulating medicines.
- Reducing clients' CHD risk scores.

Currently, there are very few lipid management services offered in the UK and there is a need to establish how, and if, the US and Canadian evidence is applicable to the UK. Community pharmacies offer the potential to improve the use of the resources invested in and the outcomes of lipid management, but good evidence from UK-based studies would help to convince commissioners.

Identifying pharmacy users with risk factors for CHD

Community pharmacists can use patient medication records (PMRs) to identify clients at high risk of CHD, by for example, searching for a range of drugs that would indicate heart disease. Studies in the US,[19] Canada,[23] and Australia[24] suggest that the use of such data to target patients with risk factors for CHD appears to be effective in identifying those at risk to provide follow-up on lipid management and advice.

However, the PHLink/RPSGB work concluded it was unclear whether or not pharmacists can play an effective part in screening activities, such as blood pressure measurement, without further research and training. Currently available evidence suggests that community pharmacy-based screening services are unlikely to be successful unless they are part of a co-ordinated, funded activity. This is important as the development of screening services should always be discussed with other local healthcare professionals who are also involved in patient care. These discussions should take place at an early stage to provide the best opportunity for the pharmacy service to become integrated with the other locally services provided (see 'How to approach the primary care organisation with a service development proposal' page 42).

Secondary prevention with aspirin

Community pharmacists could potentially perform an important role in ensuring the appropriate use of prophylactic treatment and intervening to minimise potential harm from self-initiated aspirin treatment in people with contra-indications to its use. Two audits of aspirin purchases in UK community pharmacies in 1996 and 1998 showed that 33% and 27% of patients respectively appeared to be taking prophylactic aspirin without their GP's knowledge.[25] This indicates that community pharmacy audits can identify self-initiated aspirin treatment and encourage referral for medical advice. The grey literature reviewed in the PHLink/RPSGB work[13] found that the pharmacist is perceived by pharmacy users to be an appropriate potential source of advice on aspirin and heart disease, but pharmacists are not believed by those patients taking aspirin to be currently providing the advice they need. The review concluded that patients taking aspirin have unmet information needs, which community pharmacists could provide.

Additional studies in this area include:

- Screening of patients with CHD by the community pharmacist does result in an increased uptake of aspirin therapy.[26]
- A questionnaire of patients with prescriptions for or purchasing glycerol trinitrate (GTN) in community pharmacy found that patients knowledge of GTN management was poor and not all appropriate patients were taking aspirin.[27]

Anticoagulation

Another potential role for community pharmacists is in monitoring of anticoagulant therapy and minimising negative health outcomes in this 'high risk' patient group. However, there is currently no published UK-based research to provide evidence for this. Evidence from three community pharmacies in the US suggests that this service shows promise, but more evidence is needed.[28]

Obesity and weight reduction

The incidence of obesity is increasing dramatically and there is potential for community pharmacists to advise clients on weight management and offer weight reduction programmes. Evidence from the published literature[12] suggests that further research is needed before conclusions can be reached on the effectiveness of such programmes.

Additional studies on the effect of community pharmacist intervention with CHD patients include:

- A RCT showed that a structured patient-centred intervention by community pharmacists had a positive effect on blood pressure control, self-reported adherence and patient satisfaction with pharmaceutical services.[29]
- A study showed that community pharmacists can work with GPs to deliver a specified model of care for the secondary prevention of CHD.[30]
- A study showed that potential exists for the contribution that community pharmacists make at the time of supply of GTN to improve the management of patients with angina.[31]

Skin Cancer Prevention

The community pharmacy is an ideal place for the public to obtain information on skin cancer. Pharmacy-based information, such as touchscreen technology, appears to be effective in raising awareness of sun risks, and trained pharmacists are more likely to be proactive in counselling clients. However, the effect of this advice on the behaviour of clients is currently unknown.[12]

Drug Misuse

All pharmacists play a major part in limiting the illicit availability of drugs by controlling the supply of medicines, monitoring prescriptions to identify excessive prescribing and detecting and reporting forged prescriptions. In addition, many pharmacists are involved in activities aimed at reducing the risk of harm from the illicit use of drugs (e.g. dispensing methadone and supervising consumption on the pharmacy premises). Evidence from both the peer-reviewed[12] and non peer-reviewed[13] literature demonstrates that community pharmacy-based supervised methadone administration services are acceptable to clients and achieve high attendance rates. Pharmacists can also help to reduce the demand for drugs by providing information and advice to the public on drug misuse and there is some scope to develop this role.

Pharmacists can advise drug users on the risks of contracting blood-borne viral infections, particularly HIV, hepatitis B and hepatitis C, usually from sharing needles and/or syringes, and the grey literature suggests that they are generally positive about doing so.[13] Moreover, a national UK survey of community pharmacists found that between 1988 and 1995 the percentage of pharmacists providing needle exchange services increased from 3.0 to 18.9 and that sales of injecting equipment were being made by 34.5% of pharmacists compared with 28.0% in 1988.[32] The PHLink/RPSGB work concluded that pharmacy-based needle exchange schemes have been shown to be cost effective and acceptable to users.

Additional studies in this area include:

- A report of the work in Glasgow that enabled many more GPs to treat drug injectors effectively and showed that community pharmacists have a key role in supervising the self-administration of methadone by patients in pharmacies.[33]
- An evaluation of the Greater Glasgow Pharmacy Needle Exchange Scheme which concluded that pharmacy needle exchange schemes make an important contribution to reducing harm amongst current drug injectors in the city.[34]
- A study considered the pharmacists' views and patient compliance with the introduction of a supervised methadone scheme, and found that, from the pharmacists' viewpoint, the scheme was introduced in a relatively trouble-free manor and that patient compliance with supervised methadone was high.[35]

Sexual Health (including emergency hormonal contraception)

Pharmacists have a potential role in promoting safer sex and contraception, including emergency hormonal contraception (EHC). There are now a number of UK schemes allowing the supply of EHC to under 16-year-olds using PGDs. The schemes were developed through local collaborations with family planning and sexual health services and were funded from Government monies aimed at reducing teenage pregnancies.

Published studies from the UK[36] demonstrate that pharmacists can effectively and appropriately supply EHC within the time-scale required for efficacy. In these and unpublished studies, users were satisfied with the service pharmacists provided, although there were some concerns in about one-fifth of female users about privacy and confidentiality.

Pharmacists were positive about their experience of providing EHC. Window displays in pharmacies were shown to be effective in raising client awareness and encouraged enquiries about supply, the presentation of prescriptions for emergency contraception and pregnancy tests.[37]

Immunisation

Most pharmacists interact with the general public in relation to immunisation, either in the supply of vaccines for administration at local GP surgeries or in the giving of advice related to foreign travel. Community pharmacists should take every opportunity to emphasise the importance of immunisation and the risks associated with non-vaccination compared with those of the possible side effects of the vaccines used. The PHLink/RPSGB work indicated that pharmacy PMRs are effective in identifying 'at risk' patients to prompt pharmacists to ensure that such patients are encouraged to have immunisation. This activity could increase the percentage of a target group of people immunised.

Other potential roles for community pharmacists in immunisation include:

- Participating in the strategic planning of the managed introduction of immunisation programmes (e.g. influenza in the elderly).
- Advising on systems needed to optimise the use of vaccines in the event of emergencies (e.g. measures for stockpiling product, producing PGDs to allow the legal supply and administration by non-medically qualified personnel, distribution and administration).
- Providing information on the handling and storage of vaccines. These products are particularly susceptible to changes in temperature and maintenance of the cold chain is important.
- Maintaining appropriate records. It is advisable to enter batch numbers on the PMR. Unlike other medicines that are subject to recalls, the administration of a vaccine implies protection for a considerable period of time and the requirement to recall the patient to minimise consequences of a faulty product is perhaps of greater importance in this case.

Pharmacists could be involved in immunisation itself. A US study of 19 supermarket pharmacies indicates that influenza and pneumococcal immunisation services can be safely provided through community pharmacies.[38] User satisfaction with pharmacy-based immunisation services is high[39] and more than 1000 US pharmacists received training in vaccine administration in 1997. A Dutch study showed that pharmacy PMRs can be used for case finding of 'at risk' clients to be invited for immunisation and can increase the percentage of the target group immunized.[40]

Head Lice Management

Community pharmacists provide and give advice on head lice treatments. Outside the head lice management schemes, however, service provision seems to be unstructured.[12] Where schemes are in place, they appear to be well received, although the cost of over-the-counter (OTC) head lice treatments can be a barrier to use.[13] Community pharmacists should explore provision of treatment on the NHS where this applies, and indeed, numerous minor ailment schemes now include head lice treatments in order to overcome the payment barrier. It is also important to ensure the consistency of messages about head lice infestation between pharmacists, GPs, practice staff and schools.

Oral Health

Community pharmacists have several potential roles in oral health:

- They may be asked questions about oral and dental problems (e.g. toothache, mouth ulcers, candida, gingivitis). The outcome of such an encounter may be sale of a treatment (e.g. a simple analgesic) or referral to another professional (e.g. dentist or doctor).
- They can give information on nutritional issues in relation to oral health (e.g. sugar in foods, medicines and drinks) and oral hygiene (e.g. brushing, use of toothpastes and mouthwashes).
- They can give information about the side effects of medicines in relation to the mouth. Some medicines can alter taste or result in a dry or sore mouth.

The PHLink/RPSGB work indicates that pharmacists need to take a more proactive approach to maximise opportunities in oral health. Moreover, pharmacist training on oral health is variable and needs to be improved.

Mental Health

The main point of interaction between community pharmacists and those with mental health problems has traditionally been at the point of dispensing or in sales of medicines. Drug therapy is, of course, a major part of mental health treatment. Pharmacists also help to treat those suffering from drug addiction, a condition which is often associated with mental health problems. However, pharmacists are also ideally placed to:

- recognise early symptoms of mental health problems;
- spot signs of relapse in patients;
- help with concordance;
- encourage good mental health practice in the local population;
- help to change attitudes and perceptions towards mental health patients;
- provide information on stress management, including self-help groups.

This area is reviewed in the non peer-reviewed report[13] which concludes that there appears to be potential for pharmacy staff to offer support and advice in relation to mental health issues.

Additional studies in this area include:

- The development of a medication management and information service from community pharmacists to people with mental health problems in conjunction with community mental health teams (CMHTs). This study showed that an increased exchange of information about medication was highly valued by the clients.[41]
- A study showed that community pharmacists can be successfully integrated into CMHTs. The community pharmacists provided pharmaceutical care during joint domiciliary visits with key workers. The psychiatrists felt that the scheme did make improvements to patient compliance with medication.[42]
- A study which showed that community pharmacists can make a valuable pharmaceutical contribution to mental healthcare through clinically significant interventions.[43]

Accidental Injury Prevention

Accidents are a significant cause of morbidity and mortality, especially in the young and frail, elderly populations. In 1998, there were more than 12,000 accidental deaths in the UK, including 3500 caused by road traffic accidents.[44]

Each year more than 3000 people over 65 years die as a result of falls. The risk factors for falls include disability, illness, visual impairment and polypharmacy, with patients taking sedatives and anti-hypertensives being at particular risk. Older people are particularly vulnerable as they are more likely to be affected by osteoporosis, which puts them at risk of serious injury from broken hips and wrists. Up to 14,000 people die annually in the UK as a result of osteoporotic hip fracture.

Community pharmacies are beginning to offer osteoporosis screening. One report of a pharmacy-based screening service involving pharmacist and nurse input was found to be feasible, and identified women at risk of osteoporosis.[45] Women using the scheme valued the accessibility offered by community pharmacy.

Pharmacists are ideally placed to raise awareness of the risks of medicine-related accidents, which can occur directly from overdosage or poisoning or indirectly from the medicine's effects on the central nervous system and may be associated with tasks such as driving. Measures to reduce the likelihood of accidents are routinely implemented by pharmacists in the course of their work. They control the supply of medicines and can educate the public and patients on safe storage and use of medicines and make arrangements for the safe disposal of medicines. Data collected on unwanted medicines returned to community pharmacies showed that the main reasons for returning medicines were a change in therapy, the death of the patient or adverse reactions.[46]

Community pharmacists can discuss changes in prescribing frequency with local prescribers to help prevent the accumulation of excess medicines. Instruction and warning labels, child-resistant containers, patient leaflets and targeted education campaigns all play their part. Pharmacists should also be aware of the potential risks of accidents when reviewing medication that can impair mental and /or neuromuscular function.

Additional studies in this area include:

- A study which had assessed the impact of a community pharmacy osteoporosis risk assessment service in collaboration with GP practices showed that patient knowledge about bone health increased, appropriate daily calcium intake increased and that appropriate high risk patients were referred to the GP.[47]

Folic Acid and Pregnancy

Community pharmacists and their staff are ideally placed to offer advice to women about the use of folic acid before and during pregnancy. Evidence suggests that pharmacy staff are positive about this role, but there are no published studies showing the effects of intervention on womens' behaviour.[12] Research is needed.

