Sexual health services:
Community pharmacists’ views and competences

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Abstract
Community pharmacists in England offer a range of services linked to sexual health, which have expanded and developed with time. These services include provision of emergency contraception and screening for Chlamydia infection. There is pressure for pharmacists to offer further sexual health services.

This study explores:

- The feelings of community pharmacists on their role in offering sexual health services
- The competences that pharmacists consider they need to demonstrate an equivalent standard to other NHS service providers.

Method
A postal questionnaire was sent to a random sample of 2000 practising community pharmacists in England, asking for their views on a range of sexual health services and the competencies that they felt pharmacists needed to demonstrate.

The main outcome measures were: attitude towards current and future sexual health services, drivers to provide sexual health services, competences required when offering sexual health services, respondent demographics.

Results
Responses were received from 40.8 percent of the cohort. Pharmacists expressed positive feelings towards their current role, but did not consider extension to invasive testing for sexually transmitted infections to be appropriate.

Pharmacists recognised the relevance of the competency framework to their current and future practice in both community pharmacy and other clinical settings. They did not perceive a need to demonstrate certain competences; those thought to be outside of the pharmacist’s role. Respondents also reported a need for additional training, review of facilities and a new service approach.

Conclusion
Community pharmacists are comfortable in offering the current range of non-invasive sexual health services.

A competence framework can be proposed to structure the development of learning and assessment for pharmacists offering sexual health services.
**Declaration**

No portion of the work referred to in this thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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Royal Pharmaceutical Society of Great Britain

National Pharmacy Association

Pharmaceutical Services Negotiating Committee

North West Harmonisation of Accreditation Group

World Health Organisation

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<td>British Association of Sexual Health and HIV</td>
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<td>CoDeG</td>
<td>Competency Development Group</td>
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<tr>
<td>CPPE</td>
<td>Centre for Pharmacy Postgraduate Education</td>
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<tr>
<td>DFFP</td>
<td>Diploma of the Faculty of Family Planning</td>
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<td>EHC</td>
<td>Emergency Hormonal Contraception</td>
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<td>GPhC</td>
<td>General Pharmaceutical Council</td>
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<td>GSL</td>
<td>General Sales List</td>
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<td>HAG</td>
<td>Harmonisation of Accreditation Group</td>
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<td>HR</td>
<td>Human Resources</td>
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<td>KSF</td>
<td>Knowledge and Skills Framework</td>
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<tr>
<td>LARC</td>
<td>Long acting reversible contraceptive</td>
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<td>NCSP</td>
<td>National Chlamydia Screening Programme</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>NPA</td>
<td>National Pharmacy Association</td>
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<td>OTC</td>
<td>Over The Counter</td>
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<td>P</td>
<td>Pharmacy medicine</td>
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<td>PGD</td>
<td>Patient Group Direction</td>
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<td>POM</td>
<td>Prescription Only Medicine</td>
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<td>PSNC</td>
<td>Pharmaceutical Services Negotiating Committee</td>
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<tr>
<td>RPS</td>
<td>Royal Pharmaceutical Society</td>
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<td>RPSGB</td>
<td>Royal Pharmaceutical Society of Great Britain</td>
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<td>STI</td>
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The Author

The author graduated from the University of Bradford in 1992 with a degree in pharmacy and registered as a pharmacist with the Royal Pharmaceutical Society of Great Britain. After working as a hospital pharmacist in King’s Lynn and Sunderland (setting up a pharmacist led rheumatology outpatient clinic at the latter) he made the move to become a pharmacist manager practising in community pharmacy in Chesterfield.

Whilst working in community pharmacy the author ran a successful Hba1c testing service from the pharmacy, engaging with both people living with diabetes and the local practice. He also became a local tutor for CPPE at this point, initially in Nottinghamshire and later in Derbyshire.

The author moved to the National Pharmacy Association in 1999, where he supported other community pharmacists in setting up services to meet patient need. Notable successes were in the management of a range of minor ailments, with successful services being set up in Sunderland and replicated across many parts of the North of England.

Recognising the challenges in identifying appropriate training support for pharmacists setting up new services, the author applied for a newly introduced role at CPPE as assistant director for NHS support. Initially developing national learning programmes to support the introduction of services such as NHS repeat dispensing and the national community pharmacy medicines management project, this role also offered the opportunity to develop bespoke learning programmes to support local service development initiatives.

The author is now deputy director at CPPE and has been responsible for the development of a portfolio of learning programmes for pharmacists and pharmacy technicians in the field of sexual health.
1 Introduction

1.1 Overview

This thesis investigates community pharmacists’ perceptions relating to their role in delivering sexual health services. It explores the relation between the services and the extent to which a competence framework is considered, by community pharmacists, to be an appropriate method to describe the knowledge and skills they need when supporting those who request sexual health services.

It will demonstrate that the field of sexual health encompasses many services and opportunities and that the role of the community pharmacist within it is continuing to develop. Gaining a greater understanding of what community pharmacists consider to be their current and future needs in this field, and the limits that they place on their role, will allow the development of a competence framework relevant to their role which embraces sexual health services.

The outcome of this investigation will prove helpful for those who seek to develop learning programmes to support pharmacists in meeting this skill set and in developing an assessment method to show that pharmacists are able to meet these competence standards.
1.2 The role of the community pharmacist

The community pharmacist offers services from a retail outlet. They are contracted to the NHS in the UK to supply drugs on prescriptions. Their retail role encompasses the sale of medicines and non-medical (but often health related) merchandise (1).

The Medicines Act 1968 (2) controls the sale and supply of all medicines. The legal status of medicinal products is part of the marketing authorisation. Products may be available either on a prescription (prescription only medicines (POMs)), available in a pharmacy without prescription under the supervision of a pharmacist (P), or on general sale (GSL).

Under the NHS, the traditional role of the community pharmacist was to dispense NHS prescriptions of POM, P or GSL medicines and to manage their retail environment. Over the last twenty five years the role of the community pharmacist in England has developed to allow them to make better use of their skills.

In 1986, the Nuffield Report (3) recommended that at least some of the funding for pharmacy should be linked to professional practices; the national contract for pharmacists was revised to offer a professional allowance for each pharmacy, in return for displaying a range of health education leaflets. This cemented the provision of health promotion within standard community pharmacy practice.

The National Pharmacy Association (NPA) launched its ‘Ask your pharmacist’ campaign in 1986 to encourage customers to recognise the skills of the pharmacist in managing minor ailments and to encourage pharmacists to use these skills.

It can be seen that these small steps were important milestones in moving the role of the community pharmacist from the reactive one of either dispensing what was prescribed, or supplying what was requested, to a more professional role in supporting the clinical decision of a prescriber, or helping a patient make the right choice in their self management (4).

Pharmacists are able to sell medicines which are classified as GSL or P medicines. Until the early 1990s, the range of P medicines was limited. It included analgesics, such as
paracetamol and aspirin, cough remedies and chemist nostrums. A shift in the stance of the government, coupled by European law requiring review of the legal status of medicines (5) resulted in a move towards more medicines being reclassified from a prescription only status to a pharmacy medicine status.

The pharmacist became responsible for ensuring that a medicine was appropriate for the patient and their condition; before a patient was able to obtain a pharmacy medicine, they had to satisfy the pharmacist that it was safe and appropriate for the supply to take place. Learning programmes were created both to ensure that pharmacists were aware of the criteria under which a supply could be made, and also to make sure that they, and their teams, could correctly identify whether patients met these criteria. For the pharmacy team this became known as the 2WHAM approach; for the pharmacist a range of materials on ‘Responding to symptoms’ were developed(6;7).

Within the NHS, in the late 1990s, prescriptions were primarily issued by doctors or dentists, although the legal framework also allowed midwives and other personnel to prescribe in limited circumstances. It became apparent that it was standard practice in care settings for a nurse to administer specified medicines for the management of specific conditions, without a personal prescription from the doctor. Administration of medicines in these situations was known collectively as supply under group protocol. There was no firm legal foundation for this activity.

In 1998 Dr June Crown undertook a wide ranging review of the administration, supply and prescribing of medicines (8) and a formal structure for supply of medicines for specified conditions where the patient was not known in advance was created. This authorisation in advance was termed the patient group direction (PGD). Certain groups of health professional, including pharmacists, were allowed to supply under a patient group direction. This provided an additional route through which pharmacists could supply medicines. Typically this route was funded by the NHS at a local level; the service being funded by the primary care trust. The supply of the medicine became part of a service package, rather than an intervention by itself. Thus the
pharmacist received funding for offering a service to a specific group of patients, with the supply of an appropriate medicine forming part of this service.

This added to the active engagement that pharmacists demonstrated with the professional supply of a P medicine, by engaging them more fully as members of the primary healthcare team, offering NHS services.

As health care practitioners based in the community setting, pharmacists are engaged with the public health agenda. Public health is described in the NHS as the science and art of communities and individuals preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organizations, public and private (9).

The introduction of a new NHS contract for community pharmacy in 2005 (10) allowed the developing role of the community pharmacy as a location for NHS services, together with the drive towards improving public health to be combined.

The 2005 NHS community pharmacy contract in England introduced three levels of services:

- Essential – nationally agreed to be provided by all pharmacy contractors
- Advanced – nationally specified, with accreditation required
- Enhanced – Specified, commissioned and funded by primary care trusts

The essential services included dispensing and repeat dispensing of NHS prescriptions, waste management, promotion of healthy lifestyles, directing people to resources for help, offering advice on self care and maintaining evidence of their risk management policies and procedures. Every NHS community pharmacist needed to be able to offer all of these services before they could offer the advanced or enhanced services.

The advanced services consisted of reviewing the way in which patients use their medicines. These could either be planned in advance for those who had used a pharmacy for more than three months (Medicines Use Reviews or MURs) or could be triggered at the point of dispensing (Prescription Intervention). Pharmacists offering advanced services needed to have an appropriate consultation area in which the service could be carried out and provided their feedback using a standardised form.
The pharmacist needed also to successfully pass an assessment which demonstrated that they had met nationally agreed criteria.

The introduction of the enhanced service level enabled primary care trusts to proactively plan for the development of services through pharmacies, based on a local pharmaceutical public health needs assessment. A range of national service specifications were drawn up for enhanced services (11), covering services such as:

- Minor ailments management
- Diabetes screening
- Substance misuse services
- Disease specific medicines management services
- Palliative care services
- Emergency Hormonal Contraception service
- Full Clinical medication review
- Care home services
- Head Lice management service
- Smoking cessation service
- Gluten Free food supply service
- Needle exchange scheme

Early research of the uptake of these enhanced services (12) found that the most rapidly expanding services were smoking cessation and drug misuse, reinforcing the important contribution that community pharmacy could make in improving public health. Indeed, public health activities were considered integral to all three levels of the community pharmacy contract. The community pharmacy was considered to be a key environment for the provision of public health activities (13;14). There were a number of reasons for this.
Accessibility – the number and location of community pharmacies made them the most accessible point of access for health services.

Availability – community pharmacy opening hours made them one of the longest available options, in some areas community pharmacy services were available 24 hours a day.

Expertise available – with each community pharmacy having a registered pharmacist on the premises, there was a high degree of quality assurance for the information and services provided.

The community pharmacist’s role has developed from one of responding to a prescriber’s requirements, to one of service delivery and personal responsibility for patient care. The inclusion of public health activities within their practice allowed the pharmacist to take a wider and more strategic view over the services that they offered and the health messages that they promoted. It can be seen that the role of the pharmacist had developed to encompass a wide range of services, which made use of their location, skills and availability. One area in which this development can be explored is that of sexual health.

1.3 The community pharmacist and sexual health

The range of sexual health services that are offered within the community pharmacy setting are now diverse, but have primarily developed over the last fifty years. The following time line, figure 1, illustrates the key milestones in the sexual health field relating to community pharmacy on the right, with those relating to the community pharmacy role on the left.
**Figure 1. Timeline of developments in sexual health and community pharmacy from 1957 to 2010.**

<table>
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<td>1959</td>
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<td>First oral contraceptive pill</td>
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<tr>
<td>Choosing health</td>
<td>2004</td>
</tr>
<tr>
<td>Chlamydia testing pilot starts</td>
<td>2005</td>
</tr>
<tr>
<td></td>
<td>2006</td>
</tr>
<tr>
<td></td>
<td>2007</td>
</tr>
<tr>
<td></td>
<td>2008</td>
</tr>
<tr>
<td>Chlamelle available as P medicine</td>
<td>2009</td>
</tr>
<tr>
<td>Sildenafil available through Boots</td>
<td></td>
</tr>
<tr>
<td>Pharmacy oral contraception pilots begin</td>
<td>2010</td>
</tr>
</tbody>
</table>

NB. This timeline is condensed, showing alternate years only from 1957 to 1990.
The lubricated latex condom was first launched by the London Rubber Company under the brand name Durex in 1957. At the time of launch, the latex condom was marketed through the key venue of the community pharmacy. Whilst the range of outlets which sell the condom has increased, the community pharmacy remains a key location for condom sales in the UK, recent figures suggest that around two thirds of condom sales take place through the community pharmacy setting (15).

In 1961 the first oral contraceptive pill was marketed by Searle (16). From the outset, the pill has been dispensed, with advice on its use, through community pharmacies. Both of these activities are now considered to be main-stream for the community pharmacy. However, the first attempt to link community pharmacy to the wider sexual health agenda, rather than simply the prevention of conception, appears to have come early in the 1980s. A project was run jointly by the Family Planning Association and the Pharmaceutical Society\(^1\) in 1981 and 1982, resulting in the distribution of free family planning information through 800 pharmacies in 1983 (17).

This was further developed with the Healthcare in the High Street scheme involving the first national distribution of health education leaflets through pharmacies, with contraception included as a key topic (18).

As described above, condoms have traditionally been available for purchase through pharmacies and the oral contraceptive pill has been dispensed there. The introduction of health promotion services allowed the pharmacist the opportunity to develop a role in promoting positive sexual health messages alongside this supply.

In 1992 this approach received a paradigm shift when the pharmacist became able to take full accountability and responsibility for the supply of a medicinal product without prior authorisation from a prescriber. This medicinal product was the clotrimazole 500mg pessary for the management of candidiasis (vaginal thrush). The Medicines Control Agency (MCA) reclassified Clotrimazole 500mg pessaries from a prescription only status to make them available as a pharmacy medicine. This was in recognition of two key factors.

\(^1\) The Pharmaceutical Society was not granted the right to use Royal in its title until 1988.
1. The condition of candidiasis was recurrent and, having had it diagnosed by their doctor once, women were able to recognise and self diagnose the condition, and

2. Clotrimazole had an excellent safety record.

After the introduction of the PGD regulations in 1998, services were set up for pharmacists to supply emergency hormonal contraception (EHC) under patient group directions (initially using Schering PC4™) (19), in order to improve the accessibility of the product. Unprotected sexual intercourse was considered to be a specific condition, where the patient would not be known in advance and so emergency hormonal contraception was considered appropriate for supply through this newly defined legal route of a patient group direction.

In 2001 levonorgestrel, a form of emergency hormonal contraception, was reclassified from POM to P; there was a pressing need to reduce the level of unplanned teenage pregnancies. At this time the teenage pregnancy rate in the UK was the highest in Western Europe (20). Levonorgestrel became available through many pharmacies either for purchase in terms with the P product licence, or under a PGD, for example for supply to females under the age of 16.

The engagement with the community pharmacy setting for the delivery of services for teenagers to reduce unintended pregnancies allowed commissioners to recognise and measure the value of this route of service provision.

It is recognised that sexual health services form part of the public health agenda, not only to reduce unintended pregnancy but also to reduce preventable sexually transmissible infections (STIs). The public health policy recognition of the potential role of the community pharmacy continued to drive forwards with DH publications such as Choosing Health (9) supporting increased access through the pharmacy setting to a range of services, for example provision of emergency hormonal contraception and Chlamydia screening and treatment. As the potential role of the pharmacist was realised, it resulted in pilots being developed to test for, and in some cases treat, Chlamydia infections through the community pharmacy – aimed at those aged between 16 and 25 (21-23).
Evaluation of the supply of Chlamydia testing through community pharmacy (24-26) found that users appreciated the accessibility and availability of the service as well as the anonymity of using a community pharmacy. However, it was found that additional training was needed to assist staff in overcoming embarrassment for their clients.

The Pharmaceutical Services Negotiating Committee maintained a database (27) of the funded services offered by community pharmacists in England. On 10th April 2011, this listed a total of 42 PCTs offering Chlamydia testing services through community pharmacies and 52 PCTs funding the provision of Emergency Hormonal Contraception under a PGD. This is from a total of 148 PCTs. As the data is volunteered by the PCT, the PSNC do not consider their database to be a comprehensive list of all services that are offered.

The NHS Information Centre does not record either of these locally commissioned services in its annual audit.

In 2009 the first antibiotic to be made available as a pharmacy medicine was launched in the UK. This was azithromycin, licensed for treatment of a confirmed infection of Chlamydia. The pharmacist sells a programme of care, which requires first that the customer provides a urine sample for Chlamydia testing. If the sample is positive, then the customer is able to gain a supply of azithromycin.

Personal communications with Beth Taylor OBE during 2009 over the development of screening and treatment services for Chlamydia infection highlighted that discussions have now commenced for the role of the pharmacist in screening for sexually transmitted infections to encompass other infections, such as gonorrhoea.

In the associated fields of sexual health, pharmacists have provided urine testing services for pregnancy. They also sold pregnancy testing kits and fertility kits for those wishing to plan a pregnancy. The pharmacy supplied folic acid to reduce the risk of neural tube defects developing in the foetus and supported their use through preconception and the early months of gestation.
A trial in Boots pharmacies in Manchester was considering the use of patient group directions to allow them to supply sildenafil for the management of erectile dysfunction (28).

It was proposed that pilots be set up to make the first supply of the oral contraceptive pill available through community pharmacies, again in response to the wider public health agenda (29). The first service was announced in January 2009 (30) with pharmacists offering the supply under a patient group direction.

It can be seen that services available through the community pharmacy have now extended considerably and during 2009 interest developed in the delivery of contraceptive services through the community pharmacy practice. At present it is not known to what extent these services will be offered and so it is appropriate to investigate what pharmacists themselves feel about this.

1.4 Pharmacy and the international sexual health agenda

There is a wide variation in access to sexual health services internationally. A review of the international literature using the SearchIt@JRUL tool, covering the databases Embase, EPIC and International Pharmaceutical Abstracts with the search terms ‘pharmacist’, ‘condom’, ‘contraceptive’ did not find any review of the role of the pharmacist in supply of condoms or the contraceptive pill on prescription. There was limited literature relating to the supply of emergency contraception without a prescribers prior authorisation (31;32). The key variation internationally appeared to be what overall need had been identified within the sexual health services: developed countries appeared to focus on reducing unintended pregnancy rates primarily, developing countries appeared to be focussing on reducing the spread of sexually transmitted infections – notably HIV (33-37).

A number of articles identified a developing role for the pharmacist in testing for HIV and hepatitis infection (38-42). However as these related to the diseases as transmitted through injectable drug usage, rather than as sexually transmitted diseases, they were not considered by the researcher to be relevant to this study.
Different models of practice for community pharmacy across the world mean that it is not possible to directly compare the role in the UK with other countries.

The researcher was unable to locate literature which clearly described the role of the pharmacist in the sale of condoms or other sexual health related products around the world.

1.5 Evaluation

A literature search did not find any review of the role of the pharmacy in providing condoms or of dispensing the oral contraceptive pill, nor of customer perception of these roles.

Previous research has shown that general practitioners (GPs) were content with the role of the pharmacist in making the supply of Clotrimazole 500mg pessaries (43). Additional studies considering the pharmacist perception of this supply found that the pharmacist considered it to be appropriate, but was concerned over their ability to take a full history and to minimise patient embarrassment (44).

Most of the volume of literature relating to the role of the pharmacist in sexual health related to the availability of emergency hormonal contraception from the pharmacy. The literature review found that women appreciated the more rapid access to EHC compared to clinical settings, but that for other aspects of provision and client satisfaction they favoured attendance at a clinical setting (45-55).

Where evidence is available, a recurring theme is that extending sexual health service provision to the community pharmacy results in improvements in accessibility and availability, but that pharmacists are not able to demonstrate that they have gained an equivalent level of expertise. However, there is no common agreement on what the appropriate level of expertise should be, nor how pharmacists could demonstrate that they had gained it.

1.5.1 Users’ views of the pharmacists’ role in sexual health

Despite the wide range and time period of involvement in the sexual health field, there is a limited evidence base with most of the research being undertaken into the increase in access to emergency hormonal contraception. This research into the wider
availability of emergency contraception consistently demonstrates that women appreciate being able to access this service from a community pharmacy. The reasons that they give relate to an increase in convenience – both as accessibility and availability (56;57)

The barriers which are raised to the accessibility of emergency contraception through pharmacies relate to a perceived lack of training of the pharmacist by the user.

1.5.2 Pharmacist views of their role in sexual health

The involvement of the pharmacist in screening for sexually transmitted infections and their management under a patient group direction, or through a pharmacy sale, is recent. There is a developing body of research into this role.(58-60)

It can be seen that the pace of change of the role of the pharmacist in sexual health has increased over the last ten years. The initial formal involvement in the sale of condoms was in 1957, the next change was four years later with the launch of the contraceptive pill. The last ten years have seen the availability of EHC on PGD, then as a P medicine; the introduction of Chlamydia screening, then treating on PGD, then management as a P medicine; the availability of sildenafil on PGD in a pilot scheme; the introduction of pilots for first supply of the oral contraceptive pill and most recently suggestions that pharmacists should be screening for a wider range of STIs or supplying injectable long acting reversible contraceptives.

Despite this pace of change, there is no evidence of an overall long term strategy for introducing these services, consideration of impact on other pharmacy services, time allowances for their implementation or recognition of the need for appropriate facilities to be available in the pharmacy itself. Each service is added to previous provision, without apparent planning for increasing manpower associated with the increasing workload.

There is an underlying driver in the NHS that healthcare professionals should maintain their knowledge and skills, with patients expecting that this is taking place. A review into the expectations of patients using the health service determined that “A patient is
entitled to be cared for and by healthcare professionals with relevant and up to date skills and expertise.” (61)

However, when services are newly introduced by a professional group, it can prove difficult to be assured that a suitable standard is being attained.

1.5.3 Identifying and meeting the training needs of pharmacists

Although all of the sexual health services offered as enhanced services appear to include a requirement for the pharmacist to undergo specified training – or a professional obligation to ensure competence within this area – there is no national clarity over what the level of training should be, nor which competences need to be demonstrated.

Where PCTs have commissioned sexual health services as enhanced services, their specifications are based on a national template, but this does not describe what training the pharmacists must undertake, or how they should be assessed. This is determined at a local level. In the national service specifications for Emergency contraception and Chlamydia testing (appendices A and B), the following statement is included:

“The pharmacy contractor must ensure that pharmacists and staff involved in the provision of the service have relevant knowledge and are appropriately trained in the operation of the service, including sensitive, client-centred communication skills. Pharmacists and staff providing this service should also be aware of local and national guidance on safeguarding vulnerable groups, as it is possible that people from vulnerable groups will request testing. Development of the knowledge base of staff may be facilitated by the provision of local training by the PCT.”

The service specifications list learning programmes which are available to support the service delivery, but does not require that these are undertaken. The suggested programmes are offered by the Centre for Pharmacy Postgraduate Education (CPPE). CPPE has also developed a range of learning programmes related to sexual health which PCTs may use to provide a national standard of learning with locally defined content to determine the nature of the paper work that must be completed to ensure
service quality and gain payment (62-66). The Centre has developed resources for commissioners to use at a local level to encourage a standard approach to learning provision, but there is no national requirement or expectation that this will be taken up or adopted.

Other learning programmes are available nationally for pharmacists and their staff to access. The National Pharmacy Association has produced a resource pack for pharmacists wishing to set up Chlamydia testing services (67). This may be used to support those PCTs who wish to commission services to a national standard.

1.5.4 Sexual health services from pharmacists

As has been described pharmacists are offering a range of services linked to the wide aspects of sexual health (68). It can be seen that despite pharmacists offering a wide range of sexual health services, many of which have been at the vanguard of new routes of supply and service delivery, there is a lack of specific research on many aspects of the role.

It is not clear what pharmacists think of offering these services, whether they bring workload challenges or if the services are considered to be appropriate for the community pharmacy setting. Services are set up at a local level, to the specification of the local commissioners.

Where services have been evaluated, for EHC and Chlamydia screening, the common message has been that the improvement in access and availability is welcomed, but more consideration needs to be given to training. There is however a lack of explanation of what the standard of training needs to be.

Despite an increase in the range of services and their introduction as nationally specified enhanced services, there is no coherent approach to what pharmacists need to know and to be able to do in order to offer the services. A single national provider of learning programmes, CPPE, dominates learning provision, but takes responsibility for determining the content of the programmes itself.

In order to map out an approach to training pharmacists that would support their current and potential future needs, it seems appropriate therefore to consider what a
pharmacist is expected to know and be able to do in order to offer these services, linked in to sexual health. What do they consider to be the extent of their role? What knowledge and skills do they recognise that they need to develop? These questions could potentially be addressed and assessed using a competence based approach.

1.6 Competence

Competence is generally described as the ability to carry out a job or task. A competency is a quality or characteristic needed of an individual, related to effective or superior performance (69). There is a conflict that appears between the different competency frameworks as to whether competence is the ability to undertake a particular role, or whether it is aspirational – a marker of quality and something to aim for. Some consider it to be both, with a statement describing the attribute (whether knowledge, skill or behaviour) and the individual determining the frequency with which they meet this attribute; the unstated aspiration being to meet each attribute all of the time.

As well as being used to describe a task or role, competence frameworks have also been developed to underpin the development of curricula for learning programmes.

The move towards a competence based curriculum in the UK seems to have started with the introduction of the national vocational qualification (NVQ) in 1986. This took a competence based approach to demonstrating that students who gained them were equipped to undertake particular roles. The NVQ is a work related qualification that reflects the knowledge and skills that are needed to undertake a job effectively. The purpose of the NVQ is to provide evidence that an individual is competent in the area of work to which the NVQ relates.