Asthma

Community pharmacists are ideally placed to improve management of asthma. Pharmacies and GP surgeries already do work with asthma patients. The PHLink/RPSGB work investigated the role of pharmacists in only one area – that of improving the management of asthma in schoolchildren by school teachers, where they found some benefit. However, the conclusion was that further research in this particular area is needed.

Additional studies in this area include:

- A study determined if the Jones Morbidity Index (JMI) can be used in community pharmacy when asthmatic patients collect their prescriptions to identify those who have poor asthma control. Structured questionnaires were completed by asthmatics who presented prescriptions at community pharmacies in order to assess their morbidity and knowledge of asthma and their attitudes towards, and usage of, medication. The study found that the JMI is a valuable tool to identify poor asthma control. More than half the asthmatics presenting their prescriptions at pharmacies had symptoms and signs indicating poor asthma control.[48]
- A study assessed the outcomes of a community pharmacy-led asthma clinic working closely with a nurse-led asthma clinic in a GP practice. The study demonstrated the benefits of nurses and community pharmacists working together to improve patient care.[49]
- A study in New Zealand determined the impact of a community pharmacy-based pharmaceutical care service to asthma patients. The service involved the creation of a patient record, identification of medication-related problems and development of strategies to resolve these problems and monitor outcomes. The study showed that this service led to improvements in asthma management and quality of life for the majority of patients.[50]

Diabetes

Diabetes is a significant cause of morbidity (e.g. blindness, cardiovascular disease) and mortality, and community pharmacists have a unique opportunity to demonstrate their skills and knowledge in dealing with this client group. Pharmacists can potentially:

- Promote healthy eating and physical activity to help reduce the risk of diabetes.
- Educate the public and pharmacy staff on the signs and symptoms of diabetes.
- Contribute to the early identification of diabetes.
- Ensure that diabetic patients are taking their medication regularly and attending follow-up visits at their GP practice or clinic.
- Provide medicines management services to patients with diabetes.
- Participate in multi disciplinary teams to help in the management of diabetes.

The literature makes frequent mention that community pharmacists are undertaking such activities, and the PHLink/RPSGB review concluded that pharmacy-based education and monitoring in diabetes shows promise but that further evidence is needed.[12]

Additional studies in this area include:

- A study evaluated the clinical benefits and acceptability to patients and other health professionals of HbA1c testing in 260 people with diabetes over a six month period. Before the study, only 57% of diabetic patients had received an annual HbA1c test. This rose to 100% during the study when all 260 people attended for their first HbA1c test. Of these 260 patients, 44% were deemed to have inadequate control. The service was well accepted by both patients and healthcare providers, and when regular testing was combined with education, it also helped poorly-controlled patients to better manage their diabetes.[51]
- Another study involved community pharmacists identifying 62 regular customers with Type 2 diabetes who met defined inclusion criteria. The community pharmacists undertook an initial assessment, medical case note review, review of PMR, and a 30-minute structured interview. From these interventions, a pharmaceutical care plan was prepared, which was discussed with the GP and actions agreed. A total of 178 pharmaceutical care issues were identified across the 62 patients, including drug therapy problems, inadequate monitoring and poor patient knowledge.[52]
- A survey of 93 patients who visited a UK pharmacy for advice about blood glucose meters revealed several problems. For example, half had difficulty sampling blood, a third did not keep the measuring chamber of their meter clean, and one patient had bought three meters but could not use any of them.[53]

Nutrition and Physical Activity

Community pharmacists have a role in advising the public about nutrition, physical activity and general healthy living. Many of the conditions they deal with in the pharmacy benefit from dietary change, increased physical activity and other lifestyle changes. In addition, community pharmacists see healthy, as well as sick people and by providing advice to healthy clients, they can potentially contribute to the prevention of disease in later life. The PHLink/RPSGB work identified no individual studies on these topics, although they were covered in some multi-topic community pharmacy programmes and in some studies on heart disease prevention.[12]

Multi-Topic Health Promotion Campaigns

Community pharmacy health promotion activities were first reported in the UK in the 1980s. A number of other initiatives conducted in the 1990s, for example the programmes developed in Barnet, Somerset and Glasgow, provided valuable data on the feasibility and provision of health promotion and public health activities in community pharmacies.[54-57]

A 2001 European Commission project entitled *Health Promotion in Primary Care: General Practice and Community Pharmacy* produced a database of European health promotion initiatives.[58] Client feedback from these studies has been positive with pharmacist training increasing client satisfaction and the level of pharmacy involvement.

Conclusion

Community pharmacists can make an important contribution to health development. The PHLink/RPSGB work shows that evidence from the published literature is sufficiently strong in the areas of smoking cessation and lipid management, emergency contraception and immunisation, and community pharmacists should use this evidence when approaching commissioners (see 'How to approach the primary care organisation with a service development proposal' page 42). Where evidence is lacking, this should be used as a stimulus for further research.

Can Community Pharmacists Make an Effective Contribution to Public Health?

Community pharmacists already make an important contribution to public health by providing appropriate information, advice and support to a wide variety of people on subjects ranging from contraceptive advice through medicines to alternative treatments and lifestyle issues. They also play a vital role in sign-posting patients to other appropriate health professionals. However, pharmacists can make an even greater contribution to the public's health than is presently the case. To do this, they need to identify their own public health role. Various activities have been cited as possible public health *(Table 2)* and health promotion *(Table 3)* roles. [59]

Table 2. Possible pharmaceutical public health roles

- Provide health advice on self-care.
- Provide health advice to young mothers.
- Provide support to develop effective parenting skills.
- Participate in health promotion campaigns.
- Participate in healthy living centres.
- Promote drug misuse awareness.
- Participate in needle and syringe exchange schemes.
- Promote healthy schools.
- Improve AIDS awareness.
- Provide sexual health support.
- Provide unplanned teenage pregnancy support.
- Support patients with chronic illness.
- Provide advice on how medicines work.
- Advise on complementary medicine.
- Maintain patient medication records.
- Provide monitored dosage systems.
- Promote patient medication adherence.
- Provide out-of-hours services.
- Provide collection and delivery services.
- Undertake domiciliary visits.
- Deal with pharmaceutical hazard alerts.
- Facilitate disposal of waste medicines.

(Reproduced from Walker R (2000). *Pharmaceutical public health: the end of pharmaceutical care?* Pharmaceutical Journal **264**:340-2.

Table 3: Examples of health promotion activities provided in community pharmacies

- *Healthy lifestyle* (advice on healthy eating, nutrition, exercise, alcohol, family planning, passive smoking, smoking cessation).
- *Asthma/respiratory diseases* (chronic bronchitis, allergies, inhaler devices, medicines and asthma, children, adults).
- *Healthy heart* (healthy eating, exercise, high blood pressure, angina, use of aspirin).
- *Sexual health* (HIV/AIDS safer sex, infertility, emergency contraception emotional support, sexually transmitted diseases, contraception).
- *Safety/prevention* (Safe use of medicines, dump campaigns, foreign travel, first aid, accident prevention, sports injuries).
- *Substance abuse* (solvents, alcohol, drugs [illicit or prescription drugs], needle exchange).
- *Elderly* (advice for carers, compliance devices, mobility aids, incontinence, stoma care, influenza, footcare).
- *Parents and babies* (breast-feeding, milk substitutes, folic acid, immunisation, nappy rash, teething).
- *Children* (head lice, parasites, meningitis, immunisation, vitamins, sugar and salt in food).
- *Women's health* (breast cancer, cervical cancer, migraine, stress incontinence, thrush, cystitis, menopause, osteoporosis).
- *Men's health* (prostate problems, heart attacks, lung cancer, stress, indigestion/heartburn).
- *Oral health* (cancer of the mouth, mouth ulcers, babies' teeth, dentures, dental care, cold sores, sugar-free medicines).
- *Skin care* (cancer, eczema, psoriasis, acne, sunscreens, scabies).

It has also been suggested that pharmacists can provide public health input at two levels.[60]

- To patients and individual members of the public, provided at the point of healthcare delivery.
- To NHS and social care organisations, whose role is strategic with responsibilities that relate to the whole population they serve.

The Faculty of Public Health *(Appendix 1)* identifies 10 core elements of public health practice.[61] It recognises that many different professions can contribute to delivering a public health agenda, including pharmacists, doctors, nurses, health economists and statisticians. The 10 core elements need further refinement to ensure the unique pharmaceutical contribution to public health is maximised,[60] but they provide a useful starting point for illustrating various roles pharmacists could play at a population, rather than an individual patient, level. They are:

- Surveying and assessing the population's health and well-being.
- Promoting and protecting the population's health and well-being.
- Developing quality and risk management within an evaluative culture.
- Working collaboratively for health.
- Developing health programmes and services and reducing inequalities.
- Developing and implementing policy and strategy.
- Working with and for communities.
- Strategic leadership.
- Research and development.
- Ethically managing self, people and resources.

The following explores what these 10 key roles could mean for community pharmacy and additionally how the community pharmacy makes an essential contribution to public health by being situated in the heart of the neighbourhood.

Surveying and Assessing the Population's Health and Well-Being

Health needs assessment is an important component of public health. It performs several functions, including:

- identification of unmet needs;
- ongoing assessment of the health of a specific population. A population can be defined geographically or by patient group (e.g. those with a specific disease or an ethnic sub-group);
- informing the future organisation and delivery of services.

A health needs assessment involves gathering data to define the number and identity of, say, those suffering from a particular condition within a geographical community.

Promoting and Protecting the Population's Health and Well-Being

It is well known that lifestyle changes, such as smoking cessation, nutrition and physical activity, can contribute to national targets to reduce the burden of disease from obesity, CHD and cancer. Pharmacists are well placed to deliver health promotion messages on smoking, diet, exercise and also in other areas, for example, raising public awareness of the early symptoms of oral cancer and coronary risk assessment.[12]

Health protection of both individuals and the wider population is also important. Pharmacists have long been involved in needle and syringe exchange schemes to reduce the spread of HIV and other blood borne diseases in drug misusers and the wider community.

Developing Quality and Risk Management within an Evaluative Culture

The key here is clinical governance. Clinical governance is about continuous quality improvement and incorporates clinical effectiveness, quality assurance, risk management, audit and development at the organisational and staff level. For pharmacists this involves looking critically at individual and corporate performance, identifying areas of sub-optimal patient care and addressing deficits, of both structure and process.

Working Collaboratively for Health

Pharmacy is already involved with other health professionals in delivering services such as smoking cessation and reducing teenage pregnancies and with social services through work in discharge planning and continuity of care. However, there are still opportunities for new ways of working jointly with local authorities and other agencies on issues related to health and the environment, such as the police and education services around substance misuse.

Developing Health Programmes and Services and Reducing Inequalities

Reducing health inequalities is high on the government agenda and community pharmacists have a role to play in the targeting of individuals whose health experience is below average, or who may not access current health services for a variety of reasons. Pharmacists could help to ensure that:

- Homeless people receive adequate pharmaceutical care and are provided with the information they need to empower them to make the health choices available to them.
- Rural communities without a neighbourhood community pharmacy or specialist hospital can access pharmaceutical services.

Developing and Implementing Policy and Strategy

Public health practice is about collaborative, organised effort. Community pharmacists must therefore be prepared to work within an integrated framework of health improvement strategies. Pharmacists have been successful in looking after their own practice populations, but must now look outside their traditional customer base and involve themselves in the health of the wider population.

Working with and for Communities

Acting as an advocate for the public and engaging with them is vital for the improvement of public health. Involving the public in service design can provide insight into what it is like to be a service user or to suffer from a condition such as asthma or diabetes. Pharmacists are well placed to ensure that their services are patient focused and to communicate the needs of the population to others involved in health improvement.

Strategic Leadership

Community pharmacists should alert professional colleagues to the contribution pharmacy can make to public health at both a strategic and operational level. Your case should include areas outside of those traditionally thought of as 'pharmacy', including:

- uptake of immunisations;
- reduction in inappropriate antibiotic use;
- welfare information;
- promotion of the local community.

Research and Development

New services must be underpinned with research evidence of efficacy, effectiveness and efficiency. Data which have been systematically collected and where possible generalised to the wider population, represents the most influential way of changing practice. All pharmacists should implement research evidence into their practice.

Ethically Managing Self, People and Resources

Commitment to continuing professional development (CPD) and lifelong learning is a requirement of the RPSGB's Code of Ethics, but it largely takes an individual patient and pharmacist approach, not a population perspective. A population perspective would add the dimension of equitable use of health resources, which most obviously would apply to the availability of particular drugs or treatments to a population, but could equally apply to the differential provision of pharmaceutical services across a population.

Community Pharmacy and Neighbourhood Renewal

Community pharmacy can make a real difference to local communities and this contribution should not be underestimated – particularly in terms of its impact on public health.

Community pharmacists have always played a role in promoting, maintaining and improving the health of the communities they serve. This is primarily because they are situated in the heart of communities. Research shows that in small communities, three core businesses make the difference between a viable business community and one that fails.[62] The three businesses are a health centre, a pharmacy and a source of cash (most often provided by a post office). Where these three are present, business communities are stable and grow. If any is absent, the business community declines, with an associated reduction in health and well-being for local people – and reduced access to local fresh foods and services.

The relocation of a GP surgery**,** and the subsequent closure of the local pharmacy may be the death knell for local shopping access. The New Economics Foundation – an independent think tank – published a report *Ghost Town Britain: a lethal prescription* [63] calling for the government to recognise the role of pharmacies in supporting local services. This report followed an earlier publication: *Ghost Town Britain* [64] which highlighted the speed with which local services were disappearing – especially in villages and market towns.

The New Economics Foundation's argument was that when the number of local retail outlets falls below a critical mass, the quantity of money circulating in the local economy falls as people find it is impossible to do a full shop locally and so go elsewhere. This is a finely tuned mechanism – as soon as people have to go elsewhere for one service, they tend to go elsewhere for them all, leading to local food and finance deserts. The social and economic impact of this is huge, with those least able to access alternatives notably older people, single parents and those without private transport – being worst hit. High street pharmacies are a crucial lifeline in many communities and an essential service – especially for those who do not have access to a car. If pharmacies close when, for example GPs move on, local neighbourhoods are also in danger of becoming health facility deserts. This will speed their decline.

Areas without a vibrant local economy tend to be less attractive to live in. There is no 'social glue' to hold the community together. Local people lose economic fluency. Entrepreneurs have no local economy to contribute to. The unemployed lose local routes back to work. The outcome is high crime rates and a vicious circle of decline.

The loss of local GP premises and pharmacies could have a bigger impact on the high street than the NHS realises. The knock-on effect on other local retail outlets could be significant. The Countryside Agency estimates that each post office closure results in an estimated 15% drop in trade for local shops in rural areas – and local traders report similar reductions in trade when a bank closes. If the impact of the closure of a GP and/or pharmacy premises is of the same magnitude, the impact on local shops could be devastating. As well as providing an inducement to shop locally – thereby helping to maintain a thriving and diversified high street economy where local people's income is spent in local shops– pharmacies also provide employment for local people.

Socially disadvantaged areas are particularly vulnerable to such decline – and this also has public health consequences. Levels of illness in a community are determined by wealth and levels of wealth are in turn influenced by the economic viability of the local community.

Ironically, people living in socially disadvantaged areas are likely to use primary care services more frequently than those in higher socio-economic groups. The Office of National Statistics shows that low income households make twice the number of visits to their GP as a high income professional – and it is also likely that they visit the pharmacy at least twice as often as well. This means that, for both health access and economic reasons, health services close to home are particularly important in socially disadvantaged areas.

Putting Public Health into Practice

Why should community pharmacists get more involved with public health?

Community pharmacists have always been involved in public health. Before the inception of the National Health Service in 1948, large numbers of the population consulted pharmacies to get advice and treatment for symptoms of illness, often because they could not afford to visit a doctor. Providing information and treatment to maintain and improve health has been second nature to community pharmacists for as long as they have existed. Engaging daily with a wide variety of people – both the healthy and the sick – from the communities they serve gives pharmacists a wealth of understanding of public health.

Almost every professional activity in which pharmacists are involved has implications for public health. Services such as EHC, needle exchange, supply and supervision of methadone, supply of vaccines and advice on smoking cessation and sexually transmitted diseases are ones which pharmacists will readily associate with public health. However, activities linked to the use of medicines should not be forgotten. Indeed, pharmacists are the best qualified health professionals to carry out such activities. One reason for the success of smoking cessation services in community pharmacies is that the pharmacist is able to provide advice around an effective product. Thinking more broadly, however, pharmacists who contribute to the detection and prevention of adverse drug reactions (ADRs), help patients make the best use of their medicines through medicines management services and advise on the managed introduction of new medicines into practice, are also contributing to important public health issues.

Often without realising it, community pharmacists already contribute a great deal to the public health agenda. Their position on the high street in a commercial environment in the heart of communities across the length and breadth of the UK is an enormous asset to public health – one that is increasingly recognised by the policy makers. Indeed there are now a number of policy documents across the UK that recogise the key public health role that community pharmacy has. For example:

- In England *A Vision for Pharmacy in the New NHS* [65] states that*: 'Community pharmacies are not just another shop on the high street or in the retail centre. They should be clearly seen as places where patients are able to access readily an increasing range of healthcare services. They are a valuable resource for improving health and reducing health inequalities, especially for vulnerable and deprived populations.'*
  The Vision also states that there is considerable scope to build on the current achievements in public health, and that pharmacists are probably the biggest untapped resource for health improvement. Services proposed within the new pharmacy contract will reflect the public health contribution of community pharmacists, and a pharmacy public health strategy will be published in 2005.

- In Scotland, a major report of pharmaceutical public health was published in 2002 by The Public Health Institute of Scotland .[66] This report describes current pharmaceutical public health practice and outlined recommendations to develop pharmacists' involvement in various aspects of public health. The report is also an excellent source of information for the existing public health services currently provided by community pharmacies and the evidence base for them.
- In Wales, the A*ction Plan for Remedies for Success: A Strategy for Pharmacy in Wales* [67] sets out a number of action points in relation to pharmaceutical public health.
- In Northern Ireland, *Making it Better: A Strategy for Pharmacy in the Community* [68] has a particular focus on the role of the community pharmacist in improving public health and reducing health inequalities.

If pharmacists want to make a serious contribution to the public health agenda, they must identify their own public health role. Repackaging existing activities and services is one way of doing this, but such services should be monitored and audited on an ongoing basis to provide the evidence-base that demonstrates that pharmacists can provide real added value. In short, providing undocumented advice and leaflets on health matters is not enough. The pharmacist's input to public health needs to be structured, documented, evidence-based and capable of demonstrating real added value. It must also be multi professional and focus on the needs of the population.

Identifying where Community Pharmacy can Contribute to Public Health

In order to identify where community pharmacy can become involved in pubic health, it is important to have an understanding of Government targets and to be aware of what the priorities are for the local primary care organisation (PCO).

Knowledge of local NHS priorities is key since the local PCO is more likely to fund a community pharmacy service development if it helps to meet PCO targets.

Government Targets in England

In primary care the NHS is currently concentrating on three sets of targets contained in:

- The quality indicators in the new general medical service (GMS) contract.
- The primary care trust (PCT) performance indicators.
- The Department of Health (DH) Priorities and Planning Framework 2003 – 2006.

Appendix 2 lists the key targets in each that relate to public health, and describes potential community pharmacy services that could be developed to help the local PCT meets its targets.

The PSNC resource pack *The NHS: A Guide for Community Pharmacists* is a very useful guide that describes the workings of the NHS in greater detail. This is available at www.psnc.org.uk (then 'Resources', and 'Publications').

The Quality indicators in the new GMS contract

The new GMS contract heralds a new era in primary care. Like the proposed pharmacy contract, its focus is on quality of care, rather than merely volume of work. The contract has significant new funding attached to it – with the bulk of the one-third increase in primary care funding planned over the next three years flowing into the system through GMS. The most significant part of the GMS contract for community pharmacy is the quality and outcomes framework, which awards points (and pounds) for achieving clinical, organisational and patient experience quality indicators such as:

- maintenance of a disease register;
- improved levels of measurement and intervention in patients with specified medical conditions;
- improved control of medical conditions.

Appendix 2 lists the key quality indicators that relate to public health, and describes potential community pharmacy services that could be developed to help the local GP practice meets its targets.

The GMS contract is available at www.bma.org.uk

The National Pharmaceutical Association's (NPA's) NHS Service Development Department has produced two resources to support community pharmacists working collaboratively with GP practices:

- *The New GMS Contract: A Resource to Support Community Pharmacists Working in Partnership with GMS Practices*. This pack aims to provide NPA members with the relevant background and information to support understanding of the new GMS contract, and the opportunities it creates for collaborative working with GP practices as part of the primary healthcare team. This resource outlines information that is generic and thus broadly applicable to all four countries in the UK. Where possible, any significant differences between the four countries are highlighted.
- *A Quick Reference Guide to the Quality Indicators in the New GMS Contract*. This guide describes the key GMS quality indicators, what services community pharmacy can offer to support GP practices, and gives examples of the published evidence base, and practical resources available to help with service development.

These resources are available from the NHS Service Development Department by emailing nhs.dev@npa.co.uk, or by calling 01727 858687 ext. 3217.

The PCT Performance Indicators

In December 2003, PCTs received the performance ratings which will assess PCT performance during 2003/2004 against specific targets set by the DH. The production of these performance ratings is the responsibility of the Healthcare Commision. The ratings are published every year to enable evaluation of the ongoing performance of PCTs.

The performance ratings are calculated by assessing performance against 'key targets' and 'balanced scorecard indicators'. The key targets are the most important set of targets since they determine the overall performance rating.
These targets broadly reflect the priorities outlined in the *Priorities and Planning Framework 2002 – 2006* to ensure that PCTs are focused on delivering these priorities.

PCTs are very focused on how they can improve their performance against the ratings, by meeting the performance indicators. Appendix 2 lists the key performance indicators that relate to public health, and describes potential community pharmacy services that could be developed to help local PCT to meet their targets.

Details of the performance ratings are available at www.ratings.chi.nhs.uk and www.chi.nhs.uk/eng/ratings/2004/index.shtml

The NPA's NHS Service Development Department has produced *A Quick Reference Guide to the PCT Performance Indicators 2003 – 2004*. This guide describes the key performance indicators, what services community pharmacy can offer to support the various targets, examples of the published evidence base, and practical sources of help. This guide is available from the NHS Service Development Department by e-mailing nhs.dev@npa.co.uk, or by calling 01727 858687 ext. 3217.

The DH Priorities and Planning Framework 2003–2006

The DH *Priorities and Planning Framework 2003– 2006* was launched in September 2002. This document identifies the national priorities and targets that NHS and social care organisations need to meet over the next three years. NHS priority setting has always been done on an annual basis, so this framework represents a fundamental departure for the NHS in England. Pharmacists having discussions with PCTs on potential services can now legitimately talk about longer term (i.e. three year) funding.

In England the key planning document at local level is the three-year Local Development Plan (LDP). These replace the annual targets listed in the old Health Improvement Programmes and describe how local NHS and social care organisations will meet the national priorities and targets set out in the *Priorities and Planning Framework*.

The DH *Priorities and Planning Framework 2003– 2006* is available at www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/PlanningFramework/fs/en

The NPA's NHS Service Development Department has also produced a resource, titled *A Quick Reference Guide to the DoH Priorities and Planning Framework 2003-2006* which describes how community pharmacists can contribute to the targets, and gives examples of the evidence base, sources of practical help and potential sources of funding. This guide is available from the NHS Service Development Department by emailing nhs.dev@npa.co.uk or by calling 01727 858687 ext. 3217.

Health Inequalities

The Government gave a commitment in the *NHS Plan* that, for the first time ever, local targets for reducing health inequalities would be reinforced by the creation of national health inequalities targets. The first major Government review on tackling health inequalities was published in 2002[4]. This review set out the long-term strategy to reduce health inequalities.

Following the publication of this review the Government included health inequalities targets in the *Priorities and Planning Framework 2003– 2006* which relate to improving life expectancy and infant mortality. The health inequalities targets in this document are:[5]

Life expectancy

- Ensure that prevention and treatment services for cancer and CHD reach those in greatest need or with poorest health outcomes, including disadvantaged groups and ethnic groups with high prevalence. For CHD in particular reduce hypertension and increase prescription of statins.
- Increase smoking cessation.
- Reduce excess winter deaths, including by increasing influenza immunisation.

Infant mortality

- Reduce smoking in pregnancy.
- Improve nutrition in women of childbearing age.
- Reduce teenage pregnancy.
- Increase breast-feeding initiation and duration rates.
- Provide effective ante natal care (including screening and immunisation) and promoting early ante natal booking.
- Improve the quality of midwifery, obstetric and neonatal services.
- Introduce effective education about ways to promote health, e.g. immunisation.
- Provide high quality family support (e.g. through health visitors) including particular efforts to address risk factors for Sudden Infant Death.

In 2003, the Government published a three-year plan *'Tackling Health Inequalities: A Programme for Action'* [69] to carry forward the recommendations in the 2002 *Cross-Cutting Review*. It provides the basis for meeting the 2010 national health inequalities target on life expectancy and infant mortality. The *Programme* is organised around themes including:

- To support families, mothers and children: to ensure the best possible start in life and break the inter-generational cycle of poor health.
- To engage communities and individuals: to prevent illness and provide effective treatment and care, particularly targeting areas of health inequality.
- To address the underlying determinants of health: to deal with the long-term underlying causes of health inequalities.

Key interventions to contribute to closing the life expectancy gap include:

- Reducing smoking in manual social groups.
- Preventing and managing other risks for CHD and cancer such as poor diet and obesity, physical inactivity and hypertension through effective primary care and public health interventions – especially targeting those over-50 years of age.
- Reducing accidents at home.