The NVQ was initially taken up to a high extent in engineering roles but gained a strong foothold in the field of human resources (HR), where it seemed to provide a good tool both to assess whether an individual was undertaking their role effectively, and also as a structure to identify the training and developmental needs of individuals. The approach was strengthened in HR with the production of the Competence

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2 The researcher has used these terms according to this definition throughout the document. However, these terms are used as quoted from other papers and sources. There may be some interchangeability in the usage by other authors, over which the researcher has no control.
handbook (70) and its general adoption by the Chartered Institute for Personnel Development.

As well as detailing approaches towards the development of competence frameworks, this handbook follows the progression of the application of competences from a tool to support recruitment and identify developmental needs, through to their current position in managing and developing people throughout their career.

There is a perception that a competent individual is one who will perform well. This is not necessarily the case. A competence describes the ability of an individual to undertake a specific task: it does not describe whether they undertake that task well in practice. Competence does not mean performance.

**Figure 2. An example of the difference between competence and performance**

Are you competent at counting? Can you count in a single integer progression from one? Starting with one, two, three, four: can you count?

Are there any limits to your competence in this area?

At this point, you will probably have assessed yourself and determined that you are competent at counting. You may have decided that your competence is a little limited when you reach higher numbers. For example, is a billion one thousand million or one million million? What comes after a billion?

Now test your performance. Count aloud to one thousand. Given that most people will count two integers a second, you will need to set aside just under ten minutes for this task.

When you’ve done it, rate your performance. Did your performance match your competence?

Competence is about can you, not do you.

**1.6.1 Competence and the pharmacist**

In common with other areas of professional practice, pharmacy has at times adopted a competence based approach for determining what skills, knowledge and behaviours
are required to undertake the role. However, there is no single competence framework.

The RPSGB introduced a series of behavioural competences for preregistration pharmacists in 1992, but the move towards a competence based development programme for pharmacists appears to have started in earnest with work undertaken by McRobbie et al (71). This research sought to provide a structure for the induction and development of basic grade pharmacists in secondary care. This resulted in the formation of a Competence Development and Evaluation Group (CoDeG), a collaborative network of specialist and academic pharmacists, developers, researchers and practitioners.

Their two key outputs to date are the General level framework (GLF) (69) and the advanced and consultant level framework (ACLF) (72) – both aimed at developing and supporting pharmacists and demonstrating their fitness to practice. The ACLF has in turn been used as the framework for the development of a number of specialist competence frameworks. These are listed in table 1 on page 34.

In pharmacy, the general level framework, originally developed to assure that basic grade pharmacists in hospital practice were performing to a consistent level across different trusts, was used as the basis for the development of a standard diploma in clinical pharmacy in London and the South East of England. Undertaking the diploma enables the pharmacist to gain the knowledge and skills needed to meet each competence.

The Royal Pharmaceutical Society of Great Britain (RPSGB) developed a series of competencies for the future pharmacy workforce (73) which it published in 2003. These built upon and extended the competencies for pre registration pharmacists which it introduced in 1992.

To bring the approach for all prescribing professionals together within a single coherent structure, the National Prescribing Centre developed competence frameworks for all healthcare professionals offering specific prescribing services (74-78). These demonstrated that it was possible to develop a single competence framework to describe the role of different health care professionals undertaking the same task.
None of these competence frameworks consider the role of the pharmacist in the specific area of sexual health.

1.7 Literature review

A search carried out using the databases EmBase, Medline and International Pharmaceutical Abstracts using the search terms “pharmacy AND competence AND learning” from 1990 to 4th May 2009 found only four articles with these words in the title, and 87 with these words as key words. Of these 87 only one article was of direct relevance describing the development of public health competences for pharmacists through a consensus method (79).

Further searches using the terms pharmacy or pharmacist and competence, competency, competencies identified a number of frameworks currently in use.

The two frameworks which are in greatest use for pharmacy are the Knowledge and Skills Framework from the Department of Health (80) and the General level framework.

The Department of Health introduced the Knowledge and Skills Framework in 2003. Although much effort has been taken to map roles and job descriptions against the KSF, within pharmacy departments this appears to have been done as a matter of necessity to ensure payment and grading rather than to standardise roles. The general level framework, although used to support those undertaking clinical diplomas across the South East of England, does not appear to have become standard practice for planning development or mapping abilities. The Centre for Pharmacy Postgraduate Education makes reference to both of these frameworks in its learning programmes, but has no evidence to show that these are used widely.

The general level framework (GLF) was based upon the work of McRobbie et al and extended following testing and review. It was developed by a team of pharmacist academics and hospital pharmacy managers to provide uniformity in the requirements of a basic grade position in hospital pharmacy and to support the development of these pharmacists in their first years in post.
The GLF was agreed by consensus method. The published research does not state what level of consensus had to be reached for a competency to be agreed.

The GLF was further tested against the working environment of the community pharmacist and was suggested to be an appropriate framework to support the development of this group of practitioners as well (81). This work resulted in the development of a revised version of the GLF, based on feedback from the users.

The team who developed the GLF have furthered their work in building the advanced and consultant level frameworks. These are designed to support the development of senior pharmacists as they work within more specialised areas, either as advanced or consultant level practitioners.

The Royal Pharmaceutical Society of Great Britain (RPSGB) has also developed a series of competences for pharmacists to use when they are recording their continuing professional development (CPD) (82). These are now being reworked to map against the GLF and the KSF. The process of the development of the CPD competences is not available from the RPSGB website and personal communication with Dr Peter Wilson during March 2009 on this stated that the process has been “lost in the mists of time”.

More recently the RPSGB consulted on plans to revise pharmacy undergraduate degree programmes, with the intention being that the degree course should focus more on developing the competences that will be required of pharmacists when they graduate. It did not however see the curriculum moving to a competence base.

Mills and Farmer (81) argued that there was a need for all health professionals to develop a strategy that would develop practitioners that are fit for practice. This came two years after the RPSGB had developed what they considered to be such a framework, and two years after the DH had released their national framework aimed at assuring this.
Table 1. A summary of the UK competence frameworks for pharmacy services as at 11th April 2011.

<table>
<thead>
<tr>
<th>Framework</th>
<th>Method used for framework development</th>
<th>How framework was tested</th>
<th>Subsequent refinement</th>
<th>Year published</th>
<th>Who developed it</th>
</tr>
</thead>
<tbody>
<tr>
<td>General level</td>
<td>Literature review and consensus</td>
<td>Research methodology</td>
<td>2007</td>
<td>2003</td>
<td>CoDeG&lt;sup&gt;iii&lt;/sup&gt;</td>
</tr>
<tr>
<td>Advanced and consultant level</td>
<td>Literature review and consensus</td>
<td>Research methodology</td>
<td>Not applicable</td>
<td>2005</td>
<td>CoDeG</td>
</tr>
<tr>
<td>Knowledge and skills</td>
<td>No information available</td>
<td>No information available</td>
<td>Not applicable</td>
<td>2004</td>
<td>Not stated</td>
</tr>
<tr>
<td>Medicines information</td>
<td>Role analysis</td>
<td>Expert validation</td>
<td>Not applicable</td>
<td>2001</td>
<td>Cathy Picton and UKMI&lt;sup&gt;iv&lt;/sup&gt;</td>
</tr>
<tr>
<td>Oncology pharmacist</td>
<td>No information available</td>
<td>No information available</td>
<td>Not applicable</td>
<td>2004</td>
<td>BOPA&lt;sup&gt;v&lt;/sup&gt;</td>
</tr>
<tr>
<td>Renal pharmacist</td>
<td>No information available</td>
<td>No information available</td>
<td>Not applicable</td>
<td>2009</td>
<td>RPG&lt;sup&gt;vi&lt;/sup&gt;</td>
</tr>
<tr>
<td>Community health pharmacy services</td>
<td>Role analysis</td>
<td>Expert validation</td>
<td>Not applicable</td>
<td>2003</td>
<td>Not stated</td>
</tr>
<tr>
<td>Future pharmacy workforce</td>
<td>Reference group</td>
<td>Reference group</td>
<td>Not applicable</td>
<td>2003</td>
<td>Not stated</td>
</tr>
</tbody>
</table>

<sup>iii</sup> Competency Development Group  
<sup>iv</sup> United Kingdom Medicines Information group  
<sup>v</sup> British Oncology Pharmacists Association  
<sup>vi</sup> Renal Pharmacists Group
<table>
<thead>
<tr>
<th>Pharmacists with a special interest</th>
<th>Adapted from ACLF</th>
<th>Expert review group</th>
<th>Not applicable</th>
<th>2006</th>
<th>Not stated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribing</td>
<td>Role analysis</td>
<td>Expert review group</td>
<td>Not applicable</td>
<td>2003</td>
<td>Cathy Picton and NPC</td>
</tr>
<tr>
<td>Shared decision making with patients</td>
<td>Focus group</td>
<td>Focus group review and user validation</td>
<td>Not applicable</td>
<td>2007</td>
<td>Cathy Picton and Medicines Partnership</td>
</tr>
<tr>
<td>Plan&amp;record</td>
<td>No information available</td>
<td>No information available</td>
<td>Not applicable</td>
<td>2001</td>
<td>Not stated</td>
</tr>
<tr>
<td>Mental health pharmacists</td>
<td>No information available</td>
<td>No information available</td>
<td>Not applicable</td>
<td>2001</td>
<td>Not stated</td>
</tr>
<tr>
<td>Pharmacists working in primary care</td>
<td>Role analysis</td>
<td>Focus group review and user validation</td>
<td>Not applicable</td>
<td>2000</td>
<td>Cathy Picton and NPC</td>
</tr>
<tr>
<td>Management of controlled drugs</td>
<td>Focus group</td>
<td>Focus group review and user validation</td>
<td>Not applicable</td>
<td>2005</td>
<td>Cathy Picton and NPC</td>
</tr>
<tr>
<td>Faculty of neonatal and paediatric pharmacists</td>
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<td>No information available</td>
<td>Not applicable</td>
<td>2002</td>
<td>Not stated</td>
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<tr>
<td>Pre registration standards</td>
<td>No information available</td>
<td>No information available</td>
<td>No information</td>
<td>1992</td>
<td>Not stated</td>
</tr>
<tr>
<td>North West HAG frameworks</td>
<td>Developed by commissioners</td>
<td>Reviewed by experts</td>
<td>Updated every two years</td>
<td>Range</td>
<td>HAG group</td>
</tr>
</tbody>
</table>
Mills and Farmer provided the following checklist of elements that a good competency framework should offer:

- Involve the people who will be affected by the framework
- Be clear and easy to understand
- Be relevant to all staff who will be affected by the framework
- Take account of expected changes, eg, in the organisation’s environment, new technology, future work practices
- Have discrete elements, ie, behavioural statements do not overlap
- Be fair to all affected by its use

This table summarises the available evidence from the competence frameworks themselves on whether they meet these requirements. Since many of these elements are subjective – for example who determines whether a framework is clear and easy to understand – the personal opinion of the researcher is indicated where there is a lack of objective evidence.

**Key**

- **E** Evidence available to support this statement
- **O** Personal opinion that this is met
- **?** Arguable as to whether this is met
- **X** Not met
Table 2: An assessment of current pharmacy competence frameworks against set criteria

<table>
<thead>
<tr>
<th>Criterion</th>
<th>General level</th>
<th>Advanced and consultant level</th>
<th>Knowledge and skills</th>
<th>Medicines information</th>
<th>Oncology pharmacist</th>
<th>Renal pharmacist</th>
<th>Community health pharmacy services</th>
<th>Future pharmacy workforce</th>
<th>Pharmacists with a special interest</th>
<th>Prescribing</th>
<th>Shared decision making with patients</th>
<th>plan&amp;record</th>
<th>Mental health pharmacists</th>
<th>Pharmacists working in primary care</th>
<th>Management of controlled drugs</th>
<th>Faculty of neonatal and paediatric care</th>
<th>Pre registration standards</th>
<th>North West HAG frameworks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involve the people who will be affected by the framework</td>
<td>E</td>
<td>E</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Be clear and easy to understand</td>
<td>?</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
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<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Be relevant to all staff who will be affected by it</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
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<td>E</td>
</tr>
<tr>
<td>Take account of expected changes</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
<td>X</td>
<td>O</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
<td>X</td>
</tr>
<tr>
<td>Have discrete elements</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
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<td>E</td>
<td>E</td>
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<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
</tr>
<tr>
<td>Be fair to all affected by its use</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
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</tbody>
</table>

37
In 2005, McRobbie et al (83) stated that there was a need for competence frameworks to be structured appropriately, expressing concern “that there is now a plethora of “competencies” being produced with no objective data to support them. There is a risk that competencies developed without a rigorous approach will not meet their aims.”

From this it appears that ONE stage that limits the development of many of these competence frameworks is the involvement of the people who will be affected by it.

In his consensus model Pfleger (84) again notes this omission. His decision to use the Delphi approach means that the competencies which are agreed are determined by experts, not by practitioners. He proposes further work to refine the framework taking the views of practitioners into account.

Competence frameworks are also being introduced internationally for pharmacy. In 1979 the American pharmacy association developed a series of competences for pharmacists to cover all the 52 states (85). These formed the structure of the North American Pharmacist Licensure Examination (NAPLEX). This is now accepted by all US pharmacy boards, together with law assessment, as evidence for suitability for licensing at state level. The assessment is administered, assessed and scored by the National Association of Pharmacy Boards (NAPB) rather than by individual states. Although the states then require their pharmacists to undertake either CE or CPD, none of them currently list additional competence frameworks on their websites.

Canada introduced its pharmacy framework (model standards of practice for Canadian pharmacists) in 1998 and revised it in 2003 (86;87). New Zealand introduced a general competence framework for pharmacists in 1994 and revised it in 2001 (88).

In Australia, the pharmaceutical society of Australia introduced competency standards for pharmacists in 2003 (89). The state of Queensland, Australia, has agreed to adapt and use the UK general level framework, mapped against the Australian Pharmaceutical Advisory Council Continuum of Care guidelines.

Since the ratification of EU directive 2005/36 (90), those qualified as pharmacists in member EU states are able to practice in any of the member EU states, providing their qualification demonstrates that they meet key competence criteria common to all
states. These are described in Annex v 5.6.1 of the directive. The International Pharmaceutical Federation (FIP) has started work on developing generic competences for its pharmacist members, headed up by Professor Ian Bates (School of Pharmacy, University of London) – one of the authors of the UK general level and advanced level frameworks. At the time of writing there was no published outcome of this work available from the FIP.

Many of these competence frameworks look at setting the baseline competencies that a pharmacist must be able to demonstrate to register and practice as a pharmacist. They are not aspirational and they do not seek to support the ongoing development of the pharmacist. Their purpose is solely to describe the minimum standards that a pharmacist must be able to demonstrate.

When considering the range of national competence frameworks which have been developed for pharmacists, there is no evidence of a framework which looks specifically at the role of the community pharmacist in offering sexual health services. Indeed, the competence frameworks in use do not address many of the aspects of practice in community pharmacy. Only the general level framework has been adapted and tested with this group of the profession.

1.7.1 The development of local competence frameworks

The introduction of services commissioned at a PCT level, rather than at a national level, resulted in differing standards for the same service; the standards being agreed by the commissioners within each PCT. These standards addressed all levels of the service from training provision, evidence of ability, paperwork to recording required.

In the North West NHS region of England, a decision was made to introduce a minimum standard for services to improve both the standard of services offered and the ability of a pharmacist to offer these for different PCTs. The group which was created to manage this standard setting was called the harmonisation of accreditation group (HAG). This group agreed a set of core standards with an accompanying accreditation and assessment framework for a range of services, including those that
fall under the sexual health banner – EHC and Chlamydia screening and treatment services. A copy of these frameworks is included as Appendices C and D.

These frameworks have been developed by the Harmonisation of Accreditation Group members and sent for comment to individuals with specialised knowledge in the relevant field. They are then refined and reviewed (the NW HAG guidelines do not explain how this review is carried out, nor by whom).

The HAG competence frameworks are linked only to the RPSGB competences for general pharmacists and community pharmacists. They are constructed as toolkits for service provision, addressing both appropriate training programmes, additional service level information needed and the approaches to assessment.

The use of the RPSGB general competences as the basis for the framework limits the construction of the framework to a general rather than a specific level.

1.7.2 Specialist sexual health competence frameworks

For other health care professionals practising as specialists in the field of sexual health, a single competence framework has been developed on behalf of the department of health: “Competencies for providing more specialised sexually transmitted infection services within primary care” (91). Whilst the remit of this framework includes screening for infections such as Chlamydia and testing for pregnancy, it does not address contraception or emergency contraception advice and provision which are key components of the practice of community pharmacists.

Certain of the competency clusters include a requirement for the individual to demonstrate ability to undertake an intimate clinical examination. It is possible that this element would be considered inappropriate for carrying out in a community pharmacy by practising community pharmacists.
1.7.3 Diploma of faculty of family planning competence framework

The Faculty of Family Planning has developed a competence framework (92) for those wishing to undertake their diploma and gain membership of the faculty. Although a general practitioner is not required to undertake this to be able to prescribe oral contraception, they are encouraged to undertake this diploma as part of their personal development.

1.7.4 Competence frameworks for nurses

Nurses working in primary care are encouraged to undertake Contraception, Reproduction and Sexual health programmes in order to offer sexual health services as a nurse practitioner. These courses provide credits towards certificates of professional development. However, they are not a requirement for nurses wishing to prescribe contraceptives in practice.

1.7.5 International sexual health service framework

In December 2009, the World Health Organisation (WHO) disseminated a draft copy of a single set of competencies for primary care sexual health services (93). This framework includes those areas addressed within the DFFP competence framework and adds in areas relating to appropriate completion of paperwork, audits and research. It does not consider the management of erectile dysfunction. The framework is a collation of those available to the WHO within the international community. It does not delineate the competencies according to the role of the individual undertaking them but considers what is needed for service provision in its entirety to be appropriate for patient need.

One of the challenges with the knowledge and skills framework was developing a single competence framework which could be mapped against the roles and responsibilities of staff from a range of educational backgrounds and undertaking different tasks.
This challenge is evidenced with the competence framework for sexual health services as well. As McRobbie (83) comments, “a competence framework needs to be robust and evidence based if it is to be effective in supporting and improving practice.”

1.8 What is consensus?

Many of the competence frameworks which were identified for the roles of pharmacists have been developed through a consensus approach. Consensus describes the iterative process of development as well as the way in which final decisions are made. The approach taken for making a decision within consensus methodology is known as decision rule. However, none of the frameworks stated the decision rule for consensus that was required for a statement to be included.

The decision rule for consensus development may be fixed at any of the following levels:

- Unanimous agreement
- Super majority threshold (90%, 80%, 75%, two thirds, 60%)
- Simple majority (50% plus one person)
- Executive committee decision
- Person in charge decision

As consensus describes the process, a decision made by any of these approaches would be defined as a consensus.

Pfleger (94) described a Delphi approach to determining competences in his work.

For the purposes of this first stage review of the views of pharmacists on appropriate competences, it is considered appropriate to maintain a broad inclusion of competences for future consideration. Therefore consensus for this study will be set at the 75 percent agreement super majority threshold. This will ensure that the majority of pharmacists will have found a competence was appropriate.
1.9 The current pharmacy situation

What has been found in the review of literature was that there was a need for community pharmacists to deliver an expanding range of sexual health services to meet national and local aspirations. However there was no apparent overall strategy in place. Nor did there appear to be a consideration of what the sensible boundaries of this service provision should be.

Services were being commissioned and determined at a local level and, in contrast to other health care professionals; there was no single agreed standard to which pharmacists could work in order to gain personal reassurance of their ability or to demonstrate that they were fit to practise.

Pharmacists and users have been shown to believe that sexual health services required particular skills that differed from those required for other services. In particular pharmacists retained the ability to opt out of offering sexual health services on moral or religious grounds.

The perception was that sexual health services are somehow different to other health services.

1.10 Relevant competence frameworks

In the UK the key competence framework which was recognised appears to be that of the Faculty of Family Planning. This was available for all general practitioners and nurses who wished to demonstrate a specialism in the field of sexual health. It mapped closely to the international framework being developed by the WHO and was offered by many universities across the UK. It had formed the basis for the DH competence framework for providing more specialised sexual health services.

However, some areas within this framework did not appear to relate to the role of the community pharmacist. The framework made reference to intimate and invasive examinations and the delivery of cervical smear testing. These areas appeared to be outside of the current remit of the community pharmacist. The role of the pharmacist had developed considerably within this field. Did pharmacists see their role potentially including these aspects of sexual health provision?
As has been shown, community pharmacists were engaged in offering a range of services, of which sexual health services were just one component. However, sexual health services were different in nature to many other services, requiring both particular skills in the consultation and being difficult to consider in isolation.

A contrast may be seen with the provision of stop smoking services. Although smoking increases the risk of lung cancer, heart disease and early death, pharmacists could offer smoking cessation services and products effectively without needing to undertake additional training in the areas of co-morbidity.

The supply of EHC over the counter required the pharmacist to engage in discussions relating to safer sex to reduce the chances of the customer needing EHC in the future. They also needed to signpost the customer towards other agencies to discuss their ongoing contraception needs. The lifestyle of the customer may also indicate that they were at a higher risk of Chlamydia and other STIs, again requiring intervention. Careful history taking and appropriate provision of advice and counselling was needed to get it right. With the different elements of sexual health all linking closely together in this way, it did not seem appropriate to train pharmacists solely in the provision of EHC.

This study will therefore investigate the extent to which community pharmacists consider the competences of the Diploma of the Faculty of Family Planning sexual health framework can be applied to their practice and what the limitations of this may be.

This will allow the development of a community pharmacy specific framework for sexual health services which has been designed by those who will be offering the service.
2 Aim and Objectives

2.1 Aim of the study

The aim of this study is to examine the opinions and attitudes of community pharmacists in England on their perceived scope of the role of the community pharmacist in offering sexual health services and the competencies that are required of a pharmacist in offering such services.

2.2 Objectives

Develop a survey tool to explore the opinions and attitudes of community pharmacists on the range of sexual health services

Identify a baseline set of services that community pharmacists think it is appropriate for them to offer.

Propose a competence framework for community pharmacists wishing to offer sexual health services.
3. Methods

3.1 Plan

The study consisted of two main components:

Design of a questionnaire relating to sexual health services and the role of the community pharmacist

Analysis of results to generate a list of services considered appropriate by community pharmacists and proposal of a competence framework for pharmacists offering sexual health services

3.2 Design and test of a sexual health services questionnaire

As opinions were required from a large number of pharmacists across the whole of England, it was decided to develop a paper questionnaire. This would allow dissemination across the large geography, permit tracking of responses to enable follow up and is an approach that has been used before. Internal work at CPPE during 2009 and 2010 had found that lower response rates were found when an electronic survey was used. A questionnaire (Appendix E) was developed by the researcher to serve two key purposes:

- Firstly to determine a baseline of the perceptions of practising community pharmacists on the range of services relating to sexual health that could be offered through a community pharmacy setting and whether they considered these to be appropriate; and

- Secondly to ascertain the feelings of practising community pharmacists on whether competence statements relating to sexual health service delivery were relevant to the role of the pharmacist either in the pharmacy setting, when practising as a pharmacist but outside of the pharmacy setting, in both situations, or whether they were not relevant to the role of the pharmacist at all.

3.2.1 Baseline perceptions of sexual health services

The researcher developed a list of sexual health services which were offered through community pharmacy services at the time of this research. This list was based on the
personal experience of the researcher through community pharmacy practice together with reference to the literature identified and national services listed on the PSNC database. Additional services were added to the list to address a wider delivery of sexual health services. For example, at the time of the research, pharmacists were testing for Chlamydia infection. Additional services were added describing testing methods for all sexually transmitted infections which were common in the UK.

Discussions with the supervising team, and colleagues within the Centre for Pharmacy Workforce Studies refined this list and enabled the development of a questionnaire (Appendix E) which sought to determine the views of community pharmacists on a wide range of sexual health services.

As the survey topic was of a potentially sensitive area, the initial sections were of areas more likely to be familiar to the pharmacist in order to promote completion. The questions which related to the delivery of sexual health services were used as the initial questions within the questionnaire and were designed to gain an understanding of the perceptions of pharmacists on the range of services that were being or could be offered through community pharmacies. This would enable the researcher to construct a baseline of the thoughts and concepts of the selected cohort with regards to the services that may be offered through a community pharmacy.

Each question item asked the pharmacist to indicate on a five point scale the extent to which they agreed, or disagreed, with a statement. These were consistently numbered from Strongly disagree as number one on the left, through to Strongly agree as number five on the right.

### 3.2.2 Consideration of competences

An outline competence framework was developed, based on the competences required for the Diploma of the Faculty of Family Planning as described in the introduction.

For the purposes of the questionnaire, the outline competence framework was presented as a table, with each discrete statement on its own line. The competence framework was reviewed by the researcher and his supervisors. Amendments were made to ensure that the behavioural statements were discrete and did not overlap.
Revisions were made to the wording to make sure that the proposed competence framework was clear, easy to understand and that statements were not ambiguous.

The competence framework was also reviewed by a nurse practitioner who led a sexual health clinic. Additional comments were received from a range of experts and sexual health practitioners, and the questionnaire was refined to include their remarks. These individuals are listed in the acknowledgements section and include representation from national pharmacy organisations, the British Association for Sexual Health and HIV, pharmacists overseeing the introduction of sexual health services and researchers within the field.

3.2.3  Ensuring relevance to the profession

A section recording the demographics of those responding to the questionnaire was included. This allowed the researcher to determine whether the responses that were received were from a group that reflected the cohort who were invited to respond, and thus the extent to which the responses reflected the pharmacy profession as a whole.

If sufficient responses were received, additional analysis could identify differences amongst groups within the cohort.

3.2.4  Feedback and additional information

A final section within the questionnaire allowed the inclusion of free text comments from the participants. It asked them to consider if there were additional competences that were required that were not covered in the framework, or to add in any comments or thoughts of their own that they considered relevant and appropriate.

3.2.5  Testing the questionnaire

After the questionnaire had been constructed, it was tested by a team of six pharmacists within CPPE who had a range of backgrounds and experience to assess appropriateness of language and ease of completion. The pharmacists who undertook this test included practising community pharmacists, educationalists and medical writers.
Feedback and comments from this review resulted in amendments to

- provide explicit instructions within questions, for example “for females aged over 16” was added to “It is appropriate to supply emergency contraception over the counter”

- split discrete elements in competence statements, for example separating “Is able to take cervical smears, explain results and take appropriate action” to give “Is able to take cervical smears” and “Is able to explain cervical smear results and take appropriate action,” and

- improve the guidance notes explaining how to complete the questionnaire, for example adding in examples of how to complete Section G.