Key short-term interventions to close the gap in infant mortality include:

- Reducing smoking in pregnancy and in the early years.
- Preventing teenage pregnancy.

Chapter 4 of the *Programme* describes the action plan to deliver change. One of the action points under 'Preventing illness and providing effective treatment and care' states that there should be improved access to primary care services in currently under-used areas, by e.g. making greater use of community settings and services including community pharmacy.

Tackling Health Inequalities: A Programme for Action is available at:
www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/HealthInequalities/fs/en

PSNC has produced a LPC Briefing which summarises *Tackling Health Inequalities: A Programme for Action*. This is available at www.psnc.org.uk (located in the 'Resources' section of the website under 'Publications').

Children

It is only right that the government's key health inequality targets focus on improving life chances for children. Children represent 25% of the population and the health, well-being and safety of children is of central importance to society. Whilst remedial action can be taken in later life, early life has a major impact on subsequent mental and physical health and development. Poor socio-economic circumstances in childhood have lasting effects on health. Low birth weight and small size caused by poor nutrition and smoking during pregnancy are associated with CHD, diabetes and hypertension in later life. Early intervention is highly likely to improve childrens' future health and reduce or prevent inequalities developing.

The NPA's NHS Service Development Department has produced a guide titled *Childrens Health Policy and Community Pharmacy*. This guide describes the key areas of policy affecting children, and provides guidance on how to move forward with potential service developments. This guide is available from the NHS Service Development Department by emailing nhs.dev@npa.co.uk, or by calling 01727 858687 ext. 3217.

Government Targets in Scotland

In November 2003, the Scottish Executive Health Department (SEHD) published the 12 national priorities for the NHS for 2004– 2005. These are:

- Health improvement
- Healthcare associated infection
- Cancer
- Mental health
- Service redesign
- 48 - hour access
- CHD/stroke
- Delayed discharge
- Patient focus/public involvement
- Waiting times
- Workforce development/staff governance
- Financial break even

Within these priority areas, specific targets have been set for 2004– 2005. Each NHS Board in Scotland will be measured against these targets in accordance with the performance assessment framework (PAF) for the coming year. Together, the national priorities and PAF create the main planning framework for the NHS in Scotland for 2004– 2005. The key planning document at local level is the Local Health Plan (LHP). These describe how local NHS Boards will meet the national priorities and targets. NHS Boards finalised their LHPs in early 2004 by combining plans from each Local Health Care Co-operative (LHCC) area.

Details of the 12 national priorities are available at:
www.show.scot.nhs.uk/sehd/mels/hdl2003_56.pdf
Details of the 2004– 2005 targets are available at:
www.scotland.gov.uk/library5/health/nhsnt-00.asp
Details of the performance assessment framework for 2004– 2005 is available at:
www.show.scot.nhs.uk/sehd/mels/hdl2003_53.pdf

The NPA's NHS Service Development Department has produced *A Quick Reference Guide to the NHS in Scotland Priorities and Targets 2004– 2005* which describes how community pharmacists can contribute to the targets, and gives examples of the evidence base, sources of practical help and potential sources of funding. This guide is available from the NHS Service Development Department by emailing nhs.dev@npa.co.uk or by calling 01727 858687 ext. 3217.

Health improvement

Improving Health in Scotland: The Challenge, which was published in 2003 as an annex to *Partnership for Care, Scotland's Health White Paper*: *Improving Health in Scotland* provides a strategic framework to deliver a rapid rate of health improvement in Scotland. It focuses on five of the top ten risk factors (tobacco, alcohol, low fruit and vegetable intake, physical activity levels and obesity) and expects to see progress in four priority areas:

- early years
- teenage transition
- workplace
- communities.

Targets from *Improving Health in Scotland* are included in LHPs and will be assessed through the PAF.

Improving Health in Scotland: The Challenge is available at:
www.scotland.gov.uk/library5/health/ihis-00.asp

Partnership for Care, Scotland's Health White Paper is available at
www.scotland.gov.uk/library5/health/pfcs-00.asp

In addition, GP practices will also be focusing on meeting the quality indicators in the new GMS contract (see page 35).

Government Targets in Wales

In Wales, Local Health Boards (LHBs) have annual targets to achieve. The Welsh Health Circular 2003(63) *NHS Planning and Commissioning Guidance* provides guidance to LHBs on commissioning during 2003– 2004. Each LHB must publish an Annual Service and Commissioning Plan (ASCP) to describe how it will commission and invest in local services.

In addition, from April 2003 local authorities and LHBs are required to produce a joint health, social care and well-being strategy[70] which will be implemented from 1st April 2005. The stages involved include:

- Determining who needs to be involved and consulted when formulating the strategy.
- A local needs assessment.
- Formulating the draft and consulting on it (a minimum consultation period of 12 weeks).

This will become a key local strategy for improving the health, social care and well-being of the local population.

The Welsh Health Circular 2003(63) *NHS planning and commissioning guidance* is available at
www.wales.gov.uk/subihealth/index.htm

In addition, GP practices will also be focusing on meeting the quality indicators in the new GMS contract (see page 35).

Government Targets in Northern Ireland

In Northern Ireland, Local Health and Social Care Groups (LHSCGs) have annual targets to achieve which are described in the Department of Health, Social Services and Public Safety *Priorities for Action*. Each LHSCG must publish an annual Primary Care Investment Plan (PCIP) to describe how it will deliver the targets in *Priorities for Action*.

Priorities for Action 2003– 2004 contains a number of priority areas, for example:

Under *Health development* LHSCGs are expected to:

- Have in place a local health improvement plan which describes how the targets in the *Investment for Health Strategy* will be met (by December 2003).
- Build on the current smoking cessation programmes.
- Enhance detection and management of eye diseases in people with diabetes.
- Increase the uptake of influenza vaccination in high risk groups.
- Draw up an accreditation scheme for the establishment of 'health promoting pharmacies' (by September 2003).

Under *Making services more responsive* LHSCGs are expected to:

- Submit their plans for coping with winter pressures (by September 2003).
- Improve hospital waiting times.
- Develop at least one project, which will increase the capacity of primary care to address chronic diseases such as asthma or diabetes to reduce pressure in the hospital sector.
- Extend intermediate care services (by October 2003).
- Encourage the use of PGDs in community pharmacy.

Under *Primary care* LHSCGs are expected to:

- Ensure that the community pharmacy medicines management initiative is available from at least 40% of community pharmacies (by March 2004).
- Facilitate the establishment of supplementary prescribing by nurses and pharmacists in primary care settings (by March 2004).
- By December 2003, draft action plans to implement the community pharmacy strategy (which was published in early 2004[68]).

Under *Community care* LHSCGs are expected to:

- Continue to invest in community services which focus on sustaining independence and reducing the need for hospital and residential / nursing home care.

Under *Care of older people* LHSCGs are expected to:

- Implement a falls prevention strategy of older people.

Under *Mental health* LHSCGs are expected to:

- Strengthen community mental health services.

Priorities for Action is available at www.dhsspsni.gov.uk

In addition, GP practices will also be focusing on meeting the quality indicators in the new GMS contract (see page 35).

Conclusion

In order to identify where community pharmacy can become involved in pubic health, it is important to have an understanding of government targets and be aware of what the priorities are for the local PCO and GP practice.

Knowledge of local NHS priorities is key, since the local PCO is more likely to fund a community pharmacy service development if it helps to meet PCO targets.

How to Approach the Primary Care Organisation with a Service Development Proposal

The current agenda for change in the NHS is to enhance the opportunities for pharmacists to be involved in service developments influencing public health, but PCOs need to be persuaded to invest. Pharmacists therefore need to know how to target PCOs and use effective arguments, how to construct successful bids and implement, monitor and continually improve these services.

The following section describes the key steps that should be followed when considering a service development proposal for the local PCO. Each section contains practical guidance (as boxed text) for a smoking cessation service in order to illustrate the points made.

Identify the Priorities of the Local Primary Care Organisation

Any service development proposal must state how it will help the PCO to meet its targets. An understanding of NHS priorities is therefore essential when making an approach to a PCO to discuss extended services in community pharmacy. The NHS is priority-driven and so to get your voice heard, you need to show how the services you can provide will help PCOs to meet their targets. *It is also important to continually stress the benefits of the service to patients.*

'Putting public health into practice' (page 33) describes the key government targets for the NHS. It is important to be aware of what the key public health targets are, and to build your service proposal around meeting these targets.

Speak to the local PCO to find out what their local public health priorities are. For example, in England, ask the PCT for a copy of the LDP. In addition, speak to the local GP practice and find out what their key public health targets are within the GMS quality and outcomes framework (see *Appendix 2*).

Practical guidance for a smoking cessation service

In England, key targets in the *DH Priorities and Planning Framework 2003– 2006:*

- Reduce the rate of smoking, contributing to the national target of reducing the rate in manual groups from 32% in 1998 to 26% by 2010.
- Reduce substantially the mortality rates from the major killer diseases by 2010: from cancer by at least 20% in people under 75 years of age.
- Deliver a 1% point reduction per year in the proportion of women who continue to smoke throughout pregnancy, focusing on disadvantaged groups.

Key targets in the quality indicators in the GMS contract:

- *CHD 4:* The percentage of patients with CHD who smoke, whose notes contain a record that smoking cessation advice has been offered in the last 15 months.
- *Information 5:* The practice supports smokers in stopping by a strategy, which includes providing literature and offering appropriate therapy.

Further Reading

- Craig G (2003). *Understanding the NHS in England*. Pharm J **271:** 121– 3. Available at www.pharmj.com
- Arnison S, Alexandra E (2003). *Understanding the NHS in Scotland*. Pharm J **271:** 149-51. Available at www.pharmj.com
- Parry P (2003). *Understanding the NHS in Wales*. Pharm J **271:** 177– 9. Available at www.pharmj.com

Identify the Lobbying Tools

In addition to finding out what the overarching targets are for the PCO, it is also important to use any additional government policy papers as a lobbying tool to strengthen your case. *Appendix 3* describes some key government policy papers and guidance.

Practical guidance for a smoking cessation service

In England, the Health Development Agency (see Appendix 1) has produced a guide for PCTs titled *Meeting DoH Smoking Cessation Targets: Recommendations for PCTs* which is available at www.hda-online.org.uk/index.html. This guide provides PCTs with information designed to help them plan how to continue offering high-quality, evidence-based smoking cessation services to their population and meet the targets in the *Priorities and Planning Framework*. The PCT report contains 13 recommendations, describes numerous case studies – a significant number of which include community pharmacy, and outlines key factors for a successful smoking cessation service.

Use the case studies in this guide as a lobbying tool to show the PCT that a successful smoking cessation service involves community pharmacy.

Consider the Timing of the Bid

The proposal for the service development should ideally be put to the PCO in September/October to coincide with their annual planning cycle.

Identify the Published Evidence Base for the Service

PCO budgets are under enormous pressure and so therefore they need to spend their money wisely in areas where there is already evidence of proven benefit. It is important for them to be able to demonstrate the published evidence base for service developments. 'How effective is public health' (page 16) describes the published evidence base.

Practical guidance for a smoking cessation service

What is the evidence base that community pharmacists can provide effective smoking cessation services?
Two UK RCTs, conducted in Scotland and Northern Ireland, demonstrate that there is good clinical and cost-effectiveness evidence from the peer-reviewed literature. Abstinence rates in the Scottish trial were 12% for the intervention and 7% for the controls at nine months,[14] and in the Northern Ireland trial, they were14.3% for the intervention and 2.7% for the controls at one year ($P<0.001$).[15]

Further Reading

- Jones C (2003). *The evidence-base for community pharmacy service development.* Pharm J **271:** 300–2. Available at www.pharmj.com

Identify Similar Established Service Developments

To show that the service development you are proposing has worked successfully in other areas is also a powerful tool.
The PSNC database of community pharmacy projects is available at www.psnc.org.uk and can be searched for examples of community pharmacy services.

Practical guidance for a smoking cessation service

The PSNC database of community pharmacy projects at www.psnc.org.uk can be searched for examples of smoking cessation services.

Identify the Need for the Service

All PCOs will expect some type of 'needs assessment' for any service development, i.e. identification of the current gaps in service provision and a proposal outlining how these gaps can be filled. Therefore, consider a baseline assessment in order to demonstrate a need for the service. This could be as simple as using local demographic data from the annual public health report, speaking to other health professionals, undertaking a simple patient survey or analysing the PMR or OTC sales.

Useful sources of advice and information on needs assessment include:

- Advice and resources from the RPSGB clinical audit unit at www.rpsgb.org.uk
- Hooper & Longworth (2002). *Health needs assessment workbook.* London: Health Development Agency. Available at www.hda-online.org.uk
- Series of articles in the British Medical Journal in 1998 on health needs assessment. For example: Wilkinson (1998). *Assessment in primary care: practical issues and possible approaches.* BMJ **316:** 1524–8. Available at www.bmj.com
- Porteous (2003). *Novel provision of pharmacy services to a deprived area: a pharmaceutical needs assessment.* Int J Pharm Pract **11:** 47–54. Available at: www.pharmj.com
- Williams (2000). *A pharmaceutical needs assessment in a primary care setting.* BJGP **50:** 95–9.
- Anon (2004). *Needs assessment: a practical guide to assessing local needs for services for drug users.* Glasgow: Effective Interventions Unit. Available at: www.scotland.gov.uk/library5/health/nadu.pdf

In England, the Centre for Pharmacy Postgraduate Education (CPPE) will be launching *Public Health – assessing needs for pharmacy development* which is designed to be delivered at a local level by groups, such as the Local Pharmaceutical Committees (LPCs) or Pharmacy Development Groups (PDGs), who have some influence on service development.

The training provided by CPPE will enable pharmacists to:

- understand the relevance of needs assessment;
- identify key areas for service development in their local area;
- use health needs assessment to put together bids for local services.

The programme consists of two workshops on public health needs assessment and an open learning component.

Further details are available on the CPPE website at www.cppe.man.ac.uk (then 'NHS Plan' then 'Public Health').

Practical guidance for a smoking cessation service

The RPSGB clinical audit unit has examples of various audit templates, e.g. *Health promotion – smoking cessation* which audits pharmacists' role in smoking cessation. The results of this audit could be used to show the PCO the level of unmet need in the local population. The audit templates are available at www.rpsgb.org.uk.

Consider the Service Specification

At an early stage consider the practical implications of establishing and running the service. There are numerous practical resources to help with this, which are described in *Appendix 4*.

In addition, *Appendix 5* contains the NPA guide on what to consider when establishing a community pharmacy-based screening service.

Practical guidance for a smoking cessation service

PHLink have produced numerous resources for establishing smoking cessation services which are available at www.rpsgb.org.uk

- *Sample PGD and Service Specification for Supply of NRT through pharmacies 2001.*
- *Improving Local Access to Smoking Cessation Therapies by Using PGDs 2003.*

Network with other Healthcare Professionals

It is important to show that you have networked with other healthcare professionals so that you can describe how the service development will become integrated into existing care pathways for patients, and to get their views on the standards / features of the service development.

Practical guidance for a smoking cessation service

What is the view of the local GP practice and of the specialist smoking cessation clinic on the role that the community pharmacist could play?

Identify a Champion in the PCO

Find out who is leading the implementation of public health in the PCO and approach them with your proposal. She or he is likely to be the key person to send your final proposal to.

Key contacts are:

- The Director of Public Health.
- The Pharmaceutical Adviser.
- The pharmacist member of the Executive or Board.

Consider Clinical Governance at an Early Stage

Clinical governance is an essential element of any service in the NHS. It is important to be able to demonstrate the quality of a service, manage the risks within the service and to continually monitor a service to ensure that standards are maintained, or to improve the service where failures or lapses are identified.

The standards in Part 3 'Service specifications' of *Medicines, Ethics and Practice* states that when providing any professional service, pharmacists should ensure that the tenets of clinical governance are followed:

- That an identifiable pharmacist is accountable for all activities undertaken.
- That they and staff providing services are suitably trained and competent to perform the tasks required (e.g. *see Appendix 6 for examples of postgraduate training*).
- That any necessary equipment and suitable facilities are available for the provision of the service, and that these are maintained in good order.
- That risk assessment and management procedures have been identified and are followed (e.g. *a complaints procedure in place, strict adherence to service protocols, robust patient referral systems*).
- That adequate records are maintained to enable the service to be monitored (*the PCO will be particularly interested in what outcome measures will be audited to show the success of the service*).

In order to ensure that the proposed scheme has a robust clinical governance framework early links should be formed with the clinical governance team in the PCO. For example, in England speak to the community pharmacy clinical governance facilitator at the PCT.

Further Reading:

- Anon (2001). *Clinical Governance in Community Pharmacy: Guidelines on Good Practice for the NHS*. London: Department of Health. Available at: www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ClinicalGovernance/fs/en
- Anon (1999). *Achieving Excellence in Pharmacy through Clinical Governance*. London: RPSGB. Available at www.rpsgb.org.uk/practice/clingov.htm
- Anon (2003). *Beyond the Baseline: The Role of Clinical Governance Facilitators Working with Community Pharmacists*. London: RPSGB. Available at: www.rpsgb.org.uk/practice/clingov.htm
- Anon (2002). *Implementing Clinical Governance in Community Pharmacy (in England): A Local Development Plan*. St. Albans: National Pharmaceutical Association. Available at www.npa.co.uk

Identify a Potential Source of Funding

It is important to be aware of the variety of funding sources available, particularly those that may not be immediately obvious in relation to pharmacy. In England, payment for local enhanced services in the new pharmacy contract will be based on a national tariff.

Information on funding can be found in:

- Anon (2003). *Sources of Funding: A Guide for Community Pharmacists*. LPC Support programme. Aylesbury: PSNC. Available at: www.psnc.org.uk
- Anon (2003). *A Quick Reference Guide to the DoH Priorities and Planning Framework 2003– 2006*. St Albans: National Pharmaceutical Association. Available from the NHS Service Development Department by emailing nhs.dev@npa.co.uk, or by calling 01727 858687 ext. 3217.
- Anon (2003). *A Quick Reference Guide to the NHS in Scotland Priorities and Targets 2004– 05*. St Albans: National Pharmaceutical Association. Available from the NHS Service Development Department by e-mailing nhs.dev@npa.co.uk, or by calling 01727 858687 ext. 3217.

These documents provide full details of all potential funding available to community pharmacists.

Practical guidance for a smoking cessation service

Potential sources of funding for a community pharmacy-led smoking cessation service in England includes:

Sure Start

Sure Start aims to improve the health and well-being of families and children before and from birth by setting up local programmes to improve services for families with children under four years of age. By 2004, there will be at least 500 Sure Start local programmes that will be concentrated in neighbourhoods where a high proportion of children are living in poverty. Sure Start has a number of key targets including decreasing the number of mothers who smoke. Details are available at: www.surestart.gov.uk

Smoking cessation monies

The comprehensive DH website at:
www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Tobacco/fs/en
describes Government funding for smoking cessation initiatives.

Tobacco Alliance Network

A network of 42 DH funded Tobacco Alliances covering the whole of England has been established with the aim of developing a comprehensive programme of public education to persuade smokers to quit and non-smokers not to start. It is targeting the most deprived sections of the community. Details are available at:
www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Tobacco/fs/en

Further Reading

- Parsons B, Craig G (2003*). NHS funding for community pharmacy service development in England*. Pharm J **271:** 323–5.

Summary

In summary your service development proposal should contain:

- A description of what the service development is and what it sets out to achieve.
- Why the PCO should consider the service – consider PCO targets, national lobbying tools and the results of the local needs assessment.
- How the service will be integrated with other local services.
- The evidence base for the scheme – both published papers and examples of successful schemes in other areas should be included.
- The benefits to patients.
- The benefits to other services, e.g. GP practices, social services.
- A description of the resource implications of the service.
- How the service will be monitored.

Further Resources to Help You

- Russell R (2003). *How to Establish a New Community Pharmacy Service*. Pharm J **271:** 237–9.
- Anon (2002). *Preparing a Business Proposal: a Briefing Document*. St. Albans: National Pharmaceutical Association. Available from the NHS Service Development Department by e-mailing nhs.dev@npa.co.uk or by telephoning 01727 858687 ext. 3217.

Public Health Related Organisations

Association of Public Health Observatories

A Public Health Observatory has been established in each of the NHS regions to collect information about health and health inequality in order to track changes over time. The main tasks of the observatories are to support local bodies by:

- Monitoring health and disease trends and highlight areas for action.
- Identifying gaps in health information.
- Advising on methods for health and health inequality impact assessments.
- Drawing together information from different sources in new ways to improve health.
- Carrying out projects to highlight particular health issues.
- Evaluating progress by local agencies in improving health and cutting inequality.
- Looking ahead to give early warning of future public health problems.

Website: www.pho.org.uk

Department of Health, Social Services and Public Safety in Northern Ireland

The Department of Health, Social Services and Public Safety in Northern Ireland provides the most recent information and guidance relating to public health issues in Northern Ireland.
Website: www.dhsspsni.gov.uk

Department of Health, England

The Department of Health, England provides the most recent information and guidance relating to public health issues in England.
Website: www.dh.gov.uk/Home/fs/en

Faculty of Public Health

The Faculty of Public Health is a faculty of the Royal College of Physicians of the United Kingdom. It aims to promote, for the public benefit, the advancement of knowledge in the field of public health, develop public health with a view to maintaining the highest possible standards of professional competence and practice, and to act as an authoritative body for consultation in matters of education or public interest concerning public health. It identifies three areas of public health practice: health protection and prevention; health and social care and health improvement.
NB: *This site has links to a large number of other institutions of relevance to public health.*
Website: www.fph.org.uk

Health Development Agency

The Health Development Agency (HDA) is the national authority that gathers evidence of what works, advises on good practice and supports all those working to improve people's health and reduce health inequalities. To achieve this, the HDA works in partnership across sectors to support informed decision-making at all levels and the development of effective practice.
NB: *The HDA publishes numerous evidence based reviews and guidance for the NHS on how to tackle health inequalities. These are excellent sources of information.*
Website: www.hda.nhs.uk

Health Protection Agency

The Health Protection Agency is a national organisation for England and Wales dedicated to protecting people's health and reducing the impact of infectious diseases, chemical hazards, poisons and radiation hazards. It brings together the expertise of health and scientific professionals working in public health, communicable disease, emergency planning, infection control, laboratories, poisons, chemical and radiation hazards.
Website: www.hpa.org.uk

Health Promotion Agency for Northern Ireland

The Health Promotion Agency for Northern Ireland was set up in 1990 as a special agency of the Department of Health, Social Services and Public Safety. Its aim is to provide leadership, strategic direction and support to all those involved in promoting health in Northern Ireland.
Website: www.healthpromotionagency.org.uk/index.html

Institute of Public Health

A department of the University of Cambridge, the Institute of Public Health aims to:

- Improve the health of the population by understanding the cause and natural history of disease.
- Identify and evaluate new possibilities for both primary and secondary care intervention.
- Monitor on a population basis interventions as they are currently applied.

Website: www.iph.cam.ac.uk

National Assembly, Government of Wales

The National Assembly, Government of Wales provides the most recent information and guidance relating to public health issues in Wales.
Website: www.wales.gov.uk

The National Public Health Service for Wales

The National Public Health Service for Wales brings together the public health resources of the five former health authorities in Wales, which include input from academic departments, with those of the Public Health Laboratory Service in Wales, including the Communicable Disease Surveillance Centre.
Website: www.wales.nhs.uk

The National Treatment Agency for Substance Misuse

The National Treatment Agency (NTA) aims to increase the availability, capacity and effectiveness of treatment for drug misuse in England. It has a key role in holding local Drug Action Teams to account in their role as commissioners of drug treatment services.
Website: www.nta.nhs.uk

NHS Health Scotland

NHS Health Scotland is a new special health board created on 1 April 2003 bringing together the Public Health Institute of Scotland and the Health Education Board for Scotland (HEBS) (see page 51). It provides a national focus for improving health, and works with the Scottish Executive and other key partners to take action to improve health and reduce inequalities in Scotland.
Website: www.healthscotland.com

Public Health Institute of Scotland

The Public Health Institute of Scotland is an NHS organisation, created to serve the whole of the public health community in Scotland, within the NHS and beyond. It aims to protect and improve the health of the people of Scotland by working with relevant agencies and organisations to increase the understanding of the determinants of health and ill health, help formulate public health policy and increase the effectiveness of the public health endeavour.

It aims to achieve this by working with the public health community to:

- Develop the public health information base
- Develop the public health evidence base
- Develop the public health skills base

Website: www.phis.org.uk

Health Education Board for Scotland

The Health Education Board for Scotland was established on 1 April 1991 as a special health board within NHS Health Scotland. The Health Education Board for Scotland gives leadership to the health education effort in Scotland. The Board aims to promote good health through the empowerment of individuals, groups and communities, by playing its part in:

- Ensuring that people have adequate information about health and factors which influence it.
- Helping people to acquire the motivation and skills that enable them to safeguard and enhance their own health and other people's health.
- Promoting commitment to, and participation in, health promotion at all levels in society.
- Encouraging and enabling policy-makers at all levels to recognise possible health consequences of their activities and to make policies that promote health

Website**:** www.hebs.com

PharmacyHealthLink

PharmacyHealthLink (PHLink) is a leading national charity that works to improve the health of the public through the expertise of pharmacists and their staff. PHLink provides research-based public health information to pharmacists and also influences government and the pharmacy profession.

Website: www.pharmacyhealthlink.org.uk

Public Health Electronic Library

The Public Health Electronic Library is a national 'one stop shop' for all information relating to public health. It aims to provide knowledge and know-how to promote health, prevent disease and reduce health inequalities. Its primary audience is professionals within the public health community.