3.2.6 Gaining ethical approval

A covering letter providing an overview of the research and explaining the intended group of participants was developed (Appendix F). A participant information sheet was designed offering additional information about the research study. This addressed the purpose of the study, how participants had been chosen and what action was requested (Appendix G).

The questionnaire was submitted to the Ethical committee of the University of Manchester for approval, together with the covering letter and an information pack.

The ethical committee asked that a section was included in the information pack informing participants of the complaint process and that it was made explicit in the supporting materials that not all of the listed services were currently available through community pharmacy and that there were no known plans for them to be so.

Following these revisions Ethical approval was granted (Appendix H).

3.2.7 Undertaking pilots of the questionnaire

The questionnaire was sent, to test for its appropriateness and usability, to a group of ten pharmacists who had recently accessed learning programmes relating to sexual health from CPPE. They were asked to review the questionnaire and to provide feedback on it. This pilot group consisted of practising pharmacists. Few responses
were received. When these pharmacists were followed up, reasons for not responding were that the pharmacists had not had sufficient time to complete the questionnaire and make comments. Two of the ten pharmacists completed the questionnaire and stated it was appropriate. A practising pharmacist who was known to the researcher was also asked to complete and comment on the questionnaire as a pilot.

These users stated that the questionnaire was appropriate, easy to understand and relevant to the role of the community pharmacist.

The revised questionnaire was tested for ease of analysis by a second group of pharmacists working within the research team at the University of Manchester. They were asked to review the form and provide feedback on whether amendments needed to be made so that analysis could be undertaken.

This group suggested amendments to ensure usability of the results of the questionnaire. For example, shading was applied to response lines so that it could be assured that people had answered the correct question (see sections B, C, D, E and F of the questionnaire, Appendix E).

**3.2.8 Construction of the final questionnaire**

The final questionnaire consisted of the following main sections:

- Baseline attitude with respect to offering sexual health services
- Provision of contraceptive services
- Support for reproductive health
- Screening for genital sexually transmitted infections
- Treatment of genital sexually transmitted infections
- Feelings and drivers for sexual health services
- Competences for sexual health services
- Demographic factors
- Additional Comments
This order was chosen as it allowed the pharmacist completing the questionnaire to start with the areas of traditional practice, where they were more likely to be comfortable responding.

3.3 Sampling community pharmacists

A sample size of 2000 practising community pharmacists was selected. There are approximately 24 000 community pharmacists practising in England. Using an online sample size calculator (95) it was found that a sample size of 2000 would allow a 95 percent confidence interval with a 2.1 percent margin of error for a response rate of 40 percent.7

A random sample of 2000 practising pharmacists, who had stated on their retention forms that they were in community pharmacy practice, was obtained from the Royal Pharmaceutical Society of Great Britain register. The sample requested was representative of the profession as a whole, taking into account gender, age and ethnicity.

3.3.1 Inclusion criteria

To be included in the cohort, participants had to be registered as pharmacists in England and on the practising register of the RPSGB. They had stated on their retention forms that they were practising as community pharmacists.

Pharmacists who indicated on their responses to the questionnaire that they did not fall into this category were not included in the results.

3.3.2 Dissemination of the questionnaire

Each pharmacist was allocated a four digit study ID number from 0001 to 2000. A copy of the questionnaire, together with the covering letter and information pack, was sent by post to each pharmacist within the cohort.

If no reply was received three weeks after first being sent the questionnaire, a follow up questionnaire was sent. A third and final request to complete the questionnaire was

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7 This means that if 40 percent of the sample responded, then their response offered a 95 percent chance of representing all the cohort, within a 2.1 percent margin of error. The margin of error indicates that if 60 percent of the sample agreed, then this would be true for a range of 57.9 to 62.1 percent of the cohort.
sent after a further three weeks with no response. At this final stage, participants were asked to complete a short statement indicating why they had decided not to return the questionnaire.

3.4 Data entry

When responses were received, the data from closed questions within the questionnaire was entered onto SPSS version 16 by the researcher.

Free text information, supplied as general comments or suggestions for additional competences, was typed in to a word processor for thematic analysis.

3.5 Data Analysis

3.5.1 Analysis of quantitative data

Responses were found to form a Poisson distribution. This precluded the use of the statistical tests which are used to analyse a normal distribution. The data was collated into relevant sections. Descriptive statistics were calculated using SPSS v16 and these statistics are presented in the results section.

Aggregate models were developed for groupings of services and individual demographic groups of gender, ethnicity, practice location and role were tested against these to see if these highlighted differences in response.

Tornado plots were used to highlight graphically the differences in responses.

Where it was not clear whether the group was in overall agreement that a service was appropriate or inappropriate, net agreements were calculated. These were calculated by summing up the positive (agree) responses and the negative (disagree) responses. The difference between the two was taken as the net agreement. A positive value indicated that more of the sample agreed. Conversely a negative value indicated that more of the sample disagreed. This allowed the researcher to see whether the majority considered each item to be appropriate.

Responses to the competence elements were grouped into subsets and summarised as descriptive statistics. The data was presented to demonstrate whether respondents felt that the competence described was only relevant if the pharmacist was practising
in a community pharmacy setting, only relevant if the pharmacist was practising in a
different setting, relevant in either of these settings, or whether the competence was
not applicable to the role of the pharmacist.

A priori, it was decided that there was a lack of consensus when more than 25 percent
of respondents did not agree that the competence was applicable to the role of the
pharmacist.

3.5.2 Analysis of qualitative data

Free text comments which had been added by respondents were typed into a word
processing package. It was seen that although the questionnaire asked for additional
competences and general comments to be separated, respondents had made general
comments in both sections. All free text comments were combined and analysed and
themed for common factors.

The qualitative data was analysed using a grounded theory approach, resulting in an
inductive theme set development.

Four key themes were identified and are explored using comments which the
researcher considered to be typical of the theme. These key themes are those for
which the highest level of comment was made by participants in the study.

The researcher has identified the ethnicity, gender, role and practice location of the
individual making the comment, but this should not be taken to mean that the
comment is indicative of that demographic subset.
4 Results

4.1 Response rate

Responses of a completed questionnaire were received from 789 practising community pharmacists. A further 67 pharmacists replied to indicate that they were not willing to complete the questionnaire. Of these 47 provided additional information to indicate their reasons for not completing the questionnaire. This can be seen in table three. This gives a response rate of 789 out of a sample of 1933, which is 40.8%. By entering these figures into the sample size calculator (96), it was found that a confidence interval of 2.1 percent and a confidence level of 95 percent had been attained.

Table 3. Reasons provided for not completing the questionnaire

<table>
<thead>
<tr>
<th>Reason</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of time</td>
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<td>40.4</td>
</tr>
<tr>
<td>No payment offered</td>
<td>5</td>
<td>10.6</td>
</tr>
<tr>
<td>Don't agree with sexual health services</td>
<td>4</td>
<td>8.5</td>
</tr>
<tr>
<td>Don't like questionnaires</td>
<td>3</td>
<td>6.4</td>
</tr>
<tr>
<td>Non-practising</td>
<td>1</td>
<td>2.1</td>
</tr>
<tr>
<td>Not in community pharmacy</td>
<td>13</td>
<td>27.7</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>4.2</td>
</tr>
<tr>
<td>Total</td>
<td>47</td>
<td>100.0</td>
</tr>
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</table>
4.1.1 Description of the overall cohort

Table 4 provides a summary of the cohort which responded to the questionnaire.

Table 4

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Number</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
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<td></td>
</tr>
<tr>
<td>Male</td>
<td>323</td>
<td>40.9</td>
</tr>
<tr>
<td>Female</td>
<td>466</td>
<td>59.1</td>
</tr>
<tr>
<td><strong>Age</strong></td>
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<td></td>
</tr>
<tr>
<td>21 to 25</td>
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<td></td>
</tr>
<tr>
<td>26 to 30</td>
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<td>31 to 40</td>
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<td>51 to 60</td>
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<td>60 to 65</td>
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<td>Over 65</td>
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<td></td>
</tr>
<tr>
<td>No answer</td>
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</tr>
<tr>
<td><strong>How long have you worked in community pharmacy?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 to 5</td>
<td>108</td>
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<td><strong>What is your role in community pharmacy?</strong></td>
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<td></td>
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<td>0.6</td>
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<tr>
<td><strong>What sort of pharmacy do you work in?</strong></td>
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<td></td>
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<tr>
<td>Independent</td>
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<td>18.8</td>
</tr>
<tr>
<td>Multiple</td>
<td>628</td>
<td>79.6</td>
</tr>
<tr>
<td>No answer</td>
<td>13</td>
<td>1.6</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>538</td>
<td>68.2</td>
</tr>
<tr>
<td>Asian</td>
<td>152</td>
<td>19.3</td>
</tr>
<tr>
<td>Other</td>
<td>78</td>
<td>9.9</td>
</tr>
<tr>
<td>No answer</td>
<td>21</td>
<td>2.7</td>
</tr>
</tbody>
</table>

The cohort which responded was mapped against the data for community pharmacy respondents to the pharmacy workforce census of 2008 (97). As the census includes data for all pharmacists, a breakdown of census data relating only to respondents who stated that they were community pharmacists was obtained and used for comparison.
4.2 Comparison of the cohort to the census data

The cohort was found to be a reasonable representation of each demographic aspect of the census data except gender; male pharmacists are under represented in the responses compared to female pharmacists.

Table 5. Gender and ethnicity comparison to census and RPSGB register data by percentage of community pharmacist respondents

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Study</th>
<th>Census</th>
<th>Register</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>40.9%</td>
<td>45.0%</td>
<td>43.1%</td>
</tr>
<tr>
<td>Female</td>
<td>59.1%</td>
<td>55.0%</td>
<td>56.9%</td>
</tr>
<tr>
<td>White</td>
<td>68.2%</td>
<td>67.4%</td>
<td>70.0%</td>
</tr>
<tr>
<td>Asian</td>
<td>19.3%</td>
<td>24.2%</td>
<td>20.4%</td>
</tr>
<tr>
<td>Other</td>
<td>9.9%</td>
<td>8.3%</td>
<td>9.6%</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>2.7%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Fewer men than women responded. Although there is a lower number of male pharmacists on the register, the cohort can be seen to slightly under-represent males and over-represent females.

Responses were received from all ethnicities included on the census data. For the purposes of analysis, White British and White Irish were combined to a single category of “White”, Asian and British Asian were combined to a single category of “Asian” and Mixed race, Black, Black British, Chinese and Other were combined to a single category of “Other”. Those who did not respond to this question, or who responded “Prefer not to say” were combined.

The level of response from Asian pharmacists was lower than seen in the census. It is possible that this may be due to those stating that they were of mixed race being coded as “Other” by the researcher; it is not known whether these individuals would code themselves in this way if their choices were limited. Other possibilities could include a decision not to complete the questionnaire due to a reluctance to discuss sexual health issues; the low number replying to explain why they had not completed the questionnaire does not provide sufficient data to address this.

Table 6. Employment status comparison by percentage of respondents

<table>
<thead>
<tr>
<th></th>
<th>Cohort</th>
<th>Census</th>
</tr>
</thead>
<tbody>
<tr>
<td>Owner</td>
<td>11.9%</td>
<td>12.3%</td>
</tr>
<tr>
<td>Manager</td>
<td>28.4%</td>
<td>29.2%</td>
</tr>
<tr>
<td>Relief</td>
<td>8.4%</td>
<td>8.1%</td>
</tr>
</tbody>
</table>
Table 7. Cohort comparison of gender by years of working life in five year bands

<table>
<thead>
<tr>
<th>Years worked</th>
<th>Male</th>
<th>Female</th>
<th>Total percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 to 5</td>
<td>30</td>
<td>78</td>
<td>13.8%</td>
</tr>
<tr>
<td>6 to 10</td>
<td>39</td>
<td>71</td>
<td>14.1%</td>
</tr>
<tr>
<td>11 to 15</td>
<td>29</td>
<td>75</td>
<td>13.3%</td>
</tr>
<tr>
<td>16 to 20</td>
<td>37</td>
<td>58</td>
<td>12.1%</td>
</tr>
<tr>
<td>21 to 25</td>
<td>33</td>
<td>48</td>
<td>10.4%</td>
</tr>
<tr>
<td>26 to 30</td>
<td>49</td>
<td>67</td>
<td>14.8%</td>
</tr>
<tr>
<td>31 to 35</td>
<td>39</td>
<td>31</td>
<td>9.0%</td>
</tr>
<tr>
<td>Over 35 years</td>
<td>65</td>
<td>33</td>
<td>12.5%</td>
</tr>
</tbody>
</table>

It was also seen that the cohort represented pharmacists from all bands of numbers of years worked in roughly equal proportions.

Seven respondents chose not to indicate how many years they had worked. All employment categories were represented and were very similar to the census data. For the purposes of analysis, manager, relief and second pharmacist were combined to a single category of employed pharmacist. The other roles of owner and locum were not considered separately.

There was representation from all age bands of the profession, although this was lower with the younger members of the profession.

It can be seen that the sample which provided responses for this questionnaire is generally representative of the profession as a whole when compared to the census data. As similar response rates were seen by pharmacists from all bands of working life it can be seen that the responses were not biased towards any one age group or level of experience.

The responses were also not likely to be biased towards race, working role, practice location or number of years worked in pharmacy. As males are under represented in the responses compared to females, the results may show a slight bias towards the female viewpoint.
4.3 Analysis of questionnaire responses by section

4.3.1 A baseline of feelings on providing sexual health services

Table 8. A baseline of feelings on providing sexual health services

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all</th>
<th>A little uncomfortable</th>
<th>Neither</th>
<th>Quite</th>
<th>Totally</th>
</tr>
</thead>
<tbody>
<tr>
<td>How comfortable are you overall about providing sexual health services through your pharmacy?</td>
<td>2.7% (15)</td>
<td>13.3% (74)</td>
<td>7.9% (44)</td>
<td>55.0% (307)</td>
<td>21.1% (118)</td>
</tr>
<tr>
<td>n = 558</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Statistical analysis of the responses to this section indicates that although pharmacists stated that they are comfortable at offering these services, male pharmacists are significantly more comfortable at offering these services than female (p=0.005).

Ethnicity had no impact on comfort at offering sexual health services and the significant difference in the variance between responses from owners, managers and locum pharmacists prevented statistical analysis from being appropriately carried out.
## 4.3.2 Provision of contraceptive services

### Table 9. Provision of contraceptive services.

<table>
<thead>
<tr>
<th>It is appropriate to supply</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neither</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condoms for sale n = 786</td>
<td>0.1% (1)</td>
<td>0% (0)</td>
<td>0.3% (2)</td>
<td>13.8% (109)</td>
<td>85.4% (674)</td>
</tr>
<tr>
<td>EHC OTC for females aged over 16 n = 784</td>
<td>2.2% (17)</td>
<td>1.8% (14)</td>
<td>2.5% (20)</td>
<td>24.5% (193)</td>
<td>68.4% (540)</td>
</tr>
<tr>
<td>EHC by PGD for females aged under 16 n = 783</td>
<td>3.9% (31)</td>
<td>10.3% (81)</td>
<td>7.9% (62)</td>
<td>32.3% (255)</td>
<td>44.9% (354)</td>
</tr>
<tr>
<td>Oral contraception OTC n = 784</td>
<td>6.1% (48)</td>
<td>28.1% (222)</td>
<td>13.2% (104)</td>
<td>32.2% (254)</td>
<td>19.8% (156)</td>
</tr>
<tr>
<td>Oral contraception by PGD n = 785</td>
<td>5.4% (43)</td>
<td>17.6% (139)</td>
<td>11.3% (89)</td>
<td><strong>38.9% (207)</strong></td>
<td>26.2% (207)</td>
</tr>
<tr>
<td>LARC by PGD n = 782</td>
<td>9.9% (78)</td>
<td><strong>32.8% (259)</strong></td>
<td>19.5% (154)</td>
<td>24.3% (192)</td>
<td>12.5% (99)</td>
</tr>
</tbody>
</table>
For the three services which are currently offered through community pharmacy (supply of condoms, provision of EHC over the counter for females aged over 16 and supply of EHC under a PGD for females aged under 16) the majority agreed that this activity was appropriate.

For the three services which are not currently offered through community pharmacy (sale of oral contraception for females aged over 16, supply of oral contraception under PGD for females aged under 16 and supply of long acting reversible contraceptives under PGD) there was net agreement on the appropriateness of supplying oral contraception (+17.8% for OTC supply, +43.1% for PGD supply). However there was net agreement that supplying LARC on PGD was inappropriate (-5.9%).

For all of these services, statistical analysis of the aggregate model found that, although all groups agreed it was appropriate, locum pharmacists were significantly less likely to consider that it was appropriate to offer these services (p=0.005) than owners and managers.
4.3.3 Support for reproductive health

Table 10. Support for reproductive health

<table>
<thead>
<tr>
<th>It is appropriate to offer</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neither</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supply of ovulation testing kits n = 786</td>
<td>0.3% (2)</td>
<td>0.5% (4)</td>
<td>1.9% (15)</td>
<td>31.4% (248)</td>
<td><strong>65.5% (517)</strong></td>
</tr>
<tr>
<td>Testing for pregnancy n = 786</td>
<td>0.8% (6)</td>
<td>2.5% (20)</td>
<td>3.8% (30)</td>
<td>25.3% (200)</td>
<td><strong>67.2% (530)</strong></td>
</tr>
<tr>
<td>Management of erectile dysfunction n = 785</td>
<td>5.2% (41)</td>
<td>17.7% (140)</td>
<td>14.7% (116)</td>
<td>37.8% (298)</td>
<td>24.1% (190)</td>
</tr>
</tbody>
</table>

Figure 4. Support for reproductive health

Statistical analysis of the results found no significant difference between different demographics on the responses to the question. All demographic groups agreed that these services were appropriate.
4.3.4 Screening for genital sexually transmitted infections

Table 11. Screening for genital sexually transmitted infections

<table>
<thead>
<tr>
<th>It is appropriate to screen for</th>
<th>By this method</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neither</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia n = 778</td>
<td>Testing a urine sample</td>
<td>7.0% (55)</td>
<td>12.9% (102)</td>
<td>7.7% (61)</td>
<td>41.1% (324)</td>
<td>29.9% (236)</td>
</tr>
<tr>
<td>Genital herpes n = 781</td>
<td>Swabbing the ulcer</td>
<td>36.2% (286)</td>
<td>44.2% (349)</td>
<td>8.1% (64)</td>
<td>7.5% (59)</td>
<td>2.9% (23)</td>
</tr>
<tr>
<td>Genital warts n = 778</td>
<td>Physical examination</td>
<td>41.4% (327)</td>
<td>41.1% (324)</td>
<td>8.1% (64)</td>
<td>7.5% (59)</td>
<td>2.9% (23)</td>
</tr>
<tr>
<td>Gonorrhoea n = 781</td>
<td>Vaginal or urethral swab</td>
<td>40.4% (319)</td>
<td>42.8% (338)</td>
<td>7.4% (58)</td>
<td>6.7% (53)</td>
<td>1.6% (13)</td>
</tr>
<tr>
<td>HIV n = 780</td>
<td>Taking a blood sample and counselling</td>
<td>39.9% (315)</td>
<td>35.2% (278)</td>
<td>9.8% (77)</td>
<td>10.8% (85)</td>
<td>3.2% (25)</td>
</tr>
<tr>
<td>Syphilis n = 781</td>
<td>Taking a blood sample</td>
<td>36.6% (288)</td>
<td>34.9% (275)</td>
<td>10.3% (81)</td>
<td>13.9% (110)</td>
<td>3.3% (26)</td>
</tr>
<tr>
<td>Vaginal thrush n = 781</td>
<td>High vaginal swab</td>
<td>42.3% (334)</td>
<td>40.3% (318)</td>
<td>7.9% (62)</td>
<td>5.6% (44)</td>
<td>2.9% (23)</td>
</tr>
</tbody>
</table>

Figure 5. Screening for genital sexually transmitted infections

Statistical analysis of the aggregate model found that there were no significant differences between demographic groups on their agreement with these services. All
groups expressed agreement that Chlamydia testing of a urine sample was an
appropriate service to be offered through community pharmacy. All groups expressed
that the invasive services of swabbing, blood testing or physical examinations were
not appropriate services for offering through community pharmacy.

4.3.5 OTC treatment of genital sexually transmitted infections

Table 12. OTC treatment of genital sexually transmitted infections

<table>
<thead>
<tr>
<th>It is appropriate to treat a Confirmed Infection of</th>
<th>By this treatment method</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia n = 765</td>
<td>Over the counter pharmacy supply</td>
<td>4.7% (37)</td>
<td>17.7% (140)</td>
<td>7.7% (61)</td>
<td><strong>38.5% (304)</strong></td>
<td>28.3% (223)</td>
</tr>
<tr>
<td>Genital herpes n = 752</td>
<td>Over the counter pharmacy supply</td>
<td>10.0% (79)</td>
<td><strong>26.6% (210)</strong></td>
<td>13.9% (110)</td>
<td>26.1% (206)</td>
<td>18.6% (147)</td>
</tr>
<tr>
<td>Genital warts n = 751</td>
<td>Over the counter pharmacy supply</td>
<td>10.5% (83)</td>
<td><strong>28.1% (222)</strong></td>
<td>13.4% (106)</td>
<td>25.6% (202)</td>
<td>17.5% (138)</td>
</tr>
<tr>
<td>Gonorrhoea n = 753</td>
<td>Over the counter pharmacy supply</td>
<td>12.3% (97)</td>
<td><strong>30.7% (242)</strong></td>
<td>13.1% (103)</td>
<td>23.2% (183)</td>
<td>16.2% (128)</td>
</tr>
<tr>
<td>HIV n = 754</td>
<td>Over the counter pharmacy supply</td>
<td>28.1% (222)</td>
<td><strong>35.9% (283)</strong></td>
<td>11.4% (90)</td>
<td>11.7% (92)</td>
<td>8.5% (67)</td>
</tr>
<tr>
<td>Syphilis n = 754</td>
<td>Over the counter pharmacy supply</td>
<td>15.8% (125)</td>
<td><strong>30.8% (243)</strong></td>
<td>14.6% (115)</td>
<td>20.7% (163)</td>
<td>13.7% (108)</td>
</tr>
<tr>
<td>Vaginal thrush n = 769</td>
<td>Over the counter pharmacy supply</td>
<td>1.3% (10)</td>
<td>3.7% (29)</td>
<td>2.8% (22)</td>
<td>35.1% (277)</td>
<td><strong>54.6% (431)</strong></td>
</tr>
</tbody>
</table>
Statistical analysis of the aggregate model found that there were no significant differences between the demographic groups on the responses that were given to these questions. There was clear agreement across all groups that it was appropriate to manage confirmed infections of vaginal thrush and Chlamydia with over the counter pharmacy supplies. There was also clear agreement that it was not appropriate to manage confirmed infections of HIV with over the counter pharmacy supplies. There was no clear agreement on managing confirmed infections of the other sexually transmitted infections through this route.

Calculation of the net differences in percentage responses shows that there is net agreement it is appropriate to manage confirmed infections of Genital herpes (8.1%) and Genital warts (4.5%).

There is net agreement it is inappropriate to manage confirmed infections of Gonorrhoea (-3.6%) and Syphilis (-12.2%).
### 4.3.6 PGD treatment of confirmed infections

**Table 13. PGD treatment of confirmed infections**

<table>
<thead>
<tr>
<th>It is appropriate to treat a Confirmed Infection of</th>
<th>By this treatment method</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia n = 758</td>
<td>Patient group direction</td>
<td>1.1% (9)</td>
<td>2.5% (20)</td>
<td>4.2% (33)</td>
<td>45.6% (360)</td>
<td>42.6% (336)</td>
</tr>
<tr>
<td>Genital herpes n = 770</td>
<td>Patient group direction</td>
<td>4.2% (33)</td>
<td>10.3% (81)</td>
<td>8.5% (67)</td>
<td>41.6% (328)</td>
<td>33.1% (261)</td>
</tr>
<tr>
<td>Genital warts n = 772</td>
<td>Patient group direction</td>
<td>4.9% (39)</td>
<td>11.7% (92)</td>
<td>9.5% (75)</td>
<td>40.6% (320)</td>
<td>31.2% (246)</td>
</tr>
<tr>
<td>Gonorrhoea n = 768</td>
<td>Patient group direction</td>
<td>5.8% (46)</td>
<td>12.4% (98)</td>
<td>9.5% (75)</td>
<td>40.1% (316)</td>
<td>29.5% (233)</td>
</tr>
<tr>
<td>HIV n = 771</td>
<td>Patient group direction</td>
<td>19.5% (154)</td>
<td>26.9% (212)</td>
<td>10.4% (82)</td>
<td>24.3% (192)</td>
<td>16.6% (131)</td>
</tr>
<tr>
<td>Syphilis n = 774</td>
<td>Patient group direction</td>
<td>8.4% (66)</td>
<td>16.3% (129)</td>
<td>10.6% (84)</td>
<td>37.1% (293)</td>
<td>25.6% (202)</td>
</tr>
<tr>
<td>Vaginal thrush n = 761</td>
<td>Patient group direction</td>
<td>1.0% (8)</td>
<td>4.6% (36)</td>
<td>4.7% (37)</td>
<td>33.5% (264)</td>
<td>52.7% (416)</td>
</tr>
</tbody>
</table>
Figure 7. Treatment under PGD

Statistical analysis of the aggregate model found that there were no significant differences in response within the different demographic groups. There was clear agreement that it was appropriate to manage confirmed infections of all conditions except for HIV and Syphilis under a Patient Group Direction. Calculation of the net percentage difference determined that there was net agreement (38%) that it was appropriate to treat a confirmed infection of syphilis under a PGD. There was net agreement (-5.5%) that it was inappropriate to treat a confirmed infection of HIV under a PGD.
### 4.3.7 Feelings and drivers for sexual health services

#### Table 14. Feelings and drivers for sexual health services

<table>
<thead>
<tr>
<th>My decision whether to offer these services is influenced by:</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neither</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The culture that I live in n = 778</td>
<td>12.3%</td>
<td>20.5%</td>
<td>27.1%</td>
<td><strong>31.2%</strong></td>
<td>7.5%</td>
</tr>
<tr>
<td></td>
<td>(97)</td>
<td>(162)</td>
<td>(214)</td>
<td><strong>(246)</strong></td>
<td>(59)</td>
</tr>
<tr>
<td>Whether I feel it is an ethical action n = 779</td>
<td>8.1%</td>
<td>11.2%</td>
<td>16.0%</td>
<td><strong>44.2%</strong></td>
<td>19.3%</td>
</tr>
<tr>
<td></td>
<td>(64)</td>
<td>(88)</td>
<td>(126)</td>
<td><strong>(349)</strong></td>
<td>(152)</td>
</tr>
<tr>
<td>The income that is generated n = 777</td>
<td>13.2%</td>
<td>19.1%</td>
<td><strong>31.4%</strong></td>
<td>28.9%</td>
<td>5.8%</td>
</tr>
<tr>
<td></td>
<td>(104)</td>
<td>(151)</td>
<td><strong>(248)</strong></td>
<td>(228)</td>
<td>(46)</td>
</tr>
<tr>
<td>The need to offer professional services n = 776</td>
<td>1.0%</td>
<td>4.3%</td>
<td>10.9%</td>
<td><strong>53.0%</strong></td>
<td>29.2%</td>
</tr>
<tr>
<td></td>
<td>(8)</td>
<td>(34)</td>
<td>(86)</td>
<td><strong>(418)</strong></td>
<td>(230)</td>
</tr>
<tr>
<td>Whether my religious beliefs support them n = 778</td>
<td><strong>31.2%</strong></td>
<td>24.1%</td>
<td>29.3%</td>
<td>9.4%</td>
<td>4.7%</td>
</tr>
<tr>
<td></td>
<td><strong>(246)</strong></td>
<td>(190)</td>
<td>(231)</td>
<td>(74)</td>
<td>(37)</td>
</tr>
</tbody>
</table>
Figure 8. Feelings and drivers

Statistical analysis found that there were no significant differences according to demographic criteria between their responses to these statements. There was clear agreement across all groups that decisions to offer these services were based on the need to offer the professional service and whether the pharmacist felt that it was an ethical action. There was also clear agreement that the religious beliefs of the individual did not impact on the decision to offer the services.