Website: www.phel.gov.uk

Public Health Resource Unit

The Public Health Resource Unit supports change and development within the NHS and other organisations to bring about improvements in health and healthcare. It aims to bridge the gap between research and service and works in five major areas: support to public health professional development; educational programmes; public health projects team (including workshops and conferences); public health information (intelligence).

Website: www.phru.org.uk

The Royal Institute of Public Health

The Royal Institute of Public Health is an independent organisation promoting public health and hygiene through education and training, information, quality testing and policy development.
Website: www.riphh.org.uk

The Scottish Executive Health Department

The Scottish Executive Health Department is responsible for health policy and the administration of the NHS in Scotland. The Public Health Policy Unit of the Health Department is responsible for promoting the health of the people of Scotland.
Website: www.show.scot.nhs.uk

Scottish Executive's Effective Interventions Unit

The Effective Interventions Unit was set up in 2000 to identify and disseminate effective practice to support the implementation of the drug misuse strategy, *Tackling Drugs in Scotland: Action in Partnership (1999).*
Website: www.drugmisuse.isdscotland.org/eiu/eiu.htm

UK Public Health Association

The UK Public Health Association is an independent UK-wide voluntary association, bringing together individuals and organisations from all sectors, who share a common commitment to promoting the public's health. It is a membership-based organisation that aims to promote the development of healthy public policy at all levels of government and across all sectors, and to support those working in public health either professionally or in a voluntary capacity.
Website: www.ukpha.org.uk

Priorities for Public Health in England

In order to keep up-to-date with the public health agenda the following website should be accessed on a regular basis:

- DH health inequalities website at: www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/HealthInequalities/fs/en

In primary care the NHS is currently concentrating on three sets of targets contained in the following:

- The targets in the DH *Priorities and Planning Framework 2003–2006*.
- The quality indicators in the new GMS contract.
- The PCT performance indicators.

The table below gives a summary of these targets that relate to public health and potential community pharmacy services that could be offered to support these government targets. (NB: the table contains an example of targets and is not meant as a comprehensive list:)

Area	Key government targets	What can community pharmacy offer?
Smoking cessation	***DH Priorities and Planning Framework:*** ☐ Reduce the rate of smoking, contributing to the national target of reducing the rate in manual groups from 32% in 1998 to 26% by 2010. ☐ Reduce substantially the mortality rates from the major killer diseases by 2010: from cancer by at least 20% in people under 75 years of age. ☐ Deliver a 1% point reduction per year in the proportion of women who continue to smoke throughout pregnancy, focusing on disadvantaged groups. ***PCT performance indicator:*** ☐ Number of smokers who have quit at four-week follow-up with the NHS smoking cessation services. ***GMS contract Quality Indicators:*** ☐ CHD 4: The percentage of patients CHD who smoke, whose notes contain a record that smoking cessation advice has been offered in the last 15 months. ☐ DM 4: The percentage of patients with diabetes who smoke, and whose notes contain a record that smoking cessation advice has been offered in the last 15 months. ☐ Asthma 5: The percentage of patients with asthma who smoke, whose notes contain a record that smoking cessation advice has been offered in the past 15 months. ☐ Information 5: The practice supports smokers in stopping by a strategy, which includes providing literature and offering appropriate therapy.	Community pharmacy-led smoking cessation services, as part of the integrated network of specialist NHS smoking cessation services.

Area	Key government targets	What can community pharmacy offer?
CHD	***DH Priorities and Planning Framework***: ☐ Reduce substantially the mortality rates from heart disease by at least 40% in people under 75 years of age. ☐ Update GP practice-based registers so that patients with CHD and diabetes continue to receive appropriate advice and treatment in line with NSF standards. ☐ Improve the management of patients with heart failure in line with the NICE Clinical Guidelines. ***GMS contract Quality Indicators:*** ☐ CHD 6: The percentage of patients with CHD in whom the last BP reading (measured in the last 15 months) is 150/90 or lower. ☐ CHD 8: The percentage of patients with CHD whose last measured total cholesterol (measured in the last 15 months) is 5mmol/l or less. ☐ CHD 9: The percentage of patients with CHD with a record in the last 15 months that aspirin, an alternative anti-platelet therapy, or an anticoagulant is being taken (unless a contra-indication or side effects are recorded). ☐ CHD 10: The percentage of patients with CHD who are currently treated with a B blocker (unless a contraindication or side effects are recorded). ☐ CHD 11: The percentage of patients with a history of MI (diagnosed after the 1st April 03) who are currently treated with an ACE inhibitor .	Participation in health promotion and education to promote smoking cessation, healthy eating, etc. Integration of community pharmacy screening services as part of NHS screening services for those at risk of CHD. Use community pharmacy PMRs to target patient intervention in CHD. Community pharmacy-led medicines management services for CHD patients, hypertensive patients, and patients with a history of TIA or stroke.
Drug misuse	***DH Priorities and Planning Framework:*** ☐ Increase the participation of problem drug users in drug treatment programmes by 55% by 2004 and by 100% by 2008 (against 1998 baseline), and increase year-on-year the proportion of users successfully sustaining or completing treatment programmes. ☐ Reduce drug-related deaths by 20% by 2004 (against 1999 baseline). ***PCT performance indicator:*** ☐ Percentage of GP practices in a shared care scheme for problematic drug misusers.	Integrate community pharmacy into drug misuse services, e.g. supervised methadone schemes.
Sexual health	***DH Priorities and Planning Framework:*** ☐ Achieve agreed local teenage conception reduction targets while reducing the gap in rates between the worst fifth of wards and the average by at least a quarter in line with national targets. ***PCT performance indicator:*** ☐ Teenage pregnancy: conceptions below age 18 (percentage change in rate between 1998 baseline and 2002). ***GMS contract Quality Indicator***: ☐ Con 1: The team has a written policy for responding to requests for emergency contraception.	Set up EHC PGD schemes in community pharmacy and encourage use by teenagers.

Area	Key government targets	What can community pharmacy offer?
Immunisation	***DH Priorities and Planning Framework:*** ☐ Achieve the target of 70% uptake in 'flu immunisation in people aged 65 years and over, targeting populations in the 20% of areas with the lowest life expectancy. ***PCT performance indicator:*** ☐ People vaccinated against 'flu as a percentage of number of people aged 65 years and over. ***GMS contract Quality Indicators:*** ☐ CHD 12: The percentage of patients with CHD who have a record of 'flu vaccination in the preceding 1 September to 31 March. ☐ DM 18: The percentage of patients with diabetes who have had 'flu immunisation in the preceding ☐ 1 September to 31 March. ☐ Asthma 7: The percentage of patients with asthma aged 16 years and over who have had an 'flu immunisation in the preceding 1 September to 31 March	Involve community pharmacy in campaigns to raise awareness of 'flu vaccinations. Consider a community pharmacy-based immunisation programme integrated with the local NHS 'flu campaign.
Mental health	***DH Priorities and Planning Framework:*** ☐ Reduce the mortality rate from suicide and undetermined injury by at least 20% by 2010. ☐ Ensure that by April 2004 protocols are in place across all health and social care systems for the care and management of older people with mental health problems. ***PCT performance indicator:*** ☐ PCT commissioning of *NHS Plan* deliverables: mental health (adults). ***GMS contract Quality Indicators:*** ☐ Epilepsy 3: The percentage of patients age 16 and over on drug treatment for epilepsy who have a record of medication review in the previous 15 months. ☐ MH 3: The percentage of patients on lithium therapy with a record of lithium levels checked in the previous 12 months.	Involve community pharmacy in health promotion and education about the risks associated with key classes of drug. Integrate community pharmacy into the community mental health teams to provide medication management support to patients with mental health. Community pharmacy medicines management service to support the reduction in inappropriate benzodiazepine prescribing. Community pharmacy-led medicines management services for epileptic and mental health patients. The community pharmacist could flag to patients as part of the repeat dispensing service, when the relevant tests were due.
Accidents	***DH Priorities and Planning Framework:*** ☐ All health and social care systems to have established an integrated falls service by 2005.	Medication reviews and provision of advice to patients on the side effects that some medicines have on the risk of falls. Participation in campaigns to raise awareness of ways to prevent falls in the home.

Area	Key government targets	What can community pharmacy offer?
Asthma	***GMS contract Quality Indicator:*** ☐ Asthma 6: The percentage of patients with asthma who have had an asthma review in the last 15 months.	Sustainable medicines management services to asthmatic patients. Community pharmacy-led medicines management services for asthma and COPD patients.
Diabetes	***DH Priorities and Planning Framework:*** ☐ By 2006, a minimum of 80% of people with diabetes to be offered screening for the early detection of diabetic retinopathy. ***PCT performance indicator:*** ☐ Diabetic retinopathy screening. ***GMS contract Quality Indicators:*** ☐ DM 6 *(and DM 7):* The percentage of patients with diabetes in whom the last HbA1c is 7.4 *(or 10)* or less (or equivalent test / reference range depending on local laboratory) in last 15 months. ☐ DM 12: The percentage of patients with diabetes in whom the last BP is 145/85 or lower. ☐ DM 15: The percentage of patients with diabetes with proteinuria or micro-albuminuria who are treated with ACE inhibitors (or A2 antagonists). ☐ DM 17: The percentage of patients with diabetes whose last measured total cholesterol within the previous 15 months is 5 or less.	Participation in campaigns to raise awareness of the importance of retinopathy screening. Sustainable medicines management services to diabetic patients. Community pharmacy-led medicines management services for diabetic patients.

Key Policy Papers, Sources of Information and Practical Toolkits

(NB: The table contains an example of key documentation and is not meant as a comprehensive list.)

Area	Key policy papers, sources of information and practical toolkits
Smoking cessation	**England** ***Meeting DH smoking cessation targets: recommendations for PCTs.*** **Health Development Agency January 2003** Available at www.hda-online.org.uk/index.html The HDA identifies the evidence of what works to improve people's health and reduce health inequalities. This resource pack provides PCTs with information designed to help them plan how to continue offering high-quality, evidence-based smoking cessation services to their population and meet the targets in the *Priorities and Planning Framework*. This is complemented by *Meeting DH smoking cessation targets: recommendations for service providers,* which contains recommendations for staff involved in providing treatment through smoking cessation services. The report contains numerous case studies – a significant number of which include community pharmacy - and outlines key factors for a successful smoking cessation service. ***Standards for training in smoking cessation treatments.*** **Health Development Agency June 2003** Available at www.hda-online.org.uk/index.html The purpose of this training standard from the HDA is to raise the quality of the training provided to smoking cessation advisers. It also provides individual practitioners, service providers, PCTs and strategic health authorities with a robust framework against which to measure current and future performance. The standard provides advice on the training requirements and competencies for those providing three levels of smoking cessation advice, i.e. brief interventions, intensive one-to-one support and advice, and group interventions. **Scotland** ***A breath of fresh air for Scotland. Improving Scotland's health: the challenge. Tobacco Control Action Plan.*** **Scottish Executive 2003** Available at www.scotland.gov.uk/library5/health/abfa-00.asp The action plan contains a range of actions, including an additional £4 million for smoking cessation services over two years. Chapter 4 describes smoking cessation services and contains a: ☐ a description of all the potential funding streams for smoking cessation services; ☐ a statement that 'GPs, practice nurses, midwives, dentists, pharmacists, health visitors and other health professionals all potentially have a role to play in giving smoking cessation advice'.

Area	Key policy papers, sources of information and practical toolkits
	Northern Ireland ***A five-year tobacco action plan.* DHSSPS June 2003** Available at www.dhsspsni.gov.uk/index.html The *Tobacco Action Plan* sets four key targets to: ☐ increase the proportion of 11 to 16-year olds who do not smoke from 86.5% in 2000 to 89% by 2006; ☐ increase the number of pregnant women who do not smoke from 78% in 2000 to 82% in 2005; ☐ increase the proportion of adults who do not smoke from 73% in 2000/01 to 75% in 2006/07; ☐ increase the proportion of non-smokers in manual groups from 65% in 2000/01 to 69% in 2006/07. The main actions include: ☐ Further development of sustained public information campaigns. ☐ Further development and promotion of smoking cessation services in a variety of settings. ☐ Work with the HPSS, local councils and others to promote the introduction of smoke-free policies. The *Plan* describes the role of the community pharmacist in providing advice and supplying smoking cessation products under PGD.
CHD	**England** **NSF for CHD** Available at www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/CoronaryHeartDisease/fs/en CHD is the biggest killer in the UK. The NSF for CHD is intended to enhance quality of services, reduce variations in the incidence of CHD and access to CHD services across the country. The NSF document: ☐ Sets 12 national standards of care (intended to remain relevant for 10 years or more) for preventing and treating CHD. ☐ Recommends service models enabling the efficient delivery of those standards. ☐ Suggests indicators and clinical audit criteria that can be used to assess the quality of prevention and treatment. ☐ Identifies early priorities. ☐ Describes milestones and goals that will mark progress with implementation. ☐ Describes the underpinning programmes and gives examples of practical tools to help implement the standards.
Drug misuse	**England** **National Treatment Agency for Substance Misuse** The National Treatment Agency (NTA) has a key role in holding local Drug Action Teams (DATs) to account in their role as commissioners of drug treatment services. The NTA website is available at www.nta.nhs.uk Key publications include: ***Models of Care*. NTA March 2003** This sets out a national framework for commissioning integrated drug treatment systems for adult drug misusers in England. All commissioners of drug treatment services will be expected to plan and commission services, based on the system outlined in *Models of Care*.