There was no clear agreement on the influence of culture or income generation on the decision to offer the services. Calculation of net percentage agreement to these factors found that there was net agreement that culture (5.9%) and income generation (2.5%) influenced the decision to offer these services.
4.4 **Analysis of results with respect to competences**

The competence framework was divided into discrete sections of related competences. Each of these was analysed for appropriateness for practise as a pharmacist in community pharmacy, practise as a pharmacist in a different setting and for practise as a pharmacist in both settings. Respondents were also able to state that they felt a competence was not applicable to the role of a pharmacist. As pharmacists could choose to tick either, neither or both of the settings, the totals across the row do not necessarily add up to the total number of respondents. This data is presented below.

### 4.4.1 Competences relating to consultation skills

**Table 15. Competences relating to consultation skills**

<table>
<thead>
<tr>
<th>Consultation skills</th>
<th>Needed by pharmacists in Community pharmacy</th>
<th>Needed by pharmacists wherever they practice</th>
<th>Needed by pharmacists in other settings</th>
<th>Not a pharmacist role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Takes a sexual history to assess risk of pregnancy and sexually transmitted infections n=772</td>
<td>73.4% (567)</td>
<td>58.5% (452)</td>
<td>80.4% (621)</td>
<td>4.7% (36)</td>
</tr>
<tr>
<td>Adapts consultation style to make sure that the client understands n=777</td>
<td>87.1% (677)</td>
<td>67.6% (525)</td>
<td>77.7% (604)</td>
<td>2.7% (21)</td>
</tr>
<tr>
<td>Keeps clear records n=769</td>
<td>85.7% (659)</td>
<td>66.8% (514)</td>
<td>76.9% (591)</td>
<td>4.3% (33)</td>
</tr>
</tbody>
</table>

It was clear that pharmacists felt that the consultation skills competences of sexual history taking, checking client understanding and keeping of clear records were relevant to pharmacists’ practice. There was high agreement that these competences were relevant to pharmacists, but this was primarily for those delivering sexual health services in other settings.
4.4.2 Competences related to consultations with young people

Table 16. Competences related to consultations with young people

<table>
<thead>
<tr>
<th>Consultations with young people</th>
<th>Needed in Community pharmacy</th>
<th>Needed by pharmacists wherever they practice</th>
<th>Needed by pharmacists in other settings</th>
<th>Not a pharmacist’s role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understands the importance of confidentiality</td>
<td>93.9% (734)</td>
<td>70.7% (553)</td>
<td>75.7% (592)</td>
<td>1.2% (9)</td>
</tr>
<tr>
<td>Has awareness of child protection issues</td>
<td>92.3% (722)</td>
<td>70.5% (551)</td>
<td>76.5% (598)</td>
<td>1.7% (13)</td>
</tr>
<tr>
<td>Can apply the law relating to consent (specifically for people under the age of 16)</td>
<td>87.5% (681)</td>
<td>66.7% (519)</td>
<td>75.3% (586)</td>
<td>3.9% (30)</td>
</tr>
</tbody>
</table>

When considering sexual health services, it was clear that pharmacists felt that it was appropriate for them to display competences related to consultations with young people. The majority of pharmacists stated that this was appropriate wherever the pharmacist practised.
### 4.4.3 Competences related to contraceptive practice

**Table 17. Competences related to contraceptive practice**

<table>
<thead>
<tr>
<th>Contraceptive practice</th>
<th>Needed in Community pharmacy</th>
<th>Needed by pharmacists wherever they practice</th>
<th>Needed by pharmacists in other settings</th>
<th>Not a pharmacist’s role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrates the ability to conduct an effective contraceptive choice consultation</td>
<td>73.5% (573)</td>
<td>56.9% (444)</td>
<td>80.3% (626)</td>
<td>3.2% (25)</td>
</tr>
<tr>
<td>n=780</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provides essential advice and information when providing oral hormonal contraception</td>
<td>91.3% (714)</td>
<td>72.1% (564)</td>
<td>89.0% (696)</td>
<td>4.5% (35)</td>
</tr>
<tr>
<td>for the first time</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n=782</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explains the relative and absolute contraindications for providing oral</td>
<td>73.6% (572)</td>
<td>55.5% (431)</td>
<td>76.8% (597)</td>
<td>5.0% (39)</td>
</tr>
<tr>
<td>hormonal contraception for the first time</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n=777</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advises on action to take in case of problems related to oral hormonal contraception</td>
<td>85.6% (666)</td>
<td>65.7% (511)</td>
<td>76.8% (597)</td>
<td>3.3% (26)</td>
</tr>
<tr>
<td>n=778</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provides essential advice and information prior to insertion of intrauterine method</td>
<td>26.8% (208)</td>
<td>20.0% (155)</td>
<td>66.1% (513)</td>
<td>27.1% (210)</td>
</tr>
<tr>
<td>or subdermal implant</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n=776</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can give an intramuscular injection</td>
<td>22.0% (171)</td>
<td>17.9% (139)</td>
<td>60.2% (467)</td>
<td>35.7% (277)</td>
</tr>
<tr>
<td>n=776</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrates the teaching of male and female condom use</td>
<td>49.0% (381)</td>
<td>38.3% (298)</td>
<td>75.1% (584)</td>
<td>14.3% (111)</td>
</tr>
<tr>
<td>n=778</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fits and checks diaphragms and caps</td>
<td>3.5% (27)</td>
<td>2.8% (22)</td>
<td>44.4% (344)</td>
<td>54.9% (425)</td>
</tr>
<tr>
<td>n=774</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consults for and supplies hormonal emergency contraception</td>
<td>90.5% (706)</td>
<td>67.1% (523)</td>
<td>74.0% (577)</td>
<td>2.6% (20)</td>
</tr>
<tr>
<td>n=780</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has knowledge of emergency IUD and how to refer for this</td>
<td>74.4% (582)</td>
<td>57.8% (452)</td>
<td>73.7% (576)</td>
<td>9.7% (76)</td>
</tr>
<tr>
<td>n=782</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
There was variation in the responses received from pharmacists with regards to different contraceptive practice services. Although many were seen to be relevant wherever the pharmacist practised, certain services were found not to be applicable to the role of the pharmacist and others were found to be applicable to pharmacists in other areas of practice.

Those competences which had less than 75 percent agreement were:

- Provides essential advice and information prior to insertion of intrauterine method or subdermal implant
- Can give an intramuscular injection
- Fits and checks diaphragms and caps
4.4.3 Competences related to planning a pregnancy

Table 18. Competences related to planning a pregnancy

<table>
<thead>
<tr>
<th>Pregnancy planning</th>
<th>Needed in Community pharmacy</th>
<th>Needed by pharmacists wherever they practice</th>
<th>Needed by pharmacists in other settings</th>
<th>Not a pharmacist’s role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performs a urine pregnancy test and gives result in an appropriate manner n=780</td>
<td>82.8% (646)</td>
<td>60.6% (473)</td>
<td>74.1% (578)</td>
<td>3.7% (29)</td>
</tr>
<tr>
<td>Has skills to consult on unintended pregnancy n=773</td>
<td>65.2% (504)</td>
<td>49.0% (379)</td>
<td>72.6% (561)</td>
<td>11.3% (87)</td>
</tr>
</tbody>
</table>

Competences related to pregnancy planning were seen to be relevant to pharmacists wherever they practised.
4.4.4 Competences related to knowledge of contraceptive methods

Table 19. Competences related to knowledge of contraceptive methods

<table>
<thead>
<tr>
<th>Knowledge of other methods of contraception and ability to discuss and advise clients on them</th>
<th>Needed in Community pharmacy</th>
<th>Needed by pharmacists wherever they practice</th>
<th>Needed by pharmacists in other settings</th>
<th>Not a pharmacist’s role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can discuss and advise on sterilisation (male and female) n=772</td>
<td>36.4% (281)</td>
<td>28.9% (223)</td>
<td>63.6% (491)</td>
<td>28.9% (223)</td>
</tr>
<tr>
<td>Can discuss and advise on natural family planning n=772</td>
<td>61.3% (473)</td>
<td>47.3% (365)</td>
<td>72.8% (562)</td>
<td>13.2% (102)</td>
</tr>
</tbody>
</table>

The two competences relating to sterilisation and natural family planning were not both seen to be relevant to pharmacists. It was felt that pharmacists should be able to advise on natural family planning, but not necessarily to discuss and advise on sterilisation. Over 25 percent of respondents felt that this was not relevant to the role of the pharmacist, regardless of setting.
### 4.4.5 Competences related to sexual health and infections

Table 20. Competences related to sexual health and infections

<table>
<thead>
<tr>
<th>Sexual health and infections</th>
<th>Needed in Community pharmacy</th>
<th>Needed by pharmacists wherever they practice</th>
<th>Needed by pharmacists in other settings</th>
<th>Not a pharmacist’s role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understands principles of screening programmes for sexually transmitted infections n=773</td>
<td><strong>77.9% (602)</strong></td>
<td>59.1% (457)</td>
<td>77.1% (596)</td>
<td>4.1% (32)</td>
</tr>
<tr>
<td>Can perform appropriate tests for genital infections in men and women n=771</td>
<td>14.4% (111)</td>
<td>10.8% (83)</td>
<td><strong>60.8% (469)</strong></td>
<td>35.5% (274)</td>
</tr>
<tr>
<td>Is able to counsel a client with a positive diagnosis of a sexually transmitted infection n=775</td>
<td>61.3% (475)</td>
<td>48.3% (374)</td>
<td><strong>79.5% (616)</strong></td>
<td>12.6% (98)</td>
</tr>
<tr>
<td>Understands the principles of notifying sexual partners about positive test results n=774</td>
<td>67.4% (522)</td>
<td>53.0% (410)</td>
<td><strong>76.2% (590)</strong></td>
<td>9.3% (72)</td>
</tr>
<tr>
<td>Can manage presentations of all common genital infections in men and women n=771</td>
<td>25.7% (198)</td>
<td>19.5% (150)</td>
<td><strong>66.4% (512)</strong></td>
<td>27.4% (211)</td>
</tr>
<tr>
<td>Is able to manage vaginal discharge appropriately n=773</td>
<td>49.5% (383)</td>
<td>38.6% (298)</td>
<td><strong>70.2% (543)</strong></td>
<td>18.8% (145)</td>
</tr>
<tr>
<td>Is able to manage pelvic pain appropriately n=771</td>
<td>36.2% (279)</td>
<td>27.4% (211)</td>
<td><strong>62.4% (481)</strong></td>
<td>28.8% (222)</td>
</tr>
<tr>
<td>Demonstrates knowledge and communication skills required for pre-test HIV discussion n=763</td>
<td>24.9% (190)</td>
<td>19.1% (146)</td>
<td><strong>63.2% (482)</strong></td>
<td>31.3% (239)</td>
</tr>
</tbody>
</table>
There was disparity in agreement over the applicability of all competences related to sexual health and infections and the role of the pharmacist. Although some competences, such as understanding the principles of screening programmes and partner notification, were considered to be relevant to the pharmacists’ role wherever they practised, there were several competences which over 25 percent of respondents felt were not applicable to pharmacy practice. These were:

- Can perform appropriate tests for genital infections in men and women
- Can manage presentations of all common genital infections in men and women
- Is able to manage pelvic pain appropriately
- Demonstrates knowledge and communication skills required for pre-test HIV discussion
## 4.4.6 Competences related to cervical cytology

### Table 21. Competences related to cervical cytology

<table>
<thead>
<tr>
<th>Cervical cytology</th>
<th>Needed in Community pharmacy</th>
<th>Needed by pharmacists wherever they practice</th>
<th>Needed by pharmacists in other settings</th>
<th>Not a pharmacist’s role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understands screening programmes and recall systems n=776</td>
<td>47.9% (372)</td>
<td>38.3% (297)</td>
<td>67.3% (522)</td>
<td>23.1% (179)</td>
</tr>
<tr>
<td>Is able to take cervical smears n=771</td>
<td>3.1% (24)</td>
<td>2.5% (19)</td>
<td>38.8% (299)</td>
<td>60.6% (467)</td>
</tr>
<tr>
<td>Is able to explain cervical smear results and take appropriate action n=768</td>
<td>21.7% (167)</td>
<td>18.0% (138)</td>
<td>56.9% (437)</td>
<td>39.3% (302)</td>
</tr>
</tbody>
</table>

It was apparent that pharmacists do not perceive that they need to demonstrate competence with cervical cytology competences. With the exception of their understanding of cervical screening programmes and recall systems, over 25 percent of pharmacists felt that cervical cytology competences were not applicable to the role of the pharmacist.
4.4.7 Competences related to psychosexual issues

Table 22. Competences related to psychosexual issues

<table>
<thead>
<tr>
<th>Psychosexual issues</th>
<th>Needed in Community pharmacy</th>
<th>Needed by pharmacists wherever they practice</th>
<th>Needed by pharmacists in other settings</th>
<th>Not a pharmacist’s role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understands sexual dysfunction, exploring psychological and physical factors. Gives advice n=773</td>
<td>40.6% (314)</td>
<td>31.3% (242)</td>
<td>62.4% (482)</td>
<td>28.3% (219)</td>
</tr>
</tbody>
</table>

Although there was no overall majority on the need for pharmacists to demonstrate competence in understanding sexual dysfunction, exploring psychological and physical factors and giving advice, it was seen that over 25 percent of respondents felt that this competence was not applicable to the role of the pharmacist.
4.4.8 Summary of competence statements

There were eleven competence statements where 25 percent or more of the respondents felt that it was inappropriate for pharmacists in any area of practice. These competences were:

- Provides essential advice and information prior to insertion of intrauterine method or subdermal implant
- Can give an intramuscular injection
- Fits and checks diaphragms and caps
- Can discuss and advise on sterilisation (male and female)
- Can perform appropriate tests for genital infections in men and women
- Can manage presentations of all common genital infections in men and women
- Is able to manage pelvic pain appropriately
- Demonstrates knowledge and communication skills required for pre-test HIV discussion
- Is able to take cervical smears
- Is able to explain cervical smear results and take appropriate action
- Understands sexual dysfunction, exploring psychological and physical factors. Gives advice.
4.5 Qualitative analysis of free text comments

A total of 287 respondents recorded additional comments in the sections of the questionnaire asking for additional competences or comments. Four key themes were identified through thematic analysis of the comments by the researcher. These were:

- training,
- practical aspects of delivering services,
- the different paradigm of service delivery, and
- the appropriateness of providing invasive testing procedures through a community pharmacy setting.

4.5.1 Training issues

4.5.1.1 Recognition of need for additional training

As the topic most frequently commented on by respondents to the questionnaire, it was clear that training was considered to be a key factor. However, the majority of the comments made were general in nature, stating simply that

"training would be necessary for such a service".

White female, locum, large multiple. Age 26 to 30.

Some of the general responses did however recognise that additional training was needed due to the breadth of the sexually transmitted infections that could potentially be managed

"Full training would be necessary and regularly updated to discuss many STIs."

White female, locum, large multiple. Age 46 to 50.

Whilst one respondent made the specific point that

"Extra training would be required for HIV etc, wouldn’t feel I have appropriate skills at present"

White female, manager, independent. Age 31 to 40

These comments demonstrate recognition both of a lack of knowledge in the overall topic of sexual health, whilst touching on the need for skill development to be addressed as well.
4.5.1.2 Outline proposals for necessary training

Some responses continued to outline the approaches to training that they thought would be required. These comments highlighted that some respondents had started to consider the approaches to client management that would be needed and issues that were omitted from training that was currently provided. This included the need to record patient notes and also to undertake physical examinations.

“Pharmacists will require significant training in the philosophy and practice of note taking”

White male, locum, large multiple. Age over 65

“How to do physical examinations”

White female, manager, large multiple. Age over 65

This brought with it recognition of some of the hazards of providing these services with

“how to protect ourselves legally”

White female, manager, small chain. Age 36 to 40.

being stated as a training need.

It was interesting to note that pharmacists had also considered that a staged introduction of services using the PGD approach would ensure that training was provided.

“this would be most successful under a PGD system so appropriate training is provided”

White female, manager, large multiple. Age 26 to 30.

4.5.1.3 Need for pharmacists to develop a specialism

There was some indication that pharmacists considered that the effective management of sexually transmitted infections would require pharmacists to embark on a specialist pathway.

“Some of the more advanced sexual health services should be only offered by pharmacists with further training i.e. diploma in sexual health.”

White male, locum, large multiple. Age 51 to 60.
With comments being made that linked the services to the need for an ability to prescribe.

“They must also be an independent prescriber given a certificate which indicates that they are competent on advising, prescribing and counselling.”

Asian female, locum, small chain. Aged 41 to 50

There was recognition that the specialism of sexual health is broad.

"A pharmacist must be confident that they are able to give advice and information on any related issue on sexual health”

Asian female, locum, small chain. Aged 41 to 50

demonstrating the challenge between providing training solely for an infection specific PGD or to enable pharmacists to practice confidently within the wider arena of sexual health services.

“I think unless a pharmacist has undertaken a course or shows competency, they should not be allowed to dispense or stock products related to sexual health”

Asian female, locum, small chain. Aged 41 to 50

4.5.1.4 Need for training to be formal and funded

Pharmacists did recognise the challenges of accessing the level of training that was needed.

“I would like to see some properly funded training up front,”

White male locum, medium chain. Aged 46 to 50

although there was a lack of awareness of the depth and detail of learning that may be needed,

"Perhaps a week’s residential course with backfill payment”

White male locum, medium chain. Aged 51 to 60

Responses suggested that one potential barrier was the lack of formal, funded learning for delivery of the right service.

"Relying on part time CPD and our goodwill doesn’t always get the right service in the right place at the right time.”

White male locum, medium chain. Aged 51 to 60
4.5.2 Practical aspects of service delivery

The second most commonly made comment related to the changes that respondents felt would need to be made in order to deliver the services effectively. Pharmacists expressed concerns about the size of the rooms that were available for private consultations and whether these were well enough equipped, or offered the right setting, for sexual health services to be carried out.

4.5.2.1 Consultation rooms and facilities must be of an appropriate size

In order to offer the advanced service of the Medicines Use Review, pharmacies must have a consultation area. There was general recognition that the standards set for these rooms were unlikely to be sufficient for a pharmacist to offer sexual health services of a more intimate nature.

"the current average consultation area in a community pharmacy is not private enough to conduct the sexual health services"

White female manager, small chain. Age 51 to 60

"I don't feel that the majority of community pharmacies have a sufficient room to offer vaginal swabbing etc”

White female manager, large multiple. Age 31 to 40

Comments made also suggest that the investments which were made to improve facilities to offer advanced services may deter contractors from further investment in premises in order to offer sexual health services.

"Community pharmacies are commercial undertakings”

White male locum, large multiples. Aged over 65.

“To upgrade consultation rooms would involve a considerable outlay.”

White male locum, large multiples. Aged over 65.

4.5.2.2 Current consultation rooms need to be better equipped

Pharmacists demonstrated that they had started to consider the practical aspects of providing additional sexual health services and made comments on the additional equipment that they recognised would be needed in order to engage in offering them.

There were frequent comments on the need for an appropriate couch for the client as well as the need for facilities for clinical waste such as,
“consultation areas with a patient couch”
White male locum, large multiples. Age 31 to 40.

“you need a proper sized room with a sink”
White female locum, large multiples. Age 26 to 30.

“appropriate things needed to deal with clinical waste”
White female manager, large multiple. Age 31 to 40.

4.5.2.3 **Services should be delivered within a clinic environment**

A range of concerns were addressed that the environment of the community pharmacy may not be appropriate for offering additional sexual health services. These comments related to the need for the services to be offered from within a clinical setting, away from the usual environment of a high street community pharmacy.

“*These services should be provided by pharmacists away from a commercial environment*”
Asian male locum, large multiple. Age 26 to 30.

“A more clinical setting is to be desired”
White male locum, independent. Aged over 65

“I can’t imagine how anyone would want to have a vaginal swab performed in a shop situation”
White female locum, large multiple. Age 51 to 60

4.5.3 **A new paradigm for service delivery**

Despite the overall recognition that pharmacists were comfortable in offering sexual health services seen from the quantitative responses, some concerns were expressed over whether this was a role for the community pharmacist.

It was apparent that respondents felt that a new paradigm of community pharmacy practice would be needed for the services to succeed, built on more time for the pharmacist to engage in the activities and a support team who could maintain the full range of pharmacy services.

“Due to time restrictions consultations cannot be very long”
White female locum, large multiple. Age 26 to 30.
“There is neither time, space nor support staff to do any of this in my role as a locum on a Saturday morning”

White female locum, large multiple. Age 41 to 50.

“clients are entitled to a planned, private, uninterrupted consultation”

White female manager, large multiple. Age 41 to 50.

However, many pharmacists related the provision of these services to the sexual health service that they currently offered and expressed eagerness to engage in further services.

“we already offer EHC under PGD and give out free Chlamydia tests... we are best suited to offer more services to the population”

Asian female manager, large multiple. Age 26 to 30

And pharmacists were also able to recognise that these services were valued by customers.

“My pharmacy has been providing EHC for a number of years now. The service is a great success. The comments from clients, post consultation, are usually excellent”

Asian male owner, independent. Age 51 to 60.

There was also a recognition that the mindset of the pharmacist would need to change in order for the services to be successful.

“I would find it odd to do a vaginal swab one minute, then select stock or operate the till the next”

White female locum, large multiple. Age 26 to 30.

“need to be seen by potential users as professional, caring and confidential”

White male manager, large multiple. Age 60 to 65.

4.5.4 Invasive procedures

The responses to the quantitative analysis on pharmacists undertaking physical examinations of the genitalia, or taking vaginal or penile swabs, demonstrate that pharmacists did not consider this to be a role with which they were comfortable.
Many pharmacists elucidated further on this in the comments section, reinforcing that they did not consider intimate examinations to be the role of the pharmacist. Some of these reflected their personal concerns at offering the services, for example:

“Physical examination is not a role I would be happy with”

Asian female locum, small chain. Age 41 to 50.

“I would feel uncomfortable even with further training in invasive diagnostic operations”

White female manager, medium chain. Age 51 to 60.

“I would feel uncomfortable with people of either sex disrobing in order to show me their genitalia”

White female manager, large multiple. Age 51 to 60.

“Will not touch bodies of male/female for other checks for sexual services”

White male locum, large multiple. Age 51 to 60.

Others felt that invasive procedures should not be offered within the community pharmacy setting.

“I think that these services could be performed by pharmacists, but in a relaxed situation, for example a clinic.”

White female locum, large multiple. Age 51 to 60.

“Personal invasive procedures are not suitable in a retail pharmacy environment”

White female locum, large multiple. Age 41 to 50.
There was also consideration that the invasive testing could be carried out within the community pharmacy setting, but that other health care professionals should offer it, rather than the pharmacist.

"you need a dedicated trained professional for example, a nurse, to carry these activities out."

*White female locum, large multiple. Age 26 to 30.*

However pharmacists also further explained their statements, providing insight that although they did not feel it was their role in a community pharmacy setting, they would be willing to offer such services in a different environment.

"I would be happy in a clinic setting"

*Asian female locum, small chain. Age 41 to 50.*

"Other settings may be suitable with appropriate training"

*White female locum, large multiple. Age 41 to 50.*

"I feel invasive testing procedures should be done at GUM clinics"

*White female manager, large multiple. Age 26 to 30.*

A piece of personal insight came from one respondent who explained

"if my family needed help, I would rather they consulted a medical practitioner in a specialised clinic with time allotted to giving advice, not 'do you think you could see this person now', knowing other necessary work needs your attention."

*White male locum, independent. Aged over 65.*
4.5.5 Summary of qualitative data

Pharmacists shared a broad recognition that additional training was essential to offer sexual health services, but few offered suggestions of what this training should be, or how it would best be implemented. Respondents had started to consider how services could be delivered within a community pharmacy setting, but felt that the standards set for the introduction of consultation rooms in the 2005 community pharmacy contract had not gone far enough to allow sexual health services to be offered. They thought it unlikely that additional investment would be made to raise the standard further. Comments demonstrated that the vision pharmacists had for these services would closely mirror the clinical environment seen in general practice, which they felt was not found in community pharmacies at present.