Area	Key policy papers, sources of information and practical toolkits
	It is published in two parts: ☐ Part one is for drug treatment commissioners and those responsible for local implementation. ☐ Part two is a detailed reference document for drug treatment managers and providers, and those responsible for assuring quality and appropriate delivery of local drug treatment services. ***Commissioners resource pack.*** **NTA 2003** The *Commissioners Resource Pack* will be built up over a period of time. Current service specifications include: ☐ Information, advice and support services. ☐ Needle exchange and harm reduction. **Northern Ireland** ***Prevalence of problem heroin use in Northern Ireland.*** **DHSSPS February 2003** Available at www.dhsspsni.gov.uk This report discusses various treatment options for those dependent on heroin and how these might be operated in Northern Ireland. Sections 4.1.3 and 4.1.4 gives an overview of the evidence base for the role of the pharmacist in shared-care arrangements, and the training implications. There are two key recommendations in the report for community pharmacy: ☐ 6.10 Endorses the implementation of shared-care protocols for substance misuse. ☐ 6.12 Recommends that clients should have supervised methadone consumption for at least the first six months.
Sexual health	**England** ***An evaluation resource to support the Teenage Pregnancy Strategy.*** **Health Development Agency January 2003** Available at www.hda-online.org.uk/html/resources/publications.html This strategy was commissioned by the DH Teenage Pregnancy Unit and provides an overview of how to evaluate services that are commissioned to implement the Teenage Pregnancy Strategy. It includes an overview of evaluation principles, a checklist to help structure the process, examples of good practice, plus sample questionnaires and tools. ***Effective commissioning of sexual health and HIV services: a sexual health and HIV commissioning toolkit for PCTs and local authorities.*** **DH January 2003** Available at www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SexualHealth/fs/en This toolkit supports PCTs in exploring options for improving local services. Key sections in this document include: ☐ Section 4 – best practice guidelines for contraceptive services. This states, for example, that elements of a best practice contraceptive service include arrangements for timely provision of all types of emergency contraception. ☐ Appendix 6 – further sources of help and information. ☐ Appendix 8 – a clinical governance framework. ***Effective sexual health promotion: a toolkit.*** **DH June 2003** Available at www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SexualHealth/fs/en This toolkit is for PCTs and others working in the field of promoting sexual health and HIV prevention. The toolkit aims to promote a structured approach to sexual health promotion, and offers practical advice to establish such a service.

Area	Key policy papers, sources of information and practical toolkits
	This toolkit has been produced in response to the 2002 DH action plan to implement the national strategy for sexual health and HIV. This toolkit should be used alongside two previous DH toolkits: ☐ *Health promotion toolkit: good practice and practical tips.* ☐ *Effective commissioning of sexual health and HIV services: a sexual health and HIV commissioning toolkit for PCTs and local authorities.* In addition to providing guidance to PCTs on establishing successful sexual health promotion, the toolkit also provides a useful summary of the evidence base of effective interventions for teenage pregnancy and HIV prevention. **Northern Ireland** ***Teenage pregnancy and parenthood: strategy and action plan 2002-2007.* DHSSPS November 2002** Available at www.dhsspsni.gov.uk The rates of teenage pregnancy in Northern Ireland are amongst the highest in Europe and are greatest in areas of social and economic deprivation. *The Strategy* includes targets to reduce teenage pregnancies, particularly those under 17 years of age. Targets in the strategy include a reduction in teenage pregnancies, developing a sexual health promotion strategy and making sexual health services more accessible. ***Teenage pregnancy and parenthood: strategy and action plan 2002–2007.* DHSSPS 2002** Available at: www.dhsspsni.gov.uk This strategy for Northern Ireland aims to reduce teenage pregnancies, particularly those under 17 years. Targets include developing a sexual health promotion strategy and making sexual health services more accessible. **Scotland** ***Enhancing sexual wellbeing in Scotland. A draft sexual health and relationship strategy.* Scottish Executive October 2003** Available at www.scotland.gov.uk/pages/news/2003/11/SEhd575.aspx This draft strategy encourages the development of further services from community pharmacies building on the success of existing schemes to supply of EHC via PGD, to supply *Chlamydia* testing through pharmacies, to actively take part in local health promotion campaigns, and to signpost patients to relevant services.
Mental health	**England** **NSF for mental health** Available at www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/MentalHealth/fs/en The main aim of the NSF for mental health is to improve 24-hour care for people with mental health problems. The NSF addresses five main areas of care: ☐ Mental health promotion. ☐ Primary care and access to services for anyone with mental health problems. ☐ Effective services for people with severe mental health problems. ☐ Individuals who care for people with mental health problems. ☐ Action necessary to achieve the target to reduce suicides.

Area	Key policy papers, sources of information and practical toolkits
	National suicide prevention strategy for England. **DH September 2002** Available at www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/MentalHealth/fs/en This important strategy aims to ensure that steps are being taken to meet the target of reducing the death rate from suicide and undetermined injury by at least a fifth by 2010 as described in *Saving lives: our healthier nation* and reinforced in the NSF for mental health. Implementation of the strategy will be taken forward by the National Institute for Mental Health in England (NIMHE) at www.nimhe.org.uk. NIMHE is an organisation based within the Modernisation Agency at the DH. This document describes a number of goals including: ☐ *To promote mental well-being in the wider population*– the document targets specific population groups including socially excluded and deprived groups, black and ethnic minority groups, and people who misuse drugs and/or alcohol. It also describes the tools available to help support each target, *e.g. Making it happen: a guide to delivering mental health promotion* which is available at www.nimhe.org.uk ☐ *To reduce the availability and lethality of suicide methods* – this includes a target to reduce the number of suicides as a result of self-poisoning. The document states that NIMHE will consult further with the Medicines Control Agency, the National Prescribing Centre, and PCOs to identify additional steps that can be taken to promote safer prescribing of antidepressants and analgesics and to publicise the health dangers of paracetamol in overdose. **Scotland** ***Choose life: preventing suicide in Scotland: a national strategy and action plan.*** **Scottish Executive 2002** Available at www.scotland.gov.uk This strategy for Scotland aims to tackle rising rates of suicides by achieving a 20% reduction in the suicide rate by 2013. The priority groups are those who abuse substances, people in prison, young people, people with mental health problems, people who attempt suicide, people affected by suicidal behaviour, people with mental health problems, children and young people. This document is a useful resource if you are involved in providing a service or developing the role of the community pharmacist working with drug misusers, people with severe mental health, prison services or services relating to suicide prevention. ***National programme for improving mental health and well-being in Scotland.*** **Scottish Executive September 2003** Available at www.scotland.gov.uk This is a three-year action plan which will further direct the work of the national programme in supporting national and local efforts to raise the profile of mental health, support action in mental health improvement (promotion and prevention), address the stigma of mental ill health and prevent suicide in Scotland. *The Programme* is supported by £24 million pounds of funding and has four key aims during 2003–2006 which are to: ☐ raise awareness and promoting mental health and well-being; ☐ eliminate stigma and discrimination; ☐ prevent suicide; ☐ promote and support recovery. Resources to support this *Programme* will be made available on a new website called 'wellontheweb' which can be accessed at www.wellontheweb.net

Area	Key policy papers, sources of information and practical toolkits
	Northern Ireland ***Promoting mental health strategy and action plan 2003–2008.*** **DHSSPS January 2003** Available at www.dhsspsni.gov.uk/publications/index.html This strategy and action plan comprises a number of actions grouped under policy development, raising awareness and reducing discrimination, improving knowledge and skills and preventing suicide. The actions include the development of policies and programmes to promote mental health and the development of a suicide awareness programme in each health and social services board area.
Accidents	**England** ***Preventing accidental injury: Priorities for action.*** **DH October 2002** Available at www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Accidents/fs/en The Accidental Injury Task Force was established to identify from the available evidence those steps that would have the greatest impact in preventing injury. This report by the Task Force reviews the evidence-base for accidents and gives practical guidance for the way forward. It suggests that for relatively modest investment good progress can be made quickly towards the achievement of the 2010 target in *Saving Lives: Our Healthier Nation* for injury prevention. This document should be read together with the 'Background Papers' and the 'Appendices' also on the website. Preventing injuries to older people from falls are a key part of *Preventing accidental injury: priorities for action*. For example, as an immediate priority the document describes targeting 'at risk' populations of older people towards interventions that are proven to work (e.g. prevention and treatment of osteoporosis, multi-faceted assessment and intervention programmes to prevent falls) and recommends the development of falls' services. The background paper *Priorities for Prevention: Working Group for Older People* further discusses the evidence base and also discusses targeting 'at risk' groups of elderly patients and performing detailed assessments (including medication review). ***How can we help older people not to fall again? Implementing the older people's NSF falls standard: support for commissioning good services.*** **DH July 2003** Available at www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/OlderPeoplesServices/fs/en The aim of this document is to provide guidance for commissioners on implementing the NSF for older people standard 6 on falls prevention. The document reviews the evidence base for falls, what the key interventions to prevent falls are, how local implementation should be driven forward by local implementation teams, the evidence base for effective falls prevention services (including osteoporosis prevention and treatment, and medication review), and describes established falls services. ***Guide to commissioning good services for falls prevention.*** **DH September 2003** Available at www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/OlderPeoplesServices/fs/en This document provides guidance for commissioners to support the delivery of the falls prevention section of the NSF for older people. The guidance states that interventions are most beneficial when targeted at those at risk identified through agreed assessment processes, and when integrated in a falls strategy developed with the full range of local services. The guidance reviews the evidence base for falls prevention, including medication review and promoting healthy living. The appendices contain a wealth of information on the evidence base for falls prevention. The guidance also contains advice on how to argue the case for funding falls prevention services.

Area	Key policy papers, sources of information and practical toolkits
	Wales ***Strategy for older people.* Assembly for Wales 2003** Available at www.wales.gov.uk/subisocialpolicy/content/ssg/contents-e.htm *The Strategy* sets out a framework for statutory and voluntary organisations alike to work on over the next 10 years. Its implementation will be based on collaboration between the Assembly, local government, the NHS and many others to ensure a co-ordinated approach is taken across Wales to address older people's issues. Strategy implementation began in April 2003.
Diabetes	**England** **NSF for diabetes** Available at www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Diabetes/fs/en The NSF for diabetes was published in two parts: ☐ The standards and key interventions to raise the standards of diabetes care was published in 2001. ☐ The delivery strategy, which sets out the action to be taken by PCTs, milestones, performance management arrangements and the underpinning progammes to support local delivery was published in 2002. **Wales** **NSF for diabetes** Available at: www.wales.nhs.uk The NSF for diabetes was published in two parts: ☐ The standards and key interventions to raise the standards of diabetes care was published in 2002. ☐ The delivery strategy, which sets out the action to be taken by LHBs, milestones, performance management arrangements and the underpinning progammes to support local delivery was published in 2003.

Practical Resources to Help

(NB: The table contains an example of practical resources and is not meant as a comprehensive list.)