Pharmacists were challenged by the concept of offering what they considered to be clinical services from within a community pharmacy setting, but could see that the benefits for themselves and their customers, as seen with EHC services, were likely to be forthcoming. There was recognition that provision of oral contraception was the likely next step for the profession. It was perceived that there was need for a change in mindset in order to offer more intimate examinations.

In line with the quantitative responses, pharmacists did not consider their role and remit to extend as far as examination or swabbing of the genitalia. Reasons cited included the community pharmacy setting and the professional remit of the pharmacist, but these appeared to be redacted to some extent by qualifying comments that pharmacists could offer these services in a different, more clinical setting.
5. Discussion

5.1 Overview of messages

This study set out to determine the feelings of practising community pharmacists on:

- The sexual health services that they currently offer
- The sexual health services that are being introduced into community pharmacy practice
- The sexual health services which have been proposed for future community pharmacy practice
- Other sexual health services which are not yet offered in, nor currently proposed for, community pharmacy practice.

It also sought to determine whether pharmacists considered the FSHR competence framework, which was used to support the Diploma of the Faculty of Family planning, was appropriate to their role.

5.1.1 Limitations of the sample

Although the sample size and response rate limits the generalisability of the results to the profession as a whole, this relatively large study does offer reasonable insight into the views and feelings of community pharmacists in England.

The demographic detail of the responding cohort of 789 pharmacists correlates closely with the census and register data, indicating that it offers a reasonable representation of community pharmacists as a whole. The response rate of 40.8 percent offers insight to the thoughts of the targeted group of professionals, but caution must be exercised in considering that it may allow generalizations to be made about the profession as a whole.

5.1.2 Hepatitis B as a screening service

As outlined in the introduction services relating to testing for hepatitis B were not considered during the development of this research. These services have focused on meeting a need for injectable drug users. Although the disease may be transmitted sexually, it is not considered to be a sexually transmitted infection and so was outside
of the scope of this research. The research has focused on developing a competence framework for offering sexual health services, rather than a competence framework for offering screening and testing services. Whilst this may limit the scope of the research, it does not limit the appropriateness of the competence framework to be proposed.

5.2 Are pharmacists comfortable at offering sexual health services.

Pharmacists were asked to state how comfortable they were at offering sexual health services at the start of the questionnaire. This question was skipped by more respondents than any other question (a total of 231 pharmacists did not answer this question). It is possible that this is due to a problem with questionnaire design; this question was included as Section A on the introductory page of the questionnaire. The researcher considers that participants may have missed the question as they turned straight to the top of the following page, assuming incorrectly that this question was an example.

Those who did respond to this question expressed agreement that they were comfortable in offering these services. Considering the higher response rate to other questions and agreement expressed with those questions, it seems reasonable to find that overall pharmacists are comfortable at offering sexual health services.

5.3 Sexual health services currently offered through community pharmacies

Community pharmacists are currently engaged in offering the following sexual health services, as seen in the PSNC database of pharmacy services together with the researcher’s own awareness of common community pharmacy practice:

- Supply of condoms
- Sale of ovulation testing kits
- Sale of pregnancy testing kits
- Management of vaginal thrush by over the counter supplies
- Sale of emergency hormonal contraception
• Supply of emergency hormonal contraception to females aged under 16 under a patient group direction
• Screening for Chlamydia infection through urine testing
• Treatment of confirmed Chlamydia infection under a PGD or by OTC sale

It was clear that pharmacists considered that the services that are currently offered through the community pharmacy setting were appropriate. Pharmacists have been supplying the condom since it was first launched in the UK. The rate of agreement for the appropriateness of this service, at 99.4 percent, was the highest seen in the results of the questionnaire.

Management of vaginal thrush infection was also considered to be an appropriate activity for pharmacist intervention, with 92.1 percent of respondents feeling that this was appropriate for management over the counter.

With respect to screening for sexually transmitted infections, 88.4 percent of respondents agreed that it was appropriate to offer screening for Chlamydia through urine testing.

In the introduction a timeline was presented which indicated the historical development of new services. Items relating to each of these are represented in figure 9, following the same timeline of service introduction. An overall pattern can be seen that services which are currently provided are considered to be appropriate by the cohort sampled. Services which have been introduced more recently and which are not yet available are not considered as appropriate.
Figure 9: Timeline comparison of services through pharmacy

No comparative data was identified in the literature to enable the researcher to determine whether the feelings expressed by respondents to this questionnaire demonstrate a change in perception.

Research undertaken in Grampian by MC Watson and A Shankley (98) found that 90 percent of pharmacists were willing to provide free EHC by PGD and free Chlamydia tests and over 80 percent were willing to supply free condoms and azithromycin as well as oral contraception by PGD. It also found that 40 percent were willing to sell Chlamydia tests.

In general the Grampian research supports the high level of willingness of pharmacists to engage in sexual health services such as provision of condoms and EHC found in this study. However, there are differences in responses at all levels. In particular over 70 percent of pharmacists expressed agreement that it was appropriate to screen for Chlamydia in the pharmacy in this study, with just 40 percent willing to offer this service in Grampian. The researcher considers that there are many potential factors behind this. Chlamydia screening, introduced in England in 2005 as part of the National Chlamydia screening programme, is not formally offered in Scotland, which may have an impact on willingness to offer the service. This study also looked at whether the pharmacist thought it was appropriate to screen for Chlamydia infection.
in the community pharmacy, rather than whether it was appropriate to sell Chlamydia tests as seen in the Grampian research.

It would be interesting to explore whether these subtle differences in questions and the impact of selling tests had an effect on the responses gathered.

Overall there appears to be a pattern in agreement over the services that are provided as this timeline progresses, with more recent services being considered to be less appropriate. However, this questionnaire did not identify why this was the case. It is possible that pharmacists feel more comfortable offering services which are embedded within practice; the overall trend appears to show decreasing comfort in offering services which were introduced more recently. Additional research to identify whether feelings change as the service becomes customary, or what other factors are behind these differences would be useful.

It is also interesting to note the differences stated between appropriateness of supply over the counter or under patient group direction for emergency contraception and for the treatment of Chlamydia. Pharmacists were more likely to feel it was appropriate to supply emergency contraception over the counter than under a patient group direction. For the management of Chlamydia however, pharmacists were more likely to feel it was appropriate to make the supply under a patient group direction than by an over the counter sale. The reasons behind these feelings were not explored by the researcher. This is likely to be due to a number of different factors, with possible explanations which could be related to PGDs being used primarily for those aged under 16, or that with developing familiarity in offering a service, the additional security of working under a PGD is not felt necessary.

There was some indication from the free text responses that the respondents recognised that the introduction of a service under a PGD ensured that appropriate training would be a requirement from the service commissioner before the service could be offered. This differs from the introduction of a national service. Currently only the essential service of NHS Repeat Dispensing carries with it a requirement to undergo appropriate training.
However, the researcher is also aware that the same training is provided to pharmacists offering these services, regardless of whether it is a requirement from the commissioner (for a PGD) or recognition by the individual of their own training needs. Since the sexual health training offered is identical (the same materials and assessment are provided by the same provider), with the only difference relating to necessary paperwork at a local level, it is not clear why the respondents expressed strong opinions about the benefits of training when a PGD was used. For a PGD the commissioner requires the individual to undertake the learning and pass the assessment before they can offer the service. For a non-PGD service, the individual needs to recognise their own learning needs, identify the relevant learning programme, undertake it and pass the assessment.

It would be interesting to undertake further research to identify whether feelings changed following the introduction of services into mainstream provision. Do pharmacists become more likely to feel it is appropriate to offer sexual health services when they are common practice? Are the feelings related to supply over the counter or under PGD linked to the nature of the service, familiarity with the service or some other element? Why do pharmacists feel more secure if a commissioner has identified the learning programmes that they need to undertake?

5.3.1 Perceived or actual training needs

The results of this questionnaire have not determined whether the training needs identified by the cohort are actual training needs or whether there are perceived. This was not an intended outcome of the research.

As the questionnaire was distributed by the University of Manchester, with a covering letter from the Centre for Pharmacy Postgraduate Education, it is possible that participants were inclined to think of training in their responses. Many additional services are introduced with a requirement for the individual to undergo training, as referred to in the introduction and the two HAG frameworks included in the appendices.

There is a need for pharmacists to be able to demonstrate their ability or competence. This requires them to have gained a level of knowledge and understanding, to have
developed skills and to demonstrate particular behaviours in the way that they work. Training programmes are constructed in order to provide this input. The pharmacists responding to this questionnaire may perceive that the need to be trained. Providing a competence framework, which clearly described the knowledge, skills and behaviours they were required to have, would allow the pharmacist to determine what their actual training needs were.

5.4 Services which are currently being introduced

At the time of writing a pilot service is operating in Manchester whereby pharmacists are able to manage erectile dysfunction and provide sildenafil under a PGD (99). Of those pharmacists who responded to this study, 62.2 percent agreed that managing erectile dysfunction would be an appropriate service for community pharmacists to offer. This agreement was regardless of the gender, ethnicity, role or location of practice of the respondent.

Willingness to offer this service was similar to that seen of 68.9 per cent for the over the counter management of Chlamydia infection. This service has been offered through community pharmacy since the introduction of Chlamelle in 2010.

Pilot services have also been set up to allow the pharmacist to make the first supply of the oral contraceptive pill under PGD, without prior reference to a prescriber. 52.7 percent of pharmacist respondents agree that this is an appropriate service, regardless of their gender or age, and whether they are practising as a manager, locum or second pharmacist.

Over 80 percent of pharmacists in the Grampian study expressed willingness to supply oral contraception by PGD. However, it is not clear whether this research related to the first supply or ongoing supply.

The services allowing the community pharmacist to provide the first supply of the oral contraceptive pill are running in London, Manchester and on the Isle of Wight. When the contraception service started operation on the Isle of Wight there was a limited flurry of opinion pieces in the national press, commenting that the introduction of the
service was irresponsible\(^{(100;101)}\). The earlier pilot running in London received similar press coverage expressing concern at the pharmacist involvement \(^{(102)}\).

The press response to the introduction of these services is in line with the comments made by participants that there needs to be a change in the public understanding of the role of the community pharmacist. Comments made in the articles demonstrated that the community pharmacy is seen as a commercial enterprise rather than a healthcare environment by some members of the public.

"they can go into a shop, more or less"

Andrew Turner MP, Isle of Wight \(^{(103)}\).

It was clear from comments made by respondents to the questionnaire that this unease over the community pharmacy setting is shared by pharmacists as well. However, this was tempered by the recognition that this is a service that pharmacists are well placed to offer.

It is interesting to note that the approach from the press is to raise awareness of the ability of the pharmacist to provide oral contraception to any client who can demonstrate the Gillick competences\(^{8}\), highlighting that this may mean clients as young as 13 could access oral contraception through this route. The questionnaire did not seek to gain consensus from pharmacists on the ethical aspects of contraception, however pharmacists were clear in recognising that competences in child protection were essential for pharmacists wherever they practised.

When EHC was first made available through community pharmacy there was a similar hostile reaction from the national press \(^{(104)}\); similar emotive and ethical issues were discussed. It now appears that this service is recognized and established in community pharmacy practice. It would be interesting to map the pace at which provision of oral contraception is integrated to standard practice by the profession and the national press.

\(^{8}\) Gillick competence refers to the House of Lords ruling that a person under the age of 16 could be deemed to be competent to make decisions on their own behalf. The ruling can be found at http://www.bailii.org/uk/cases/UKHL/1985/7.html
The use of the competence framework for pharmacists would allow the profession to demonstrate that services were being offered by individuals trained to a comparable level as other service providers. This would then allow research to concentrate on whether objections related to the setting of the service or the overall provision of the service.

5.5 Future service provision

It was clear from the responses received from pharmacists to this questionnaire that they do not consider invasive testing procedures to be appropriate to the community pharmacy setting. Regardless of whether the testing method was blood sampling, swabbing or physical examination of the genitalia, pharmacists did not agree that this was appropriate.

Comments made relating to this suggest that the key reasons for this are the recognition that to offer these services would require time which is not available in the community pharmacy setting. There was also a strong feeling that the facilities available in the community pharmacy are not appropriate for offering these services.

But there was also recognition that this was a role that the pharmacist could undertake.

Although it was not significant, pharmacists appeared to be more likely to feel it was appropriate to undertake blood testing than swabbing or physical examination. This study did not seek to determine whether pharmacists felt that blood testing for sexually transmitted infections was the concern, or whether blood testing itself was the issue.

Comments made about the lack of appropriate clinical facilities appeared to focus on the need for privacy and for there to be an appropriate level of space for physical examinations to be undertaken.

The introduction of the community pharmacy contract in 2005 (105) brought with it a standard for a consultation room that was sufficient to engage in private conversations with patients about their medicines and the way that were used. The standard was not
rigorous enough to enable the provision of clinical services, such as those requiring
testing for sexually transmitted infections. The comments that were made by
respondents to the questionnaire suggest that this is considered both a missed
opportunity for the planning of future extended services and also a barrier to further
capital investment in pharmacy premises which were upgraded at that point. The
potential for return on investment by a contractor would need to be clearly
demonstrated.

The Grampian research (98) asked pharmacists whether they would make their
consultation rooms available to other professionals for them to provide services and
two-thirds agreed to this. This study did not specifically ask whether pharmacists
would offer this service. Although comments were made that sexual health services
should be offered by other health professionals, there was no clear indication that they
should offer them from within the community pharmacy.

Overall it appears that pharmacists consider there to be a clear limit on the services
that they would offer from a community pharmacy setting. If the service requires the
pharmacist to undertake a physical examination of a client’s genital areas, undertake
swabbing or blood sampling related to sexually transmitted infections, or engage in
discussions related to cervical smear testing, then pharmacists do not consider it
appropriate that they offer this service.

If the service relates to provision of appropriate therapy, either by over the counter
sale or under a patient group direction, then the pharmacists consider it appropriate to
offer the service.

5.6 Reasons for offering sexual health services

The questionnaire included questions that were asked to try to determine the drivers
that underpinned the decisions that pharmacists made about offering sexual health
services.

Factors which respondents felt were to influence the decision were whether there was
a need to offer the professional service and whether the pharmacist considered it to
be an ethical action.
The other factors, the culture within which they lived, the potential for income generation and whether their religious beliefs supported service delivery, were not perceived to have an influence on the decision to offer the service.

This has not offered a good understanding of why pharmacists choose to offer services. The need for the service does not change when that service becomes available for offering through the community pharmacy setting; the difference is the availability of the service. And the need for services such as the screening and management of sexually transmitted infections is high, but pharmacists did not agree it was appropriate for them to offer these services, despite a strong argument that it would be more ethical to improve access to these services for patients.

It was clear that religious beliefs have no impact on the decision to offer services for the majority of the pharmacists who replied, suggesting that pharmacists recognise the professional approach of putting the needs of the patient first.

It would appear that this section of the questionnaire, which was intended to gather insight into why pharmacists chose to offer sexual health services, has not been successful. The results and comments that have been captured on this section do not offer a comprehensive view on why pharmacists would choose to offer sexual health services, nor on how more pharmacists could be encouraged to engage with offering these services. The researcher was also unable to identify from the results and comments any approaches that could be tried in the future to gather information on this area.

The researcher considers that this remains an interesting area for future investigation.

5.6.1 Summary

Pharmacists recognise their role across the wide sphere of sexual health service delivery and express agreement that the services which have traditionally been offered through pharmacy, together with those introduced over the last ten years, are appropriate. There is less certainty over the introduction of some of the newer services and it is not clear whether initial uncertainty when a service is introduced
demonstrates improvement as the service becomes familiar; there is a lack of research within this area.

Pharmacists consider that the delivery of sexual health services is relevant and appropriate for the community setting, with many recognizing the accessibility and availability of their practice. They expressed concerns at both the availability of appropriate training to support their role as it developed in sexual health services and felt that the structure offered by a PGD would offer them encouragement in offering new services.

5.6.2 Implications for pharmacy practice

It appears from this research that the pharmacists surveyed consider that they have now reached the limits of non-invasive roles for provision of sexual health services in the current community pharmacy setting. From this it may be seen that the current lack of provision, together with a lack of desire to engage in provision of invasive testing such as blood testing or to undertake physical examination in a community pharmacy setting, presents a barrier to the further development of additional sexual health services in community pharmacy.

Both of these services would need the pharmacy to offer appropriate consultation spaces and clinical facilities. Comments indicate that pharmacists believe that they will also need to manage their time effectively.

5.7 Development of a competence framework

Responses to the questionnaire indicate that the proposed competence framework is largely relevant to the role of the pharmacist, whether working in community pharmacy or in a different area of practice.

Each of the statements described what a healthcare professional may need to know or be able to do to offer sexual health services and pharmacists were asked to consider whether they felt it was applicable to the role of the community pharmacist when practising in community pharmacy, when practising in other settings, wherever they were practising or whether it was never the role of the pharmacist.
5.7.1 Competences relating to consultations skills

It was clear that pharmacists felt that there was a need to demonstrate competences related to their ability to undertake consultations. Although there was a higher proportion of pharmacists who felt that the need to take a sexual history to assess risk of pregnancy and sexually transmitted infections was relevant when pharmacists practised settings other than the community pharmacy, 73.4 percent of pharmacists felt that this was appropriate in a community pharmacy setting.

Higher proportions of pharmacists felt that it was important in the community pharmacy to adapt the consultation style to make sure that client could understand (87.2 percent) and to keep clear records (85.7 percent), with over two thirds of the group stating that these competences were needed wherever the pharmacist was practising.

With less than five percent of respondents stating that these competences were not needed for the pharmacist's role, it is clear that pharmacists recognise the importance of consultation skills in practice when offering sexual health services.

5.7.2 Competences relating to consultations with young people

There was a high level of agreement from respondents that they needed to demonstrate competence in their consultations with young people. Confidentiality was the most recognized competence, with 93.9 percent of respondents stating that this was essential in the community pharmacy setting. This links to the comments made about the need for areas to be available in the pharmacy that offer a high level of privacy, so that clients can talk without being overheard.

There was some discussion over the need for the prescriber to be made aware of the discussions held with clients in order to maintain a complete medical record, suggesting that some pharmacists are not clear on current practice within sexual health services.

Looking at the apparent need of the pharmacist to link with the prescriber on this issue, together with their preference for offering new services under a PGD protocol,
suggests that there is a need for pharmacists to feel confident that they are offering the services to the correct standard.

It is perhaps a little concerning that some pharmacists did not recognise the need for them to demonstrate competences in their awareness of child protection issues. As health professionals practising in England, all pharmacists are currently expected to be engaged in Child protection and to have appropriate safeguarding systems in place.

5.7.3 Competences related to contraceptive practice

When considering their competences related to contraceptive practice, there was an apparent variation in the extent to which pharmacists engaged. This correlated overall with the services that they had stated they were comfortable to offer.

Pharmacists did not feel that they needed to demonstrate competence in fitting and checking the diaphragm and cap in the community pharmacy setting; only 3.5 percent of respondents stated that this was appropriate. There was however recognition that pharmacists in other settings may be engaged in this activity, in which case the group felt that it was appropriate to demonstrate competence, with 44.4 percent considering this to be appropriate compared with 54.9 percent who felt it would never be appropriate.

Pharmacists showed a similar reluctance to engage in administering intramuscular injections in the community pharmacy setting, but could see that this may be a role in a different situation.

There was a difference between the agreement that a pharmacist needed to demonstrate competence in consulting for and supplying emergency hormonal contraception (90.5 percent of pharmacists agreed that this was needed) with those agreeing that pharmacists needed to have knowledge of emergency IUD and how to refer for this (74.4 percent of pharmacists agreed that this was needed). Current service structures, both using the license for the pharmacy product and PGD criteria for the prescription only product, require the pharmacist to be aware of local
procedures for the use of an emergency IUD when the time limit for use of EHC has been reached.

The researcher considers this to demonstrate a learning need for pharmacists in current practice in understanding the place of the emergency IUD and their role in referring for this.

5.7.4 Competences related to planning a pregnancy

Pharmacists recognised their role in supporting clients with planning pregnancies. In the quantitative section, 92.5 percent of pharmacists agreed that it was appropriate for pharmacists to offer testing for pregnancy. However, only 82.8 percent of respondents stated that pharmacists would need to demonstrate competency at performing a urine pregnancy test and giving results in an appropriate manner. It is possible that this reflects the availability of accurate home pregnancy tests which in many cases have replaced the pharmacy based testing service.

5.7.5 Competences related to knowledge of contraceptive methods

Pharmacists did not agree that they needed to be competent in discussing and advising on sterilisation methods for either males or females. This discussion is not invasive and would not require a different standard of consultation room to that which is currently given. No comments were made by respondents relating to engaging in discussions about sterilization so it is not known from this research why pharmacists felt that this was not a required competence.

Considering the shift seen in agreement over appropriateness of services with the passage of time, the researcher considers that the concept of discussing sterilisation is alien to the pharmacists who responded and so they could not see this being their role.

There was however a recognition that the pharmacist should be able to discuss and advise on natural family planning, with the majority (72.8 percent) considering that this would be when practising within settings other than the community pharmacy.
The researcher considers that the discussion regarding natural family planning is currently alien to community pharmacy practice. It is interesting to note that this concept was found to be more relevant to the role of the pharmacist than that of sterilization.

This is likely to prove an interesting an area for future exploration.

5.7.6 Competences related to sexual health and infections

There was general agreement that pharmacists should understand the principles of screening programmes for sexually transmitted infections, with 77.9 percent of respondents feeling that this was needed in community pharmacy practice.

When asked about the appropriateness of screening for sexually transmitted infections, 71 percent of pharmacists considered it was appropriate to screen for Chlamydia – less than 20 percent of pharmacists considered that it was appropriate to screen for any of the other named sexually transmitted infections.

However there was general agreement that pharmacists did not need to demonstrate competence in performing appropriate tests for men and women, with only 14.4 percent considering that this was needed in community pharmacy practice.

This may suggest that pharmacists associate screening with the management of Chlamydia infections; the pharmacist supplies the kit and sends a patient provided sample away for testing. The concept of testing for genital infections may therefore have been associated with the other genital infections named in the questionnaire.

Again most pharmacists did not agree that they needed to demonstrate competence in managing presentations of genital infections. Just 25.7 percent considered this to be relevant to community pharmacy practice, with 27.4 percent stating that this was not the role of the pharmacist. Earlier responses showed that around 40 percent of pharmacists felt it was appropriate for them to manage confirmed infections over the counter (except HIV – 20 percent and Chlamydia – 70 percent) and around 70 percent of pharmacists felt it was appropriate to manage confirmed infections under a PGD (except HIV – 40 percent and Chlamydia – 90%).
As 66.4 percent of respondents stated that the competence was required for those pharmacists practising in a different setting, this would suggest that many pharmacists consider the management of sexually transmitted infections to be a role that would be undertaken outside of the community pharmacy setting.

We have already seen that reasons for this include the perceived lack of privacy, the inappropriate provision of consultation rooms and lack of professional time.

However again there is a mismatch between the perceived appropriateness of providing a service and the need to demonstrate competence in that area.

5.7.7 Competences related to cervical cytology

It was apparent that pharmacists do not consider that they need to demonstrate competence in relation to cervical cytology. Less than half of the pharmacists considered that they needed to demonstrate competence in understanding screening programmes and recall systems – despite this being a large public health issue and a potential role for the pharmacist to engage with.

Pharmacists were clear that they did not consider it their role to be able to take cervical smears with 60.6 percent stating that this was not the role of the pharmacist. There was some suggestion that pharmacists could see this being a role that they could undertake, but not in the community pharmacy setting.

Pharmacists were also clear that they did not perceive that they had a role in being able to explain smear results and taking appropriate action. Although 56.9 percent of pharmacists could see that they could do this in a setting other than the community pharmacy, 39.3 percent of pharmacists did not consider that this was the pharmacist’s role.

Overall, there was a clear pattern from pharmacists that they consider issues relating to cervical cytology to be outside of the remit of those practising within community pharmacy.
5.7.8 Competences related to psychosexual issues

The final competence group related to psychosexual issues. There was no clear agreement from pharmacists on their need to demonstrate competence within this area. Over 25 percent of pharmacists did not consider it to be the role of the pharmacist meaning that consensus was not achieved for this competence. However, 62.4 percent of pharmacists considered that they would need to demonstrate this competence if practising in a setting other than the community pharmacy.

Although no direct comments relating to this competence were recorded in the comments section, there was indication from the comments that issues related to the need to counsel clients on the long term implications of sexually transmitted infections – for example with HIV testing – was an area where pharmacists were not fully comfortable.

The researcher considers that there may be a lack of understanding of exactly what this competence statement refers to, which may have made it difficult for participants to understand. The statement was not challenged during the testing and piloting processes however.

5.8 Developing a competence framework

5.8.1 Setting a consensus level

The guide to developing competences from the Chartered Institute of Personnel and Development advises that consensus should be achieved on determining whether to include a particular competence statement. It does not state the level of agreement at which consensus can be said to take place.

None of the literature on the development of competence frameworks for pharmacists which used a consensus method stated the level of consensus which had to be attained, or the approach to consensus that was taken. It was decided to use a 75 percent consensus point for this competence framework.
5.8.2 Competences where consensus was not attained

Applying the level of 75 percent found that the following competences were not felt to be applicable to the role of the pharmacist, regardless of setting.

These were:

- to be able to fit and check the fitting of a diaphragm and a cap, and
- To be able to take cervical smears.
- To be able to provide essential advice and information prior to insertion of intrauterine method or subdermal implant
- To be able to give an intramuscular injection
- To be able to discuss and advise on sterilization for male and females
- To be able to perform appropriate tests for genital infections in men and women
- To be able to manage presentations of all common genital infections in men and women
- To be able to manage pelvic pain appropriately
- To demonstrate knowledge and communication skills required for pre-test HIV discussion
- To be able to explain cervical smear results and take appropriate action, and
- To understand sexual dysfunction, exploring psychological and physical factors and give advice.

We have seen that this demonstrates a correlation between the reluctance of the pharmacist to engage in screening of an invasive nature and the demonstration of competences related to invasive procedures.

Removing these competences from the framework would provide a consensus model against which learning programmes and assessments could be constructed.
5.8.3 Competences relating to specific sexually transmitted infections

Whether this framework would be applicable to services being offered through the community pharmacy setting would require additional testing as this research asked pharmacists to consider their practice as a pharmacist in other settings as well. It was clear from the responses gathered that pharmacists considered the management of Chlamydia to be appropriate through the community pharmacy setting, but other STIs, requiring invasive testing procedures, were not felt to be appropriate for pharmacist management.

However, two of the competences considered not to be applicable for pharmacy services did not differentiate between the management of different STIs. They were possibly too general for a pharmacy service model which manages only certain STIs. These statements were:

- To be able to perform appropriate tests for genital infections in men and women
- To be able to manage presentations of all common genital infections in men and women

It would seem appropriate that pharmacists who offered testing services for a specific genital infection, or who managed that infection, were able to demonstrate competence in that particular genital infection.

The researcher proposes that these statements should be made specific to the infections to be tested for and managed within the pharmacy setting and that an additional competence statement regarding referral of other infections be included within the framework.

Additional research which considered each sexually transmitted infection would allow this hypothesis to be tested. This was not undertaken with this research as it would have resulted in the survey tool becoming much longer and more unwieldy. Reasons given for not completing the questionnaire demonstrate that some of the cohort already considered the questionnaire to be too long.
Including specific sexually transmitted infections within the competences listed would allow a competence framework to be developed for pharmacists which met the criteria described within the introduction. Specific learning modules could then be developed for pharmacists who wished to manage additional sexually transmitted infections.

5.8.4 Assessment of the competence framework

The competence framework proposed here can be assessed against the key criteria which were discussed in the introduction.

- Does it involve the people who will be affected by the framework?
- Is it clear and easy to understand?
- Is it relevant to all staff that will be affected by the framework?
- Does it take account of expected changes, e.g. future work practices?
- Does it have discrete elements?
- Is it fair to all affected by its use?

5.8.5 Does it involve the people who will be affected by the framework?

This framework has been considered by community pharmacists who are in current practice. The sample who responded were representative of ethnicity, role and practising location of the profession, but women were over represented compared to men. The framework has therefore involved the people who would be affected by it, but further consideration relating to the views of male pharmacists may be useful to add insight relative to their perceptions.
5.8.6 Is it clear and easy to understand?

Before the framework was tested by pharmacists, it underwent three distinct review processes to remove ambiguities and to ensure that it was clear and easy to understand. Testing the framework has resulted in the modification of two of the competence statements regarding testing for and managing infections.

Overall response rates to the competence statements were high (n ranges from 771 to 782 out of 784 total respondents). This suggests that respondents were able to understand the statements as presented.

The framework has been tested to be clear and easy to understand.

5.8.7 Is it relevant to all staff that will be affected by the framework?

The framework was tested against the staff group who would be affected by the framework. Some caution must be expressed in that the sample size offers insight to the population of community pharmacists as a whole but may not be generalisable to the whole profession. There was also over representation of women compared to men.

5.8.8 Does it take account of expected changes, e.g. future work practices?

As the framework considered services which are currently offered, those which are being introduced at present, those which have been proposed for the future and those which are not proposed, nor offered, the framework may be considered to take account of expected changes for the professional role and future work practices.
5.8.9 **Does it have discrete elements?**

Testing of the framework prior to dissemination of the questionnaire sought to ensure that the competence statements were discrete. Reflection on the final competence statements during the analysis stage has demonstrated that some broad statements may benefit from being made explicit, for example specifying the sexually transmitted infections for which competence should be demonstrated.

Overall the framework was shown to have discrete statements.

5.8.10 **Is it fair to all affected by its use?**

The competence framework has been tested by a large population of pharmacists who were seen to offer good representation of the profession as a whole. This shows that it is appropriate for all affected by its use. The concept of fairness is more challenging to test. Issues relating to contraception and sexual health evoke strong responses according to the beliefs of individuals concerned. Those with strong beliefs in this area may feel that any competence framework related to these issues would not be fair to them. However, there was no evidence in the responses that the majority of pharmacists considered that offering sexual health services was inappropriate for their professional role. Just two pharmacists felt strongly enough about the impact of offering sexual health services on their personal morals and belief structure to include these thoughts in their responses. Their comments were however detailed and demonstrated very strong feelings.

The framework has been agreed by a majority of pharmacists, showing general representation of the profession as a whole. Less than 25 percent of respondents have disagreed with any of the competence statements. This would suggest that the framework was fair to the majority of those affected by its use. Testing of the proposed competence framework with community pharmacists would allow the fairness of the framework to be confirmed. From this research, the researcher considers it is appropriate to say that the framework has been shown to be relevant to all affected by its use.
5.9 Summary

The responses to the research have demonstrated that pharmacists clearly consider that the sexual health services which they currently offer, whether traditional or introduced over the last ten years, are appropriate for their practice. There was also recognition, as seen throughout the questionnaire, that sexual health services are linked and that pharmacists need to be competence across many different areas.

Introducing additional services to community pharmacy practice is likely to meet with approval where the service is non-invasive and ideally introduced at first under a PGD system.

Before services which require blood testing or examination of genitals is introduced, consideration must be given to improving the clinical facilities which are available within the community pharmacy, supporting the ability of the pharmacist to engage in time consuming professional discussions and in helping pharmacists recognise the need for a paradigm shift in their thoughts of their role. It has been found in the research that clients prefer a clinical setting and this was reinforced by the responses to this study.

There remains concern with regards to the workload of the pharmacist and the availability of sufficient professional time to meet the needs of the customers in introducing new services.

Research into those sexual health services which have been introduced has indicated that appropriate training is needed and this was reinforced by the respondents to this study who indicated that they needed appropriate training, although they were not clear on what this training needed to be. The competence framework offers one approach by which structured learning programmes may be developed. These learning programmes would then have been developed specifically to meet the needs of the full range of sexual health services which were being provided.

Pharmacists recognised the relevance of the competence framework to their current and future practice in both community pharmacy and other clinical settings.
6. Conclusions

It was seen that community pharmacists are comfortable at offering certain sexual health related services and that this is true regardless of the gender, ethnicity, role or practising location of the individual.

Those services which include invasive procedures were not widely considered to be appropriate to the role of the community pharmacist as facilities were not appropriate, although it was recognized that pharmacists could offer these in other settings, given appropriate training and sufficient time.

The competence framework of the Faculty of Sexual and Human Reproduction had many areas of relevance to the developing role of the community pharmacist and the following framework in table 23 has been shown to be appropriate and suitable for ongoing development.

Table 23. Proposed competences for pharmacists offering sexual health services

<table>
<thead>
<tr>
<th>Consultation skills</th>
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<tbody>
<tr>
<td>Takes a sexual history to assess risk of pregnancy and sexually transmitted infections</td>
</tr>
<tr>
<td>Adapts consultation style to make sure that the client understands</td>
</tr>
<tr>
<td>Keeps clear records</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Consultations with young people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understands the importance of confidentiality</td>
</tr>
<tr>
<td>Has awareness of child protection issues</td>
</tr>
<tr>
<td>Can apply the law relating to consent (specifically for people under the age of 16)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Contraceptive practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrates the ability to conduct an effective contraceptive choice consultation</td>
</tr>
<tr>
<td>Provides essential advice and information when providing oral hormonal contraception for the first time</td>
</tr>
<tr>
<td>Explains the relative and absolute contraindications for providing oral hormonal</td>
</tr>
</tbody>
</table>
contraception for the first time

Advises on action to take in case of problems related to oral hormonal contraception

Demonstrates the teaching of male and female condom use

Consults for and supplies hormonal emergency contraception

Has knowledge of emergency intrauterine device and how to refer for this

**Pregnancy planning**

Performs a urine pregnancy test and gives result in an appropriate manner

Has skills to consult on unintended pregnancy

**Knowledge of methods of contraception and ability to discuss and advise client on them**

Can discuss and advise on natural family planning

**Sexual health and infections**

Understands principles of screening programmes for sexually transmitted infections

Can perform appropriate tests for Chlamydia in men and women*

Is able to counsel a client with a positive diagnosis of a sexually transmitted infection

Understands the principles of notifying sexual partners about positive test results

Can manage presentations of Chlamydia in men and women*

Is able to manage vaginal discharge appropriately

Refers appropriately for genital infections outside of their competence

**Cervical cytology**

Understands cervical screening programmes and recall systems

*As additional sexually transmitted infections are moved across to management within a community pharmacy setting, this competence framework should be amended to include them.
This framework provides a structure which could be used to support the development of learning programmes for pharmacists who are offering sexual health services. It would also allow the development of an assessment tool which would reassure the pharmacist, and the service commissioner, of their ability and competence.
7. References


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(39) Spooner LM. The expanding role of the pharmacist in the management of hepatitis C infection. J Manag Care Pharm 2011 Nov;17(9):709-12.


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(64) CPPE. Emergency contraception open learning programme. Manchester: CPPE; 2005.

(65) CPPE. Dealing with difficult discussions open learning programme. Manchester: CPPE; 2006.


(72) CoDeG. A developmental framework for pharmacists progressing to advanced levels of practice. London: Competency Development Group; 2009.


(92) Faculty of family planning. Checklist for assessment for the Diploma of the faculty of family planning. London: Faculty of Family Planning; 2005.


(97) Seston EM, Hassell K. Pharmacy Workforce Census 2008: Main findings. Manchester: Centre for Pharmacy Workforce Studies; 2009 Jul.


(102) Laing A. Teenage girls offered contraceptive pill over the counter in drive to cut pregnancies. Daily Telegraph 2009.


8. Appendices

Appendix A: National service specification for provision of Emergency Hormonal Contraception

NHS Community Pharmacy Contractual Framework
Enhanced Service – Emergency Hormonal Contraception Service

1. Service description

1.1 Pharmacists will supply Levonorgestrel Emergency Hormonal Contraception (EHC) when appropriate to clients in line with the requirements of a locally agreed Patient Group Direction (PGD). The PGD will specify the age range of clients that are eligible for the service; it may facilitate supply to young persons under 16 in appropriate circumstances.

1.2 Pharmacies will offer a user-friendly, non-judgmental, client-centred and confidential service.

1.3 The supply will be made free of charge to the client at NHS expense.

1.4 Pharmacists will link into existing networks for community contraceptive services so that women who need to see a doctor can be referred on rapidly.

1.5 Clients excluded from the PGD criteria will be referred to another local service that will be able to assist them, as soon as possible, e.g. GP, community contraception service, or will be invited to purchase the Pharmacy medicine product if the exclusion from supply via the PGD is only due to an administrative matter, e.g. age range determined by the commissioner.

1.6 The pharmacy will provide support and advice to clients accessing the service, including advice on the avoidance of pregnancy and sexually transmitted infections (STIs) through safer sex and condom use, advice on the use of regular contraceptive methods and provide onward signposting to services that provide long-term contraceptive methods and diagnosis and management of STIs.

2. Aims and intended service outcomes

2.1 To increase the knowledge, especially among young people, of the availability of emergency contraception and contraception from pharmacies.

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9 Example PGDs are available on the National Electronic Library for Medicines PGD portal: www.nelm.nhs.uk.
10 EHC is available for sale in pharmacies as a Pharmacy medicine only in compliance with the requirements of the marketing authorisation for the over the counter product.
11 Emergency contraception methods are not limited to EHC and include the use of Intra-uterine devices (IUDs). Though this service would only supply EHC, it would raise awareness of other methods of emergency contraception that are available and facilitate access to these.
2.2 To improve access to emergency contraception and sexual health advice.

2.3 To increase the use of EHC by women who have had unprotected sex and help contribute to a reduction in the number of unplanned pregnancies in the client group.

2.4 To refer clients, especially those from hard to reach groups, into mainstream contraceptive services.

2.5 To increase the knowledge of risks associated with STIs.

2.6 To refer clients who may have been at risk of STIs to an appropriate service.

2.7 To strengthen the local network of contraceptive and sexual health services to help ensure easy and swift access to advice.

3. Service outline

3.1 The part of the pharmacy used for provision of the service provides a sufficient level of privacy (ideally at the level required for the provision of the Medicines Use Review service\(^\text{12}\)) and safety and meets other locally agreed criteria.

3.2 A service will be provided that assesses the need and suitability for a client to receive EHC, in line with the PGD\(^\text{13}\). Where appropriate a supply will be made; where a supply of EHC is not appropriate, advice and referral to another source of assistance, if appropriate, will be provided. Clients who have exceeded the time limit for EHC will be informed about the possibility of use of an IUD and should be referred to a local service as soon as possible.

3.3 Inclusion and exclusion criteria, which are detailed in the PGD, will be applied during provision of the service. The Summary of Product Characteristics should be consulted when service documentation is being developed (www.medicines.org.uk).

3.4 The service will be provided in compliance with Fraser guidance\(^{14}\) and Department of Health guidance on confidential sexual health advice and treatment for young people aged under 16\(^{15}\).

3.5 The service protocols should reflect national and local child and vulnerable adult protection guidelines\(^{16}\).

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\(^{13}\) Commissioners may wish to consider the inclusion of pregnancy testing as part of the service.

\(^{14}\) Fraser Guidelines – based on a House of Lords Ruling; A health professional can give advice or treatment to a person under 16 without parental consent providing they are satisfied that;
  - The young person will understand the advice;
  - The young person cannot be persuaded to tell his or her parents or allow the doctor to tell them that they are seeking contraceptive advice;
  - The young person is likely to begin or continue having unprotected sex with or without contraceptive treatment; and
  - The young person's physical or mental health is likely to suffer unless he or she receives contraceptive advice or treatment.

\(^{15}\) Guidance available at www.dh.gov.uk/sexualhealth.
3.6 Verbal and written advice on the avoidance of STIs and the use of regular contraceptive methods, including advice on the use of condoms, will be provided to the client. This should be supplemented by a referral to a service that can provide treatment and further advice and care.

3.7 The pharmacy contractor has a duty to ensure that pharmacists and staff involved in the provision of the service have relevant knowledge and are appropriately trained in the operation of the service, including sensitive, client centred communication skills. This may be facilitated by the provision of local training by the PCO.

3.8 The pharmacy contractor has a duty to ensure that pharmacists and staff involved in the provision of the service are aware of and operate within local protocols.

3.9 The pharmacy must maintain appropriate records to ensure effective ongoing service delivery and audit. Records will be confidential and should be stored securely and for a length of time in line with local NHS record retention policies.

3.10 Pharmacists may need to share relevant information with other health care professionals and agencies, in line with locally determined confidentiality arrangements, including, where appropriate, the need for the permission of the client to share the information.

3.11 The PCO should arrange at least one contractor meeting per year to promote service development and update pharmacy staff with new developments, knowledge and evidence.

3.12 The PCO will need to provide a framework for the recording of relevant service information for the purposes of audit and the claiming of payment.

3.13 The PCO will need to provide up to date details of other services which pharmacy staff can use to refer service users who require further assistance. The information should include the location, hours of opening and services provided by each service provider. Details of services for young people can be obtained from the local Teenage Pregnancy Coordinator.

3.14 The PCO will be responsible for the promotion of the service locally, including the development of publicity materials, which pharmacies can use to promote the service to the public.

3.15 The PCO will be responsible for the provision of health promotion material, including leaflets on EHC, long-term contraception and STIs to pharmacies.

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16 The cross government guidance on child protection, Working Together to Safeguard Children, should be referred to and is available at www.everychildmatters.gov.uk/workingtogether
17 Commissioners may wish to consider the inclusion of condom supply as part of the service and the integration of participating pharmacies into the local Chlamydia screening programme.
4. **Suggested Quality Indicators**

The pharmacy has appropriate PCO provided health promotion material available for the client group, actively promotes its uptake and is able to discuss the contents of the material with the client, where appropriate.

The pharmacy reviews its standard operating procedures and the referral pathways for the service on an annual basis.

The pharmacy participates in an annual PCO organised audit of service provision.

The pharmacy co-operates with any locally agreed PCO-led assessment of service user experience.

Pharmacists and appropriate support staff attend a PCO organised update meeting each year.

**Background information – not part of the service specification**

Reducing the under-18 conception rate by 50% by 2010 is a Department of Health and Department for Education and Skills Public Service Agreement.

All areas have agreed 2010 local reduction targets for under 18 conception rates.

Choosing Health Through Pharmacy  A programme for pharmaceutical Public Health, published in April 2005 encourages PCTs to consider commissioning sexual health services through pharmacy, including access to EHC, condoms and signposting to appropriate sources of advice and support, particularly in disadvantaged areas

**CPPE training which may support this service:**

Emergency Hormonal Contraception Open Learning Pack

Emergency Hormonal Contraception Workshop

Sexual Health: testing and treating Open Learning Pack

Sexual Health: testing and treating Workshop

Contraception Open Learning Pack

Child Protection: a guide for the pharmacy team Open Learning Pack
Appendix B National service specification for screening for Chlamydia infection

NHS Community Pharmacy Contractual Framework
Enhanced Service – Chlamydia testing and treatment

Background

Genital chlamydia infection is the most commonly diagnosed bacterial sexually transmitted infection (STI) in England. Prevalence of the infection is highest in sexually active young men and women under the age of 25 years. Untreated infection can have serious long-term consequences. In women it can lead to pelvic inflammatory disease (PID), ectopic pregnancy and tubal infertility. In men it can lead to epididymitis and epididymo–orchitis. In both men and women it can lead to Reiter’s Syndrome. The infection often has no symptoms but is easy to diagnose and treat. Treatment and partner notification can reduce complications which are estimated to cost the NHS millions of pounds per year.

The National Chlamydia Screening Programme (NCSP) in England was established in 2003. It offers free opportunistic testing, treatment and partner management and prevention to sexually active young men and women under the age of 25. The goals of the programme are to:

- Prevent and control chlamydia through early detection and treatment of asymptomatic infection;
- Reduce onward transmission to sexual partners;
- Prevent the consequences of untreated infection.

The NCSP is managed by the Health Protection Agency. All Primary Care Trusts (PCTs) in England have received Department of Health (DH) funding to commission local chlamydia testing programmes. The NCSP has produced guidance to support PCTs in the delivery of the programme including specific advice for general practice and community pharmacy\(^\text{18}\).

Community pharmacies are likely to play an increasing role in the delivery of sexual health services building on the success of pharmacy-based emergency hormonal contraception (EHC) programmes. The 2008 Pharmacy White Paper\(^\text{19}\) includes a range of specific proposals on the contribution that pharmacies can make to sexual health services nationally. In 2008/09 2% of tests were carried out in community pharmacies, with wide regional and local variation in their engagement in the programme.

\(^{18}\) NCSP guidance documents, including the Core Requirements are available at www.chlamydiascreening.nhs.uk.

\(^{19}\) www.dh.gov.uk/en/Healthcare/Medicinespharmacyandindustry/PharmacyWhitePaper/index.htm
Maximising the capacity of both community pharmacy and general practice to deliver chlamydia testing, treatment and partner management is likely to be a cost effective strategy. Indeed as the DH chlamydia testing pilot demonstrated, high testing coverage is feasible when core community based services are major contributors. Core community based services can be defined as:

Contraception and Sexual Reproductive Health services
Abortion services
Community Pharmacy
General Practice

If the currently engaged core community service venues tested at least one person a day, over 1.8 million young people would be tested in a year. This equates to approximately 26% coverage of the 15-24 year old population generated through core services alone. If engagement of core services increased to 60% and each of them tested one young person a day, close to 4 million young people would be tested each year which would afford 58% coverage of the 15-24 year old population.

In November 2005 DH procured a community pharmacy based pilot of free chlamydia testing and treatment for 16-24 year olds. The evaluation demonstrated that over 87% of young people reported they would recommend the service. This demonstrates that pharmacy is an ideal setting for the provision of Chlamydia testing services. PCTs across the country are commissioning Chlamydia testing services alongside EHC, condom distribution and other sexual health services from community pharmacies.

1. **Aims and intended service outcomes**

To increase access to the NCSP by providing additional locations where people can access testing and treatment for Chlamydia.

To increase access to treatment of asymptomatic individuals with Chlamydia infection.

To increase access for young people, to sexual health advice and referral on to specialist services where required.

To increase clients’ knowledge of the risks associated with STIs.

To strengthen the network of contraceptive and sexual health services to help provide easy and swift access to advice.

2. **Service description**

2.1 Pharmacies will provide Chlamydia testing kits to people under the age of 25, for example when young people purchase condoms, when oral contraceptive pills are
dispensed and supplied to patients and when supplying EHC, as specified by the commissioner.

2.2 Advice on how to utilise the kit, how to return it for testing and what will happen following completion of the test will be provided in line with the approach adopted by the commissioner.

2.3 The service will form part of the locally run NCSP. The NCSP core requirements specify that providers of any element of Chlamydia testing should:

Identify a named Chlamydia lead to communicate with the commissioner and other relevant stakeholders.

Utilise and prominently display relevant national and local sexual health and Chlamydia testing materials.

Ensure that staff are appropriately trained to deliver the programme.

Offer user friendly, non judgemental, patient centred and confidential services in line with the 'You’re Welcome' criteria.

Provide people testing for Chlamydia, with an information leaflet as part of the consent process.

Adhere to national and local requirements regarding the management of under 18s.

Be responsible for ensuring timely onward referral for those people who they are not able to support or manage.

Be responsible for providing all mandatory data reporting to the commissioner and relevant stakeholders.

2.4 Pharmacies may inform people of their results, undertake contact tracing and/or offer treatment in line with the requirements of a locally agreed Patient Group Direction (PGD) if required by the PCT. A number of combinations of these options are available including:

Solely distribute postal Chlamydia testing kits;

Provide Chlamydia testing;

Provide treatment and instigation of partner notification;

Provide Chlamydia testing, treatment and instigation of partner notification.

In all instances the service should be offered to sexually active people under 25 years old.

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21 Examples of PGDs are available on the PGD portal at www.nelm.nhs.uk.
2.5 Pharmacies distributing postal Chlamydia testing kits should provide advice on how to utilise the kit, how to return it for testing and what will happen following completion of the test including how people will be notified of their results.

2.6 Pharmacies providing Chlamydia testing should deliver the services identified below to people who are either requesting Chlamydia testing or seeking advice about other sexual health concerns or as part of a service to all people in the appropriate age group:

People should be provided with information about Chlamydia and other sexual health promotion including the benefits of testing, specimen collection, management of results and access to free treatment;22

People declaring symptoms suggestive of sexual ill health should be offered referral to an appropriate service. This may include referral to the local sexual health service;

If following risk assessment, the person is identified as being eligible for testing, the appropriate electronic or paper form should be completed;

Contact details should be requested and preferably two methods of contact should be recorded and verified;

Samples and forms should be collected for analysis in a timely manner, as defined by the local operational guidance;

People should be signposted to other sexual health services as appropriate; and

Free condoms should be available (subject to commissioning of the service).

2.7 Pharmacies will link into existing local networks of community sexual health services so that there is a robust and rapid referral pathway for people who need onward signposting to services that provide on-going contraception, for example long acting reversible contraception (LARC) and diagnosis and management of other STIs.

2.8 Pharmacies will provide support and advice to people accessing the service, including advice on safe sex, condom use and advice on the use of regular contraceptive methods, when required.

3. Service outline

The pharmacy will offer people less than 25 years of age, a Chlamydia testing and treatment service; the benefits of testing will be explained. People less than 16 years of age will be provided with the service, if deemed Fraser competent. A locally agreed referral pathway will provide for the referral of people less than 16 years of age who

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22 People requiring treatment for STIs should receive this free of any prescription charge or, if this is not possible (e.g. where FP10 prescriptions are used) and the service user is not exempt, they should be offered access to another provider if they wish. Medication for the treatment of STIs should ideally be supplied at the time of diagnosis.
present for testing and who are not deemed to be Fraser competent, and those over 25 years of age.

The service will be provided in compliance with Fraser guidance\(^{23}\), Department of Health guidance on confidential sexual health advice and treatment for young people aged under 16 years\(^{24}\) and the ‘You’re Welcome’ standards\(^{1}\).

The pharmacy staff will obtain informed consent and comply with the local and core NCSP requirements, including providing the person with a copy of the NCSP national leaflet. The pharmacy staff will describe the testing process and how results will be communicated to the person. The person will be supplied with a Chlamydia testing kit, supplied by the commissioner (or via other locally agreed arrangements)\(^{25}\).

The part of the pharmacy used for the provision of the service must provide a sufficient level of safety and privacy (including visual privacy where appropriate), which in most circumstances will be at the level required for the provision of the Medicines Use Review service\(^{26}\).

The pharmacy contractor must ensure that pharmacists and staff involved in the provision of the service have relevant knowledge and are appropriately trained in the operation of the service, including sensitive, client-centred communication skills. Pharmacists and staff providing this service should also be aware of local and national guidance on safeguarding vulnerable groups, as it is possible that people from vulnerable groups will request testing. Development of the knowledge base of staff may be facilitated by the provision of local training by the PCT.

The pharmacy contractor must have a standard operating procedure in place for this service. The pharmacy contractor must ensure that pharmacists and staff involved in the provision of the service are aware of and operate within national and locally agreed protocols.

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\(^{23}\) Fraser Guidelines – based on a House of Lords Ruling; a health professional can give advice or treatment to a person under 16 without parental consent providing they are satisfied that:

- The young person will understand the advice;
- The young person cannot be persuaded to tell his or her parents or allow the doctor to tell them that they are seeking contraceptive advice;
- The young person is likely to begin or continue having unprotected sex with or without contraceptive treatment; and
- The young person’s physical or mental health is likely to suffer unless he or she receives contraceptive advice or treatment.

\(^{25}\) Some PCTs test for gonorrhoea as part of the sample analysis. Where this additional test is undertaken, the person must be made aware of testing for gonorrhoea and provide informed consent for this.

\(^{26}\) The requirements for consultation areas are detailed in The Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2005 as amended (\texttt{www.dh.gov.uk/assetRoot/04/10/75/97/04107597.pdf}).
The pharmacy must maintain appropriate records to ensure effective ongoing service delivery and audit. Records are confidential and should be stored securely and for a length of time in line with local NHS record retention policies.

Pharmacists may need to share relevant information with other health care professionals and agencies, in line with local and national confidentiality and data protection arrangements, including the need for the permission of the person to share the information.

The PCT will provide a framework for the recording of relevant service information (including the national core dataset) for the purposes of audit and the claiming of any payment.