In addition to the sources of information described in the table, the Centres for Pharmacy Postgraduate Education across the UK also offer various training materials on public health interventions:

- Centre for Pharmacy Postgraduate Education in England at www.cppe.man.ac.uk
- Northern Ireland Centre for Postgraduate Pharmaceutical Education and Training at www.nicppet.org
- Scottish Centre for Post Qualification Pharmaceutical Education at www.nes.scot.nhs.uk/pharmacy
- Welsh Centre for Post-Graduate Pharmaceutical Education at www.cf.ac.uk/phrmy/WCPPE/pindex.html

Area	Practical resources
Smoking cessation	From the NPA NHS Service Development Department by e-mailing nhs.dev@npa.co.uk ☐ *Developing smoking cessation services resource list.* 2003. From the NPA Education and Training Department by e-mailing training@npa.co.uk ☐ *Smoking cessation.* 2003. From the RPSGB at www.rpsgb.org.uk ☐ Guidance on the audit of smoking cessation services from the Clinical Audit Unit. ☐ *The pharmacist's role in smoking cessation.* RPS e-PIC references 2004. From PHLink at www.pharmacyhealthlink.org.uk ☐ *Pharmacists: can you do more to help smokers stop smoking?* ☐ *Sample PGD and service specification for supply of NRT through pharmacies.* 2001. ☐ *Improving access to smoking cessation therapies by using PGDs.* 2003.
CHD	From the NPA NHS Service Development Department by emailing nhs.dev@npa.co.uk ☐ *Screening resource list.* 2003. From the Community Pharmacy Medicines Management Project at www.medicinesmanagement.org.uk ☐ *Community pharmacy medicines management: a resource pack for community pharmacists.* 2003. From PHLink at www.pharmacyhealthlink.org.uk ☐ Public health information leaflets. From the RPSGB at www.rpsgb.org.uk ☐ Guidance on the audit of various aspects of CHD (e.g. aspirin, nitrate use) from the Clinical Audit Unit. ☐ *Practice guidance on blood pressure monitoring.* 2003.
Drug misuse	From the NPA NHS Service Development Department by e-mailing nhs.dev@npa.co.uk ☐ *Drug misuse resource list.* 2003. From the PSNC by e-mailing psnc@psnc.org.uk ☐ *Community pharmacy based substance misuse services resource pack.*

Area	Practical resources
Sexual health	From the NPA NHS Service Development Department by e-mailing nhs.dev@npa.co.uk ☐ *First wave EHC schemes – lessons learnt to date.* 2000. From the RPSGB at www.rpsgb.org.uk ☐ *Practice guidance on the supply of EHC as a pharmacy medicine.*
Mental health	From the RPSGB at www.rpsgb.org.uk ☐ *Practice guidance on the care of people with mental health problems.* 2000. From the pharmaceutical care model schemes website in Scotland at www.show.scot.nhs.uk/pcms ☐ *Steps framework on mental health.* 2003. From PHLink at www.pharmacyhealthlink.org.uk ☐ Public health information leaflets. From the PSNC at www.psnc.org.uk ☐ *NSF for Mental Health: a guide for community pharmacists.* 2003.
Accidents	From the NPA NHS Service Development Department by emailing nhs.dev@npa.co.uk ☐ *Discussion paper on preventing falls in older people.* 2002. ☐ *Developing community pharmacy medication review as part of a falls prevention strategy: resource list.* 2003. From PHLink at www.pharmacyhealthlink.org.uk ☐ *Promoting physical activity in older people. An information pack for pharmacists.* 2002. ☐ Various resources and advice on health promotion. From the pharmaceutical care model schemes website in Scotland at www.show.scot.nhs.uk/pcms ☐ *Steps framework on frail elderly.* 2003.
Asthma	From the RPSGB at www.rpsgb.org.uk ☐ *Practice guidance on the care of people with asthma and COPD.* 2000.
Diabetes	From PHLink at www.pharmacyhealthlink.org.uk ☐ Various resources and advice on health promotion. From the PSNC at www.psnc.org.uk ☐ *Diabetes services: a guide for community pharmacists.* 2002. From the RPSGB at www.rpsgb.org.uk ☐ *Practice guidance on the early identification of diabetes by community pharmacists.* 2001. ☐ *Practice guidance on the care of patients with diabetes by community pharmacists.* 2001.
Health promotion	From the NPA Education and Training Department by emailing training@npa.co.uk ☐ *Health Promoters.* 2003. From PHLink at www.pharmacyhealthlink.org.uk ☐ Various resources and advice on health promotion.

The NPA Guide on What to Consider When Establishing a Community Pharmacy-Based Screening Service

If you are thinking about setting up a screening service, you should be asking yourself the following:

1. **Which general standards should be followed?**
   Key general standards and guidance include:
   - The RPSGB *Medicines, ethics and practice* guide, which contains brief advice on diagnostic testing and health screening (available at www.rpsgb.org.uk).
   - Detailed practice guidance on the testing of body fluids has also been produced by the RPSGB (available at www.rpsgb.org.uk).

2. **What specific standards should be followed for a particular service?**
   Taking blood pressure (BP) monitoring as an example:
   - Always follow nationally recognised standards, e.g. the British Hypertension Society guidelines at www.hyp.ac.uk/bhs/home.htm, which describe the current national guidance and lists recommended BP measuring devices. For example, a number of BP measurements should be taken over a period of time in order to correctly establish a patient's baseline BP.
   - The RPSGB has also produced detailed practice guidance on BP monitoring (available at www.rpsgb.org.uk).

3. **What are the implications of providing a screening service?**
   Consider the following:
   - *What will be the impact on your workload?*
     For example, how will you arrange patient consultations?
   - *Have you got the capacity currently - or have plans in place - to change ways of working to accommodate this service?*
     For example, do you have a suitable consultation area for patient counselling and for undertaking therapeutic monitoring?
   - *What are the potential costs of providing the service?*
     For example, pharmacist time, staff time, training, changes to premises, monitoring equipment, administration, advertising, etc.

4. **What are the key clinical governance issues to consider?**
   Clinical governance is an essential element of any service in the NHS. It is important to be able to demonstrate the quality of a service, manage the risks within the service and to continually monitor a service to ensure that standards are maintained or to improve the service where failures or lapses are identified. The standards in part 3 'Service specifications' of *Medicines, ethics and practice* states that when providing any professional service pharmacists should ensure that the tenets of clinical governance are followed:
   - That an identifiable pharmacist is accountable for all activities undertaken.
   - That they and staff providing services are suitably trained and competent to perform the tasks required.
   - That any necessary equipment and suitable facilities are available for the provision of the service, and that these are maintained in good order.
   - That risk assessment and management procedures have been identified and are followed (*e.g. a complaints procedure in place, strict adherence to service protocols, robust patient referral systems*).
   - That adequate records are maintained to enable the service to be monitored.

5. **Who should be involved in planning the service?**
   The development of the screening service should always be discussed with the other local healthcare professionals who are also involved in patient care. These discussions should take place at an early stage to provide the best opportunity for the pharmacy service to become integrated with the other services provided locally and to let other healthcare professionals give their view on what type of pharmacy service they would find the most helpful. For example, how will the pharmacy screening service refer suitable patients back to the GP practice? Should standard written referral forms be produced? What advice is provided to patients by other local healthcare professionals (since the advice provided in the pharmacy should be consistent)?

   Patients should also be involved in the planning of any service development.

6. **How should the local PCO be approached to fund the service?**
   If the PCO is to be approached to fund a NHS pharmacy screening service then the following points should be considered:
   - *What are the local priorities for the PCO?*
     PCOs are priority-driven and so any proposal for a service development must state how it will help the PCO achieve its targets.
   - *Is there a need for the service?*
     All PCOs will expect some type of 'needs assessment' for any service development, i.e. identification of the current gaps in service provision and a proposal outlining how these gaps can be filled. Consider a baseline assessment in order to demonstrate a need for the service.
   - *Is there an evidence-base for the service?*
     PCO budgets are under enormous pressure and so PCOs must spend their money wisely in areas where there is already evidence of proven benefit. Therefore it is important to be able to demonstrate the published evidence base for service developments. An excellent source of information is *Evidence Relating to Community Pharmacy Involvement in Health Development: A Critical Review of the Literature 1990–2001*[12] available at www.rpsgb.org.uk

- *How will the service be audited?*
  Any service development proposal needs to consider what outcome measures will be audited to show the success of the service.
- *Identify a champion in the PCO*
  Find out who leads the PCO in the area in which your service proposal lies. This is likely to be the key person in the PCO to who to send your final proposal.

7. Which sources of information provide ideas for screening services?

The PSNC database of community pharmacy projects is available at www.psnc.org.uk This can be searched for examples of pharmacies already providing screening services.

Useful references can also be found on a regular basis in the pharmacy press.

Training Resources

(NB: This list contains examples of training resources and is not meant as a comprehensive list:)

Faculty of Public Health
The Faculty of Public Health provides a useful background to training in public health and has a number of useful links on its website.
Website: www.fph.org.uk

PHLink / CPPE
PHLink and CPPE provide a distance learning pack on health promotion entitled *Improving the Public's Health through Health Promotion: A Distance Learning Course for Pharmacists.*
This is available from CPPE at www.cppe.man.ac.uk

Postgraduate qualifications in Public Health

The following universities offer masters and other postgraduate programmes in public health:

Birmingham University
Masters Programme in Public Health
Website: www.publichealth.bham.ac.uk/mph

Cambridge University
The Master of Studies in Public Health
Website: www.phpc.cam.ac.uk/mst

Cardiff University
Master of Public Health
Website: www.uwcm.ac.uk/mph

Dundee University
Master of Public Health
Website: www.dundee.ac.uk

Edinburgh University
Master of Public Health
Website: www.ed.ac.uk

Glasgow University
Master of Public Health
Website: www.gla.ac.uk

Kings College, London
Master of Public Health
MSc Public Health
Postgraduate Diploma in Public Health
Website: www.kcl.ac.uk/kis/schools/life_sciences/life_sci/msc/msc_pub_health.html

London School of Hygiene & Tropical Medicine
MSc Public Health
Website: www.lshtm.ac.uk/prospectus/masters/msph.html

Medical College of London
Masters in Public Health
Website: www.mcl-edu.co.uk

Oxford Brookes University
MSc/Postgraduate Diploma in Public Health
Website: www.brookes.ac.uk/courses/currentpg/msc_pgdip_publichealth.html

GLOSSARY

Clinical governance A framework through which NHS organisations are accountable for continuously improving the quality of their services.

Disease prevention Disease prevention covers measures not only to prevent the initial occurrence of disease (primary prevention), such as risk factor reduction, but also to arrest the progress of existing disease and reduce its consequences (secondary prevention).

Epidemiology The study of the distribution and determinants of health states or events in specified populations and the application of this study to the control of health problems. Epidemiological information, particularly defining individual, population and/or physical environmental risks is at the core of public health and helps to define disease prevention activities.

Health Defined by the World Health Organization constitution of 1948 as 'a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity'. It is a resource that permits people to lead an individually, socially and economically productive life.

Health determinants The range of personal, social, economic and environmental factors that determine the health status of individuals or populations.

Health development The process of continuous, progressive improvement of the health status of individuals and groups in a population. Health promotion is an essential element of health development.

Health education Comprises consciously constructed opportunities for learning involving some form of communication designed to improve knowledge of health and development of life skills, which are conducive to individual and community health. It is concerned not only with communication of information, but also with fostering the motivation, skills and confidence necessary to take action to improve health. Health education should be distinguished from health promotion. The latter term covers action directed towards alteration of the social, economic and political environment.

Health gain A way to express improved health outcomes. It can be used to reflect the relative advantage of one form of health intervention over another in producing the greatest health gain.

Health goal Summarises the health outcomes, which, in the light of existing knowledge and resources, a country or community might hope to achieve in a defined time period. Health goals are statements of intent and aspiration.

Health impact assessment Analyses the impact on health of a decision the prime objective of which is something other than health. Examples might include the traffic impact of a new development or the effects of a Single Regeneration Budget on health.

Health inequalities Differences between the health of sections of the population that occur as a consequence of differences in social and educational opportunities, financial resources, housing conditions, nutrition, work patterns and conditions and unequal access to health services.

Health needs assessment Describes health problems in a population and differences within and between different groups. The aim is to determine health priorities and unmet needs. It should identify where people are able to benefit either from health service care or from wider social and environmental change, and balance any potential change against clinical, ethical and economic considerations. In other words what should be done, what can be done and what can be afforded.

Health outcomes A change in the health status of an individual, group or population which is attributable to a planned intervention or series of interventions, regardless of whether such intervention was intended to change health status.

Health promotion Defined by the *Ottawa Charter for Health Promotion* as 'the process of enabling people to increase control over, and to improve their health'. Not only does it embrace actions directed at strengthening skills and capabilities of individuals, but also action directed towards changing social, environmental and economic conditions so as to alleviate their impact on public health and individual health. It is directed at creating the conditions which offer a chance of there being a relationship between the efforts of individuals and groups and subsequent health outcomes.

Health target For a given population, health targets state the amount of change that could be reasonably expected within a defined time period. Targets are generally based on specific and measurable changes in health outcomes.

Long-term service agreements Agreements between PCTs and NHS Trusts on the services to be provided for a local population. These will replace the annual contracts of the internal market and cover a minimum of three years in order to provide greater stability.

National Service Frameworks (NSF) Evidence-based NSFs set out what patients can expect to receive from the NHS in major care areas or disease groups.

Public health The science and art of promoting health, preventing disease and prolonging life through the organised efforts of society. It is a social and political concept aimed at improving health, prolonging life and improving the quality of life among whole populations through health promotion, disease prevention and other forms of health intervention. Supporting healthy lifestyles and creating supportive environments for health are crucial parts of creating, maintaining and protecting public health.

Quality of life Defined as individuals' perceptions of their position in life in the context of the culture and value system where they live, and in relation to their goals, expectations, standards and concerns. It incorporates physical health, psychological state, level of independence, social relationships and personal beliefs.

Risk factor A social, economic or biological status, behaviour or environment, which is associated with or a cause of increased susceptibility to a specific disease, ill health or injury. Risk factors, once identified, can be a focus for health promotion strategies and activities.

Social capital Consists of the stock of active connections among people: the trust, mutual understanding, and shared values and behaviours that bind the members of human networks and communities and make co-operative action possible.

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