The PCT will provide up to date details of other services, which pharmacy staff can use to refer on service users who require further assistance. The information should include the location, hours of opening and services provided by each service provider. The information could be assigned a review date, in order to allow pharmacy contractors to be assured that they are using the current version of the PCT information.

The PCT should arrange at least one contractor meeting per year to promote service development and update pharmacy staff with new developments, knowledge and evidence.

The PCT will be responsible for the provision of health promotion and other promotional material, including the NCSP patient leaflet, leaflets on EHC, long-term contraception and other STIs to pharmacies.

The PCT will coordinate the promotion of the service locally, including the development of publicity materials and the use of nationally produced materials, in order to ensure young people and other local health care providers are aware that the service is available from local pharmacies. Pharmacies should use these materials to promote the service to the public and should ensure they coordinate their promotional activities with those of the PCT.

**Notification of results and contact tracing**

Where the pharmacy is responsible for notifying people of the result of testing and/or contact tracing, a locally agreed protocol will be followed that complies with the core requirements of the NCSP.

Verbal and written advice on the avoidance of STIs and the use of regular contraceptive methods, including advice on the use of condoms²⁷, shall be provided to

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²⁷ Commissioners may wish to consider the inclusion of condom supply as part of the service and the integration of participating pharmacies into the local Chlamydia testing programme.
the person. This should be supplemented by a referral to a service that can provide further advice and care where appropriate.
Treatment of infection

3.16 Where the pharmacy is commissioned to provide a treatment service, locally agreed guidance will be followed that complies with the core requirements\(^{28}\) of the NCSP. The pharmacy will assess the suitability of the person to receive the locally agreed antibiotic treatment, in line with the inclusion and exclusion criteria detailed in the PGD. Where appropriate a supply will be made; where a supply of the specific antibiotic is not appropriate, the person should be referred to the local sexual health services.

4. Quality Indicators and Key Performance Indicators (KPIs)

The pharmacy has appropriate PCT-provided health promotion and other promotional material available for the client group, actively promotes its uptake and is able to discuss the contents of the material with the client, where appropriate.

The pharmacy is making full use of promotional material provided by the PCT.

The pharmacy reviews its standard operating procedures and the referral pathways for the service on an annual basis.

The pharmacy participates in an annual PCT organised audit of service provision.

The pharmacy co-operates with any national or PCT-led assessment of service user experience.

The pharmacy can demonstrate that pharmacists and staff involved in the provision of the service have undertaken CPD relevant to this service.

Pharmacists and appropriate support staff attend a PCT organised update meeting each year.

4.8 The following three KPIs are considered by the NCSP as being core for services commissioned to provide the relevant elements of the Chlamydia pathway:

- **Number of Chlamydia tests**

- % of the target population each provider is responsible for testing.

  (Standard: performance against specific agreed targets for each participating community pharmacy that are linked to another PCT funded sexual health service).

- **Turnaround time from the date of the test to notification of results**

  Time from date of test to notification of result by provider, laboratory or other provider as appropriate.

\(^{28}\) National Chlamydia Sc [www.chlamydiascreening.nhs.uk](http://www.chlamydiascreening.nhs.uk).
(Standard: 90% of results notified within 10 working days of test taken).

Partner notification

Rate of partner notification for Chlamydia and gonorrhoea by provider.

(Standard: at least 0.4 contacts per index case in large conurbations or 0.6 contacts elsewhere within four weeks).

Treatment rates

% of Chlamydia positive index cases receiving treatment.

(Standard: 95% of index cases confirmed to have received treatment).

<table>
<thead>
<tr>
<th>Background information – not part of the service specification</th>
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<tbody>
<tr>
<td>The following documents and websites provide background information on Chlamydia testing and treatment:</td>
</tr>
<tr>
<td>National Chlamydia Screening Programme</td>
</tr>
<tr>
<td><a href="http://www.chlamydiascreening.nhs.uk">www.chlamydiascreening.nhs.uk</a></td>
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<tr>
<td>Standards for the Management of STIs (2009)</td>
</tr>
<tr>
<td><a href="http://www.medfash.org.uk">www.medfash.org.uk</a></td>
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<tr>
<td>The Manual for Sexual Health Advisors</td>
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<tr>
<th>CPPE products which may support this service:</th>
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<tbody>
<tr>
<td>Sexual Health: testing and treating (Open Learning Pack)</td>
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<tr>
<td>Contraception (Open Learning Pack)</td>
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<td>Dealing with difficult discussions (Open Learning Pack)</td>
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<td>Safeguarding Children (Open Learning Pack)</td>
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<td>Child health: working with the NSF for Children, Young People and Maternity Services (Open Learning Pack)</td>
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Appendix C HAG framework for provision of an EHC service

Community Pharmacy Enhanced Services

Competencies and Training Framework

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<tr>
<th>Enhanced Service:</th>
<th>Provision of an Emergency Hormonal Contraception (EHC) Service</th>
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<tr>
<td>Version:</td>
<td>Version 2c (See Section 9 for how this version differs from the previous version)</td>
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<tr>
<td>Issue Date:</td>
<td>May 2009</td>
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<td>Review Date:</td>
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<td>Harmonisation of Accreditation Group (HAG)</td>
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1. **Introduction**

Community Pharmacists wishing to provide EHC as an enhanced service via a Patient Group Direction must be accredited and have their names on an enhanced service provider list kept by the PCT on whose behalf they are providing the service. Throughout this document the abbreviation PCT is used in place of “Primary Care Trusts or other Commissioning Bodies”.

The information in this document outlines the purpose and design of suitable local training, which will allow Community Pharmacists to become accredited and recognised by all PCTs that endorse the standards set by the Harmonisation of Accreditation Group (HAG).

The HAG has approved the following process.

2. **Core Competencies**

These core competencies have been linked, where appropriate, to the general pharmacist competences of the Royal Pharmaceutical Society of Great Britain which are shown in [ ] and are mapped to the General Level Framework (available at www.codeg.org).

   a) Able to communicate with clients appropriately and sensitively [G1, G2].
   b) Able to counsel and advise on emergency contraception and regular methods of contraception [G2, G7].
   c) Understands how and when to refer clients and when to ask for support and advice [G7].
   d) Understands confidentiality issues and is aware of their role in the process of child protection [G8].
   e) Understands the different types and methods of hormonal contraception and non-hormonal contraception; their use, advantages, failure rates and complications [G1].
| f) | Understands the pharmacotherapy for the full range of available medication and appropriate clinical guidance (e.g. NICE). [G1] |
| g) | Understands and is able to apply the medico-legal aspects of EHC provision in accordance with a Patient Group Direction [G5]. |
| h) | Able to demonstrate knowledge of the clinical content of the relevant Patient Group Direction(s). [G1] |

3. **Framework of Training**

3.1 **Underpinning Knowledge**

Three Centre for Pharmacy Postgraduate Education (CPPE) learning packs provide pharmacists with the necessary knowledge to underpin the provision of EHC as an enhanced service:

- CPPE Emergency Contraception Open Learning Programme (3 Hours)
- CPPE Contraception Open Learning Programme (12 Hours)
- CPPE Child Protection Open Learning Programme (1.5 Hours)

Successful completion of the Emergency Contraception Open Learning Programme and the assessment is a pre-requisite to attending the PCT Commissioned Workshop. The Contraception and Child Protection Open Learning Programmes and their assessments should be completed before or within 3 months of attending the Workshop. The CPPE programmes provide pharmacists with a record of assessment which must be retained by the pharmacist, together with the EHC *Patient Group Direction, and copies sent to the accrediting PCT. Alternatively, individuals can also allow access to their online records by switching on the CPPE viewer via the My CPPE page on the CPPE website ([www.cppe.ac.uk](http://www.cppe.ac.uk)).

Individual commissioners may agree to recognise other training courses provided that they deliver the equivalent knowledge and learning outcomes (see Section 8) as the CPPE programme(s) stipulated above. The current versions of learning programmes must be completed as part of any training undertaken. The latest versions of CPPE Open Learning Programmes can be confirmed by accessing [www.cppe.ac.uk](http://www.cppe.ac.uk).

(*A CPPE Open Learning Programme is available for those Pharmacists who are not familiar with the concept of Patient Group Directions and wish to learn more.*)

3.2 **PCT Commissioned Workshop**

PCTs may wish to deliver this training over more than one session where appropriate. Training providers should decide on the most suitable format for the Workshop, which may vary according to local provision and need. CPPE provides advice on running workshops to train pharmacists and their teams on enhanced services through its *local solutions* programmes. See the CPPE website to download the *local solutions* materials for the Emergency Hormonal Contraception service.

**a) Aims**

The aim is to enable Community Pharmacists to become competent to provide an EHC service that includes the supply of a Prescription Only Medicine in accordance with a Patient Group Direction, and understanding the clinical, ethical, cultural and legal aspects of this work. The workshop must address relevant clinical issues linked to such medicine use.

**b) Objectives**

The workshop should review and support the underpinning clinical knowledge required to provide an EHC service. Pharmacists should experience problematic situations through role-play, and gain confidence in dealing with them. On completion of the training, pharmacists are able to:

1. Understand the aims of an EHC service and its place in Contraception and Sexual Health Services overall.
II. Understand confidentiality issues and be aware of safeguarding children and vulnerable adults.

III. Understand and apply the medico-legal aspects of aspects of the Patient Group Direction - especially as applied to under-age females (i.e. under 16yrs) [Fraser Ruling].

IV. Undertake the administration of the Patient Group Direction(s), including all necessary record keeping and associated paperwork **.

V. Apply the clinical content of the Patient Group Direction(s).

VI. Be aware of the details of when to carry out a pregnancy test, and the actions to be taken following the result.

VII. Understand how and when to refer clients (signpost) and when to ask for support and advice from the local Contraception and Sexual Health Services.

VIII. Counsel and advise clients appropriately and sensitively, and refer for further contraceptive care.

IX. Know what sources of support are available to the pharmacists involved in the provision of this service. **

c) Features of the Workshop

- A Contraception and Sexual Health Clinician(s) must be present and participate in the running of the Workshop.
- The Workshop must include various appropriate role-play scenarios and assessment. An assessed role-play should involve a facilitator observing and/or participating in a role-play involving each of the pharmacists being assessed. Pharmacists’ performance must be to an acceptable standard. (** See Section 7: Cross Accreditation Process)

4. **Summary of Assessment & Accreditation**

Each pharmacist must have attended the PCT Commissioned Workshop session(s) and successfully completed the:

a) *CPPE Emergency Contraception Open Learning Programme and accompanying assessment prior to attending the workshop.

b) *CPPE Contraception Open Learning Programme and *CPPE Child Protection Open Learning Programme and their accompanying assessments either prior to or within 3 months of the workshop.

c) Role Play assessment to an acceptable standard.

(* Or other appropriate training courses as described in Section 3.1)

Accreditation is proven by possession of a current, expiry dated certificate provided by the accrediting PCT, which bears the HAG standard mark. The certificate must list any Service Extensions and / or Prescription Only Medicine(s) provided under Patient Group Direction(s) which were covered in the training.

PCTs are recommended to maintain accreditation records for a minimum of three years.

5. **Maintenance of Accreditation**

Where changes are introduced to the commissioned service, relevant information must be provided by the PCT; pharmacists and staff will need to update themselves as part of their usual continuing professional development.

Accreditation status must be reviewed at least every three years. This should be in the form of a self-declaration of competency (see appendices). Where there are concerns regarding poor performance, this should be addressed separately as a clinical governance matter.
6. **Service Extension Requirements**  
No service extensions have been identified for this Enhanced Service.

7. **Cross Accreditation**  
Accredited Pharmacists must be advised by the accrediting PCT that if they wish to provide an EHC service to another PCT, they must contact that PCT to find out if they are commissioning this service and for details about their service specification, paperwork, sources of support and payment systems before providing the service.  

PCTs may or may not be commissioning this service. If they are, local paperwork, sources of support, extent of the service, etc., may differ. PCTs should however recognise the accreditation certificate, which bears the HAG standard mark, and hence will only need to ensure that pharmacists understand differences of operation in their area.  
In the future, Enhanced Services may be commissioned by other bodies e.g. Practice Based Commissioners.

8. **Learning Outcomes from Training Programmes (Section 3.1)**

8.1 CPPE Emergency Contraception Open Learning Programme  
After completing this programme pharmacists are able to:  
- State the four main reasons why emergency contraception is requested.  
- State and apply the licensed indications for the use of levonorgestrel emergency hormonal contraception (EHC).  
- Describe the mechanism of action of EHC.  
- List the information they need to obtain from the client before making a supply of EHC.  
- Develop their practice of appropriate questions and advice for women requesting EHC.  
- Explain the possible side effects of EHC.  
- Identify when clients requesting EHC might need to be referred to another agency or service.  
- Discuss the possible alternatives to EHC.  
- Develop referral links with other local family planning providers.  
- Understand the legal issues/considerations associated with the supply of EHC.

8.2 CPPE Contraception Open Learning Programme  
After completing this programme pharmacists are able to:  
- Identify and use key reference sources to maintain up-to-the-minute knowledge about the different forms of contraception.  
- Deal confidently with common issues that they may encounter when providing contraception services.  
- Describe their personal barriers to providing effective contraceptive services in their professional setting.  
- Develop a referral checklist for clients who need to access other contraceptive services.

8.3 CPPE Child Protection Open Learning Programme  
After completing this programme pharmacists are able to:  
- Summarise the background and policy surrounding child protection and the issues this raises for pharmacists and pharmacy technicians.  
- Convey the importance of pharmacists and pharmacy technicians increasing their awareness of child abuse and working with other health professionals to develop best practice to deal with situations involving suspected abuse.  
- Highlight situations in which they are best placed to observe signs of abuse.
and the legal issues to consider when making a referral.

- Identify sources of useful information and contacts for the development of local procedures for dealing with suspected child abuse observed in a pharmacy setting.

9. How this version differs from the previous version

This Version 2c includes the following summary of differences between this document and Version 1b that was originally published in January 2007.

- The document title and logo has been updated to “Community Pharmacy Enhanced Services”.
- All core competencies are now being mapped to the General Level Framework (www.codeg.org) (Section 2).
- This document contains two additional core competencies:
  f) Understands the pharmacotherapy for the full range of available medication and appropriate clinical guidance (e.g. NICE). [G1]
  h) Able to demonstrate knowledge of the clinical content of the relevant Patient Group Direction(s). [G1]
- There is now a requirement for the CPPE Child Protection Open Learning Programme (1.5 Hours) and assessment to be completed before or within 3 months of attending the workshop.
- As an alternative to sending copies of their record of assessment to accrediting PCTs, individuals can allow access to their online records by switching on the CPPE viewer via the My CPPE page on the CPPE website (www.cppe.ac.uk) (Section 3.1)
- It is acknowledged that individual commissioners may agree to recognise other training courses provided that they deliver the equivalent knowledge and learning outcomes (which are listed in Section 8) as the CPPE programme(s) stipulated in this document (Section 3.1).
- Information has been included about a CPPE Open Learning Programme that is available for those Pharmacists who are not familiar with the concept of Patient Group Directions and wish to learn more (Section 3.1).
- The current versions of learning programmes must be completed as part of any training undertaken (Section 3.1).
- It is recognised that PCTs may wish to deliver training over more than one session where appropriate, which may vary according to local provision and need (Section 3.2).
- CPPE provides advice on running workshops to train pharmacists and their teams on enhanced services through its local solutions programmes. See the CPPE website to download the local solutions materials for the EHC service (Section 3.2).
- There is no longer a requirement for workshops to involve MCQ testing as part of the assessment process. Instead, workshops must include appropriate role-play assessment that involves a facilitator observing and/or participating in a role-play involving each of the pharmacists being assessed. Pharmacists’ performance must be to an acceptable standard (Section 3.2c).
- Accreditation status must be reviewed at least every three years (extended from the original 2 years), which should be in the form of a self-declaration of competency (Section 5).
- The document now includes a list of the learning outcomes from each of the CPPE training programmes quoted (Section 8).
- The Certificate of Accreditation requires the Pharmacist’s registration number to be stated on the certificate.
- A “Maintenance of Accreditation Self-Declaration Form” has been included as an appendix.
10. **Copies of this document available from:**
All HAG documents, including this one are hosted on:
- NW Pharmacy Workforce Website at: http://www.pharmacyworkforcenw.nhs.uk

**Enquiries about HAG to:**
Clive Moss-Barclay, Project Director
North West Pharmacy Education, Training & Development.
Email: clive.moss-barclay@salford.nhs.uk
Tel: 0161 212 6042; Fax: 0161 212 6046.

**Local Service and Training Provision:**
Pharmacists requiring information about local service and training provision should contact their local PCT.
SAMPLE LETTER TO ACCREDITED PHARMACISTS

(An editable copy can be downloaded from http://www.pharmacyworkforcenw.nhs.uk)

Dear Pharmacist,

Emergency Hormonal Contraception Service

Please find enclosed your Certificate of Accreditation, which authorises you to provide an Emergency Hormonal Contraception (EHC) Service in …………………… PCT.

I am pleased to advise you that our accreditation process for EHC complies with the Competencies and Training Framework developed by the Harmonisation of Accreditation Group (HAG). This should enable you to provide EHC services to other PCTs, which recognise the HAG standards, without the need to be re-accredited by each PCT.

If you wish to provide an EHC service outside of this PCT, you should first contact the relevant PCT(s) to find out if they are commissioning this service and for details about their service specification, paperwork, sources of support and payment systems.

If you require any further assistance please do not hesitate to contact me.

Yours sincerely,
Certificate of Accreditation for Community Pharmacy Enhanced Services

This is to certify that
Insert Pharmacist’s Name and Registration Number
is accredited to provide an

“Emergency Hormonal Contraception Service”

Covering the following PGDs &/or Service Extensions:

a) ..................................................

b) ..................................................

Insert Signature

Insert name of signatory here
Insert designation of signatory here
Insert name of PCT here
Insert contact details here

Issue Date: ............................ 20__
Review Date: ............................20__

The above named person is accredited to provide this enhanced service within the issuing PCT only. This accreditation may be recognised by other PCTs that, if the Pharmacist wishes to provide this service, should be contacted for further information.
HAG recommends that accreditation status must be reviewed at least every three years. HAG also recommends that the individual pharmacist takes responsibility to ensure that they maintain their accreditation status. This self-declaration form may be used by pharmacists to reflect on standards of service delivery; new guidance and legislation; and fitness to practise in relation to the specific service.

The pharmacist should work through this form, reflect on the issues raised, comment on any actions required and sign the declaration at the end of the form. The completed and signed form may be used as evidence of maintenance of accreditation for the PCT.

Enhanced service being delivered: “Emergency Hormonal Contraception Service”

Date of initial accreditation or last self declaration:

Complete BOTH sections in Part A and tick a minimum of THREE sections in Part B.

The information that you provide below must relate to the time period since your initial accreditation or last self-declaration of maintenance of accreditation.

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<tr>
<th>Part A (Complete both A.1 and A.2)</th>
<th>Ye s</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. 1 I have reviewed the most recent service documentation for the provision of this enhanced service (e.g. Patient Group Directions, handbook revisions, etc.) and I confirm that I have implemented any necessary changes in service delivery.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. 2 I have reviewed guidance and legislation relevant to the provision of this enhanced service. <strong>List here with approximate review dates:</strong></td>
<td></td>
<td></td>
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</table>

<table>
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<th>Part B (Tick all that apply – must be a minimum of THREE)</th>
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<tbody>
<tr>
<td>B.1 I have completed at least one entry in my CPD record relating to this enhanced service within the last 12 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.2 I have undertaken a minimum of 12 relevant consultations in</td>
<td></td>
<td></td>
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</tbody>
</table>
the last 12 months.

<p>| | |</p>
<table>
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<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>B.3</td>
<td>I have undertaken the following training courses or programmes which are relevant to this enhanced service. <strong>List the courses here with approximate dates:</strong></td>
</tr>
<tr>
<td>B.4</td>
<td>I have revisited the Standard Operating Procedures I have in place within the pharmacy to support the delivery of this service.</td>
</tr>
<tr>
<td>B.5</td>
<td>I have completed an audit of this enhanced service in the last 12 months and acted appropriately on the outcomes.</td>
</tr>
<tr>
<td>B.6</td>
<td>I have undertaken training / development with the pharmacy team in the last 12 months to update them on this enhanced service.</td>
</tr>
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</table>

I have reviewed the most recent version of the HAG Competencies and Training Framework* for this enhanced service & believe that I continue to demonstrate competence in these areas.

I declare that I am competent to continue the provision of this service.

Pharmacist’s signature: .......................................................... Date: ..............................................

Print name: .......................................................... Registration No: ......................

Please return this form to: [Insert PCT address here]

(*All HAG documents, including “Competencies and Training Frameworks”, are hosted on the Primary Care Commissioning Website at http://www.pcc.nhs.uk and the NW Pharmacy Workforce Website at: http://www.pharmacyworkforcenw.nhs.uk)
Appendix D HAG framework for provision of a Chlamydia testing and treating service

Community Pharmacy Enhanced Services

Competencies and Training Framework

<table>
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<th>Enhanced Service:</th>
<th>Provision of a Pharmacy Chlamydia Testing and Treatment Service</th>
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1. **Introduction**

Community Pharmacists wishing to provide a Chlamydia Testing and Treatment Service (CT&TS) (including further management as a possible extension) as an enhanced service via a Patient Group Direction must be accredited and have their names on an enhanced service provider list kept by the PCT on whose behalf they are providing the service. Throughout this document the abbreviation PCT is used in place of “Primary Care Trusts or other Commissioning Bodies”.

The information in this document outlines the purpose and design of suitable local training which will allow accredited Community Pharmacists to become accredited and recognised by PCTs that endorse the standards set by the Harmonisation of Accreditation Group.

This document complies with the British Association for Sexual Health and HIV (BASHH) guidelines and standards. The HAG has approved the following process.

2. **Core Competencies**

These core competencies relate to the provision of both testing and treatment of Chlamydia infection. The full range of competencies is not necessary where only a testing service will be provided.

These core competencies have been linked, where appropriate, to the general pharmacist competences of the Royal Pharmaceutical Society which are shown in [ ] and are mapped to the General Level Framework (www.codeg.org).

**LEVEL 1 (Pharmacy Testing)**

This level covers the provision of “Pharmacy Testing” only service
i) Able to raise or respond to the issue of sexual health and/or make the offer of Chlamydia testing to men and women [G1].

j) Able to communicate with clients appropriately and sensitively [G2, C1].

k) Able to counsel and advise on testing [G1, G2, C1, C2].

l) Understands and is aware of common Sexually Transmitted Infections (STI) including signs and symptoms [G1].

m) Able to give advice on safer sex [G2, G3].

n) Understands how and when to refer clients for further testing and when to ask for support and advice [G1, C4].

o) Understands confidentiality issues relating to STI regulations [G1, G5].

p) Has an awareness of their role in the process of safeguarding children and vulnerable adults [G1, G5].

q) Able to support the Pharmacy Team in the delivery of a safe and effective service [G6].

**LEVEL 2 (Pharmacy Testing & Treatment)**

This level includes the provision of “Treatment” and expands on the Level 1 (Pharmacy Testing only) competencies. The following competencies also apply:

r) Able to take a brief sexual history that includes for example questioning about unprotected sex, multiple partners and other risk behaviours [G2].

s) Able to counsel and advise on the treatment of Chlamydia Infection [G1, G2, C1, C2].

t) Able to carry out assessment and treatment of asymptomatic Chlamydia infection [G1, G2].

u) Able to instigate basic partner notification (*see below) where this service is required [G1, G2].

v) Understands the pharmacotherapy for the full range of available medication treatments and appropriate clinical guidance [G1].

w) Understands and is able to apply the medico-legal aspects of medicine provision in accordance with a Patient Group Direction [G5].

x) Able to demonstrate knowledge of the clinical content of the relevant Patient Group Direction(s) if applicable [G1].

(*"instigate basic partner notification" refers to the routine activity undertaken at the time of the consultation (i.e. counselling and provision of appropriate partner notification slips). If required by commissioners, additional competencies relating to further partner management or contact tracing activity are included within Section 6).
first programme which must be retained by the pharmacist, together with the
*Patient Group Direction (if applicable) and a copy sent to the accrediting PCT.
Alternatively, individuals can also allow access to their online records by switching
on the CPPE viewer via the My CPPE page on the CPPE website
(www.cppe.ac.uk).
Individual commissioners may agree to recognise other training courses provided
that they deliver the equivalent knowledge and learning outcomes (see Section 8)
as the CPPE programme(s) stipulated above. The current versions of learning
programmes must be completed as part of any training undertaken. The latest
versions of CPPE Open Learning Programmes may be confirmed by accessing
www.cppe.ac.uk.

b) The CPPE online assessment CPPE Safeguarding child e-assessment may
be used by pharmacists to confirm awareness of their role in the process of child
protection as stated in the Core Competencies (Para 2h above).

(*A CPPE Learning Programme is available for those Pharmacists who are not
familiar with the concept of Patient Group Directions and wish to learn more.)

3.2 Information Pack for LEVEL 1 (Pharmacy Testing only)

a) Aims
The aim is to enable community pharmacists to provide a Chlamydia Testing
Service (CTS) only. Information packs on the provision of a CTS may be available
separately from Level 2 training so as not to limit access to CTS.

Local accreditation should take the form of pharmacists self certifying that they
have read and understood the information pack issued by the PCT, in addition to
completing both CPPE open learning programmes (See 3.1 above).

Pharmacists should ensure that staff members, who are involved in the delivery of
the CTS, receive appropriate training linked to their level of involvement.

b) Objectives
The information pack must define the aims of the CTS, explore the links with other
health professionals and describe how the service is administered.

Having read the information pack, pharmacists will be able to:
   I. Understand the aims of a CS&TS and how it is integrated within local
      Sexual Health Services.
   II. Define the purpose of the CT only Service.
   III. Describe the CTS to a member of the public (use of leaflets, marketing
        information).
   IV. Undertake the administration of the scheme, including all paperwork.
   V. Describe local signposting arrangements and sources of information.
   VI. Clearly identify roles for staff members within the CTS.
   VII. Review their own and their staff competencies against roles.

c) Features of the Information Pack
The pack should provide the information to achieve the objectives defined in
Section B above and also include:
   • Details of condition covered.
   • Inclusion and exclusion criteria.
   • Referral mechanisms.

3.3 PCT Commissioned Workshop for LEVEL 2 (Pharmacy Testing
and Treatment)
Training providers should decide on the most suitable structure for the Workshop, which may vary according to local provision and need. CPPE provides advice on running workshops to train pharmacists and their teams on enhanced services through its local solutions programmes. See the CPPE website to download the local solutions materials for the “Chlamydia testing and treatment: community pharmacy enhanced service”.

a) Aims
To enable community pharmacists to become competent to provide a CT&TS in accordance with a Patient Group Direction, understanding the clinical, ethical, cultural and legal aspects of this work.
Local training must take the form of a workshop to address relevant clinical issues as the service involves the use of Patient Group Directions to supply POMs.

b) Objectives
The workshop should review the underpinning clinical knowledge required to provide a CT&TS and should ensure that the pharmacist:

X. Understands the aims of the CT&TS and how it is integrated within local Sexual Health Services.
XI. Understands confidentiality issues and has an awareness of safeguarding children and vulnerable adults.
XII. Understands how and when to refer clients and provide information for the treatment pathways available to a client.
XIII. Understands and is able to apply the medico-legal aspects of Sexual Health Services provision - especially as applied to under 16 year olds (Fraser Guidelines).
XIV. Understands and is able to use the Patient Group Directions for the indicated Prescription Only Medicine and associated paperwork. ***
XV. Understands the process of specimen collection including how to prepare samples for laboratory testing and the actions to be taken following the result.
XVI. Understands how and when to refer clients (signpost) and when to ask for support and advice from the local specialist service.
XVII. Is able to counsel and advise clients appropriately and sensitively, and refer appropriately to other services for sexual health care.
XVIII. Experiences problematic situations through role play, and gains confidence in dealing with them.
XIX. Knows what sources of support are available to the pharmacists involved in the provision of this service. ***

c) Features of the Workshop
- Sexual Health Clinician(s) must be present and participate in the running of the workshop.
- The Workshop should include various appropriate role-play scenarios and assessment. An assessed role-play should involve a facilitator observing and/or participating in a role-play involving each of the pharmacists being assessed. Pharmacists’ performance must be to an acceptable standard.

(*** See Section 7: Cross Accreditation Process)

4. Summary of Assessment & Accreditation
At Level 1 (Pharmacy Testing only), each pharmacist must self certify that they have read and understood the information pack issued to pharmacists by the PCT and successfully completed:
- CPPE Sexual Health: testing and treating Open Learning Programme and accompanying e-assessment.
- CPPE Dealing with difficult discussions Open Learning Programme (there is no formal assessment for this programme).
At Level 2 (Pharmacy Testing and Treatment), where Patient Group Directions are part of the service, the training must include in addition to Level 1 above, attendance at the PCT Commissioned Workshop session(s) and successful completion of role play assessment to an acceptable standard. Accreditation is proved by possession of a current, expiry dated certificate provided by the accrediting PCT, which bears the HAG standard mark. The certificate must list any Service Extensions and / or Prescription Only Medicine(s) provided under Patient Group Direction(s) which were covered in the training.

PCTs are recommended to maintain accreditation records for a minimum of three years.

5. **Maintenance of Accreditation Status**
   Where changes are introduced to the commissioned service, relevant information must be provided by the PCT; pharmacists and staff will need to update themselves as part of their usual continuing professional development.

   Accreditation status must be reviewed at least every three years. This should be in the form of a self-declaration of competency (see appendices). Where there are concerns regarding poor performance, this should be addressed separately as a clinical governance matter.

6. **Service Extension Requirements**

   **6.1 Further Management of Chlamydia Infection**
   The following additional competencies relate to the provision of an extended CT&TS, which includes the further management of patients with Chlamydia Infection beyond, that specified for the CT&TS (See 2).
   a) Able to carry out partner management, in conjunction with appropriate colleagues.
   b) Able to counsel and advise clients on tracing partners.
   c) Able to advise on testing, treatment and vaccinations for associated infections.

   The commissioning PCT must resource the necessary training and assessment for pharmacists wishing to provide this extended service.

7. **Cross Accreditation**

   Accredited Pharmacists must be advised by the accrediting PCT that if they wish to provide a Chlamydia Testing and Treatment Service to another PCT, they should contact that PCT to find out if they are commissioning this service and for details about their service specification, paperwork, sources of support and payment systems before providing the service.

   PCTs may or may not be commissioning this service. Even so, local paperwork, sources of support, extent of the service, etc, may differ.

8. **Learning Outcomes from Training Programmes quoted in Sections 3.1 & 6.1**

   **8.1 CPPE Sexual health in pharmacies: developing your service, Blended Learning Programme**
   On completion of all aspects of this programme you should be able to:
   - Describe the presentation, diagnosis and treatment of the most common sexually transmitted infections (STIs) and access reliable sources for keeping
that knowledge up to date.

- Advise clients on how to reduce the risk of contracting STIs.
- Contribute to the development and implementation of sexual health services and campaigns developed by local commissioners and the local sexual health clinical network and refer and signpost clients appropriately within that network.
- Cascade training on knowledge, skills and attitudes to pharmacy staff to ensure a seamless service.
- Take an appropriate sexual history including risk assessment for HIV and hepatitis B.
- Describe the importance of partner notification.
- Complete an appropriate sexual health consultation including regard to confidentiality, completion of required paperwork and good clinical governance.
- Reflect on and assess your sexual health counselling competence over time.

8.2 CPPE Dealing with difficult discussions Open Learning Programme

On completion of all aspects of this programme you should be able to:

- Describe what would make a difficult discussion for you.
- Describe factors that can contribute to making a discussion difficult.
- List some common traps that healthcare professionals can fall into.
- Identify your own barriers to effective communication.
- Describe the potential outcomes for a discussion.
- List at least four key communication strategies for dealing with difficult discussions.
- Describe how you could use the communication strategies to raise difficult issues.
- Describe some strategies that you could use to deal with resistance.

9. How this version differs from the previous version

The following is a summary of differences between this Version 2a and Version 1 that was published in April 2008.

- The logo has been updated to “Community Pharmacy Enhanced Services”.
- The title of the service has been changed from “Screening” to “Testing” to reflect the nature of the service being offered by Community Pharmacies.
- The document now complies with British Association for Sexual Health and HIV (BASHH) guidelines and standards (Section 1).
- All core competencies are being mapped to the General Level Framework (www.codeg.org) (Section 2).
- Safeguarding vulnerable adults and supporting the Pharmacy Team in the delivery of a safe and effective service have been added to Level 1. The ability to carry out the taking of sexual history has been moved to Level 2 competencies (Section 2).
- The core competencies in Level 2 which relate to the supply of medicines under a Patient Group Direction have been amended (Section 2).
- The differences in CPPE’s sexual health open learning programme, apart from the name, are that the new programme was developed with the input of clinicians from the British Association for Sexual Health and HIV. Both the STIs section (which is a separate e-learning module) and the section on sexual history taking benefit from their influence. The open learning concentrates on what makes a good sexual health consultation, including “joined-up” thinking on STIs, safe sex, and contraception (Section 3.1).
- An e-assessment is now available for the Sexual Health CPPE programme. As an alternative to sending copies of their record of assessment to accrediting PCTs, pharmacists can allow access to their online records by switching on the CPPE viewer via the My CPPE page on the CPPE website (www.cppe.ac.uk) (Section 3.1)
• Current versions of learning programmes must be completed as part of any training undertaken (Section 3.1).
• Information has been included about a CPPE Open Learning Programme that is available for those Pharmacists who are not familiar with the concept of Patient Group Directions and wish to learn more (Section 3.1).
• Training providers should decide on the most suitable structure for the Workshop, which may vary according to local provision and need. CPPE provides advice on running workshops to train pharmacists and their teams on enhanced services through its local solutions programmes. See the CPPE website to download the local solutions materials for the “Chlamydia testing and treatment: community pharmacy enhanced service” (Section 3.3.).
• There is no longer a requirement for workshops to involve MCQ testing as part of the assessment process. Instead Workshops should include various appropriate role-play scenarios and assessment. An assessed role-play should involve a facilitator observing and/or participating in a role-play involving each of the pharmacists being assessed. Pharmacists’ performance must be to an acceptable standard (Section 3.3c).
• The section “Summary of Assessment and Accreditation” has been amended in line with the changes made to the previous sections (Section 4).
• There is now a requirement on PCTs to provide relevant information where changes are introduced to the commissioned service and for Pharmacists and their staff to keep themselves up to date as part of their CPD (section 5).
• Accreditation status must be reviewed at least every three years (extended from the original 2 years), which should be in the form of a self-declaration of competency (Section 5).
• The document now includes a list of the learning outcomes from the CPPE training programmes quoted (Section 8).
• Information is provided on where to obtain copies of this document and access to information about local service and training provision (Section 10).
• The Service title on the Sample Letter and Certificate has been amended appropriately.
• The Certificate of Accreditation requires the Pharmacist’s registration number to be stated on the certificate and there is a section to add PGDs &/or Service Extensions.

A “Maintenance of Accreditation Self-Declaration Form” has been included as an appendix.

10. Enquiries
Copies of this document available from:
All HAG documents, including this one are hosted on:
• Primary Care Commissioning Website at: http://www.primarycarecommissioning.nhs.uk/200.php.
• NW Pharmacy Workforce Website at: http://www.pharmacyworkforcenw.nhs.uk

Enquiries about HAG to:
Clive Moss-Barclay, Project Director
North West Pharmacy Education, Training & Development.
Email: clive.moss-barclay@salford.nhs.uk
Tel: 0161 212 6042; Fax: 0161 212 6046.

Local Service and Training Provision:
Pharmacists requiring information about local service and training provision should contact their local PCT.
Dear Pharmacist,

**Re: Pharmacy Chlamydia Testing (and Treatment) Service**

Please find enclosed your Certificate of Accreditation which authorises you to provide a Chlamydia Testing (and Treatment) Service in ………………… PCT.

**OR**

**Re: Pharmacy Chlamydia Testing and Treatment Service**

Please find enclosed your Certificate of Accreditation, which authorises you to provide a Pharmacy Chlamydia Testing and Treatment Service in ………………… PCT.

I am pleased to advise you that our accreditation process for Pharmacy Chlamydia Testing (and Treatment) complies with the Competencies and Training Framework developed by the Harmonisation of Accreditation Group. This should enable you to provide Pharmacy Chlamydia Testing (and Treatment) Service to other PCTs which recognise the HAG standards, without the need to be re-accredited by each PCT.

**If you wish to provide a Pharmacy Chlamydia Testing (and Treatment) Service outside of this PCT, you should first contact the relevant PCT(s) to find out if they are commissioning this service and for details about their service specification, paperwork, sources of support and payment systems.**

If you require any further assistance please do not hesitate to contact me.

Yours sincerely,

(delete as appropriate)
Certificate of Accreditation for Community Pharmacy Enhanced Services

This is to certify that

Insert Pharmacist’s Name and Registration Number

is accredited to provide a

“Pharmacy Chlamydia Testing / and Treatment Service”

(delete as appropriate)

Covering the following PGDs &/or Service Extensions:

a) ................................................................

b) ................................................................

Insert Signature

Insert name of signatory here
Insert designation of signatory here
Insert name of PCT here
Insert contact details here

Issue Date: .................................... 20__
Review Date: ..................................20__

The above named person is accredited to provide this enhanced service within the issuing PCT only. This accreditation may be recognised by other PCTs who, if the Pharmacist wishes to provide this service, should be contacted for further information.
HAG recommends that accreditation status must be reviewed at least every three years. HAG also recommends that the individual pharmacist takes responsibility to ensure that they maintain their accreditation status. This self-declaration form may be used by pharmacists to reflect on standards of service delivery; new guidance and legislation; and fitness to practise in relation to the specific service.

The pharmacist should work through this form, reflect on the issues raised, comment on any actions required and sign the declaration at the end of the form. The completed and signed form may be used as evidence of maintenance of accreditation for the PCT.

| Enhanced service being delivered: “Pharmacy Chlamydia Testing / & Treatment Service” |
| Date of initial accreditation or last self declaration: |

Complete BOTH sections in Part A and tick a minimum of THREE sections in Part B.

The information that you provide below must relate to the time period since your initial accreditation or last self-declaration of maintenance of accreditation.

### Part A (Complete both A.1 and A.2)

<table>
<thead>
<tr>
<th>Core Statements</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. 1 I have reviewed the most recent service documentation for the provision of this enhanced service (e.g. Patient Group Directions, handbook revisions, etc.) and I confirm that I have implemented any necessary changes in service delivery.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. 2 I have reviewed guidance and legislation relevant to the provision of this enhanced service. <em>List here with approximate review dates:</em></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Part B (Tick all that apply – must be a minimum of THREE)

<table>
<thead>
<tr>
<th>Additional Statement</th>
<th>Yes</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.1 I have completed at least one entry in my CPD record relating to this enhanced service within the last 12 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.2 I have undertaken a minimum of 12 relevant consultations in the last 12 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.3 I have undertaken the following training courses or</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
I have reviewed the most recent version of the HAG Competencies and Training Framework* for this enhanced service & believe that I continue to demonstrate competence in these areas.

I declare that I am competent to continue the provision of this service.

Pharmacist’s signature: ................................................ Date:
……………………………………

Print name: ................................................................. Registration No.……………..

Please return this form to: [Insert PCT address here]

(*All HAG documents, including “Competencies and Training Frameworks”, are hosted on the Primary Care Commissioning Website at [http://www.pcc.nhs.uk/200] and the NW Pharmacy Workforce Website at: [http://www.pharmacyworkforcenw.nhs.uk])
Appendix E Sexual health services in community pharmacy questionnaire

Sexual health services in community pharmacy questionnaire
Sexual health services in community pharmacy questionnaire

The community pharmacy is one of the places where people wishing to maintain good sexual health can access health services. The range of products and services available through a community pharmacy has changed over the last 30 years. This survey asks for your opinions about providing contraceptive products, managing sexually transmitted infections and providing support for sexual health in community pharmacy. We know that there are many demands on your time, but would be very grateful if you could spare the 30 minutes that it should take to complete the questionnaire.

Please be frank and honest as your answers will only be seen by the research team. We have coded the questionnaire for administrative purposes; however, we will ensure that no person will be identifiable by name or location. A FREEPOST envelope is provided to allow you to return the completed questionnaire direct to us. If you have any queries, please do not hesitate to contact matthew@cppe.ac.uk or on 0161 778 4011.

Please indicate which of the responses is closest to your personal feelings about providing sexual health services. Mark your answer by ticking the relevant circle.

Not at all comfortable  2  A little uncomfortable  3  Neither  4  Quite comfortable  5  Totally comfortable

SECTION A: A baseline on your feelings on providing sexual health services

Before you look through the rest of the survey, please take a moment to think about how you feel overall about providing sexual health services.

How comfortable are you overall about providing sexual health services through your pharmacy. Mark ONE answer only.

Not at all comfortable  2  A little uncomfortable  3  Neither  4  Quite comfortable  5  Totally comfortable
SECTION B: Provision of contraceptive services

This section considers the provision of different types of contraceptive through the community pharmacy. Some of these you may already offer, others you may have heard of and some may not yet be available through the routes stated.

For each, please indicate the extent to which you agree that this method of supply is appropriate through a community pharmacy.

<table>
<thead>
<tr>
<th>It is appropriate to supply</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condoms for sale</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Emergency contraception over the counter for females aged over 16</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Emergency contraception under a patient group direction for females aged under 16</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Oral contraception over the counter for females aged over 16, without them seeing their doctor</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Oral contraception under a patient group direction for females aged over 16, without them seeing their doctor</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Long acting reversible contraceptives under a patient group direction, for females aged over 16 without them seeing their doctor</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

*NB: A patient group direction supply is one where the pharmacist works within guidelines and processes agreed by the commission of the service.*

Section C: Support for reproductive health

Regardless of whether you offer them or not, please state the extent to which you think that the community pharmacy is an appropriate place to offer the following services.

<table>
<thead>
<tr>
<th>It is appropriate to offer</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supply of ovulation testing kits</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Testing for pregnancy</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Management of erectile dysfunction (and other related)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

*NB: This service would typically involve checking that the supply of a product such as sildenafil was appropriate for an individual and then supplying the product under a patient group direction.*
Section D. Screening for genital sexually transmitted infections

In this section please think about the role of the community pharmacist in undertaking the screening for sexually transmitted infections.

For each of these please state the extent to which you agree that the community pharmacy is an appropriate place to offer the following services.

<table>
<thead>
<tr>
<th>It is appropriate to screen for:</th>
<th>By this method:</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia</td>
<td>Testing a urine sample</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Genital herpes</td>
<td>Swabbing the ulcer</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Genital warts</td>
<td>Physical examination</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>Vaginal or urethral swab</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>HIV</td>
<td>Taking a blood sample and counseling</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Syphilis</td>
<td>Taking a blood sample</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Vaginal thrush</td>
<td>High vaginal swab</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

*NB: Although vaginal thrush is not a sexually transmitted infection, we have included it in this section as it is an infection of the female genitalia.*

Section E. Treatment of genital sexually transmitted infections

In this section please think about the role of the community pharmacist in providing treatment for a confirmed sexually transmitted infection.

For each of these please state the extent to which you agree that the community pharmacy is an appropriate place to offer the following services.

<table>
<thead>
<tr>
<th>It is appropriate to treat a Confirmed Infection of</th>
<th>By this treatment method</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia</td>
<td>Over the counter pharmacy supply</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Patient group direction</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Genital herpes</td>
<td>Over the counter pharmacy supply</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Patient group direction</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Genital warts</td>
<td>Over the counter pharmacy supply</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Patient group direction</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>Over the counter pharmacy supply</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Patient group direction</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>HIV</td>
<td>Over the counter pharmacy supply</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Patient group direction</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Syphilis</td>
<td>Over the counter pharmacy supply</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Patient group direction</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Vaginal thrush</td>
<td>Over the counter pharmacy supply</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Patient group direction</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
SECTION F: Your feelings and drivers for sexual health services

There are many factors that can influence your thoughts and feelings about offering sexual health services. Some of these may be positive factors; some negative and some may not impact on you at all. For each of the factors listed here, please tick the box to show what impact it has on you.

<table>
<thead>
<tr>
<th>My decision whether to offer these services is influenced by:</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The culture that I live in</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Whether I feel it is an ethical action</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>The income that is generated</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>The need to offer these professional services</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Whether my religious beliefs support them</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

*Nb You can add personal comments on the final page of this survey.*
Section G: Competences

In the next section, potential competences for those offering sexual health services are listed.

These are short statements describing what a healthcare professional may need to know or be able to do to offer sexual health services.

Please read each statement and consider whether you think it is a reasonable description of what a community pharmacist would need to know, or be able to do, to offer sexual health services.

For each statement, consider whether you think that this would be appropriate in a community pharmacy that was offering sexual health services. If you think that it would be, please tick the column titled “Delivered by community pharmacy”.

Pharmacists are now offering services in other locations, for example in sexual health clinics or other private practices. If you think that the competence would be needed by a pharmacist practising in that setting, please tick the column “Delivered by pharmacists in other settings”.

If you think that the competence listed would never be appropriate for a pharmacist, then please tick the column “not applicable”.

For example, if you think that a pharmacist should be able to keep clear records if offering sexual health services in the community pharmacy and other settings, then your response would look like this:

| Keeps clear records | ✔ | ✔ |

If you think that this should only happen when practising in settings other than the community pharmacy then your response would look like this:

| Keeps clear records |   | ✔ |

If you think that it would never be appropriate for a pharmacist to be able to keep clear records, then your response would look like this:

<p>| Keeps clear records |   | ✔ |</p>
<table>
<thead>
<tr>
<th>With reference to sexual health services</th>
<th>Delivered in community pharmacy</th>
<th>Delivered by pharmacists in other settings</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Consultation skills</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Takes a sexual history to assess risk of pregnancy and sexually transmitted infections</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adapts consultation style to make sure that the client understands</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Keeps clear records</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Consultations with young people</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Understands the importance of confidentiality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has awareness of child protection issues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can apply the law relating to consent (specifically for people under the age of 16)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Contraceptive practice</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrates the ability to conduct an effective contraceptive choice consultation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provides essential advice and information when providing oral hormonal contraception for the first time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explains the relative and absolute contraindications for providing oral hormonal contraception for the first time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advises on action to take in case of problems related to oral hormonal contraception</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provides essential advice and information prior to insertion of intrauterine method or subdermal implant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can give an intramuscular injection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrates the teaching of male and female condom use</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fits and checks diaphragms and caps</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consults for and supplies hormonal emergency contraception</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has knowledge of emergency intrauterine device and how to refer for this</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Pregnancy planning
- Performs a urine pregnancy test and gives result in an appropriate manner
- Has skills to consult on unintended pregnancy

### Knowledge of methods of contraception and ability to discuss and advise clients on them
- Can discuss and advise on sterilisation (male and female)
- Can discuss and advise on natural family planning

### Sexual health and infections
- Understands principles of screening programmes for sexually transmitted infections
- Can perform appropriate tests for genital infections in men and women
- Is able to counsel a client with a positive diagnosis of a sexually transmitted infection
- Understands the principles of notifying sexual partners about positive test results
- Can manage presentations of all common genital infections in men and women
- Is able to manage vaginal discharge appropriately
- Is able to manage pelvic pain appropriately
- Demonstrates knowledge and communication skills required for pre-test HIV discussion

### Cervical cytology
- Understands cervical screening programmes and recall systems
- Is able to take cervical smears
- Is able to explain cervical smear results and take appropriate action

### Psychosocial issues
- Understands sexual dysfunction, exploring psychological and physical factors. Gives advice
Section H – About you

1. Are you:  
   - Male  
   - Female

2. How old are you?  
   - 21 – 25  
   - 26 – 30  
   - 31 – 40  
   - 41 – 50  
   - 51 – 60  
   - Over 65 years  
   - Prefer not to say

3. How long have you worked in community pharmacy? _______ (years)  
   (If you have worked for less than 1 year, please write in the number and write months)

4. Which of the following categories best describes your role in community pharmacy?  
   (please tick one box as appropriate)
   - a. Pharmacist proprietor/owner  
   - b. Pharmacist branch manager  
   - c. Second pharmacist  
   - d. Locum pharmacist  
   - e. Relief pharmacist  
   - f. Other (please state below)

5. Which of the following best describes the type of community pharmacy that you work in?  
   (Please tick one as appropriate: If you regularly work in more than one pharmacy, select the category in which you most often work)
   - a. Single independent pharmacy  
   - b. Member of a small chain (2 to 5 branches)  
   - c. Member of a medium chain (6 – 25 pharmacies)  
   - d. Member of a large chain (over 25 stores)

6. How would you describe your ethnicity?  
   - White British  
   - White Irish  
   - Mixed race  
   - Asian  
   - British Asian  
   - Black  
   - Black British  
   - Chinese  
   - Other  
   - Prefer not to say

Thank you for taking the time to complete this survey. Please send it back to Matthew Shaw at the freepost address below:
Are there any other competences that you think pharmacists would need to demonstrate in order to provide professional sexual health services? If so, please write them here. If you think that they would only apply to certain conditions, please state which would be?

If you would like to make any other comments with regards to offering sexual health services, please write them here.
Appendix F Covering letter sent to participants with questionnaire

Dear Colleague,

As the range of services available through community pharmacy increases, so there is a need to understand how this affects practitioners, both personally and practically in terms of their learning needs. Community pharmacists have expressed concerns about their role in supporting different sexual health services and the challenges that this brings to them ethically and professionally. As proposals seek to expand the role of the pharmacist to include managing contraceptive services and support for the treatment of sexually transmitted infections, it is important to investigate how this may impact on pharmacists and what their feelings are.

We are conducting a survey of community pharmacists in various settings in order to study their feelings on the different aspects of support for:
- Contraceptive services
- Reproductive health
- Sexually transmitted infections screening
- Sexually transmitted infections treatment

This survey is being conducted by a researcher within the Centre for Pharmacy Postgraduate Education at the University of Manchester. The RPSGB has given us permission to invite a random sample of its registered members to take part in the survey. I would like to emphasise that the survey is anonymous, and the information you provide will be used only for our own research. We expect that the findings will identify those areas where pharmacists will benefit from additional support in terms of learning programmes and demonstrating competence.

I have enclosed an information sheet that explains the nature of the survey in more detail, as well as the survey itself. It is entirely for you to decide whether or not you wish to take part. If you have any queries or comments concerning the survey please do not hesitate to contact me using the details at the top of this letter.

Yours sincerely,

Matthew Shaw
Deputy director, CPPE
Encs.
Appendix G Participant information sheet

SCHOOL OF PHARMACY AND PHARMACEUTICAL SCIENCES

Participant Information Sheet:

Introduction
You are being invited to take part in a research study conducted by the University of Manchester. In order to help you decide whether or not to take part, this information sheet provides you with further details about the study. The information sheet explains the purpose of the study and what it will involve.

What is the purpose of this study?
The aim of this study is to determine how community pharmacists feel about offering different services linked to sexual health and what competences they feel pharmacists would need to demonstrate in order to do this safely. The study is being conducted by researchers from the Centre for Pharmacy Postgraduate Education at the University of Manchester and will contribute to the award of a postgraduate degree.
This study seeks to determine where the boundaries of service provision may lie. Some of the services that are listed are not available through community pharmacy and there are no known plans for them to be so. We ask you to tell us how you would feel if they were proposed.

Why have I been chosen?
We would like to involve a group of respondents that is representative of practising community pharmacists in general. For this reason we have obtained permission from the Royal Pharmaceutical Society of Great Britain to approach a sample of their members who are practising community pharmacists.

What will I be asked to do if I take part?
We have enclosed a questionnaire:
If you wish to take part, then we would like you to complete the questionnaire at your own convenience, and then return it to us using the freepost address provided. We expect that it will take no longer than 30 minutes to complete the questionnaire. If it is more convenient for you to do so, you may complete an online version instead of the paper version that we have sent you. You can find this at [website]. Please note that by completing and returning the questionnaire, you are consenting to it being included in our study.

Do I have to take part?
You do not have to take part in the study. If you do not wish to take part, then do not complete the questionnaire.

We will send reminders to people who don’t respond, but you may ignore these if you do not wish to take part.

What are the benefits of taking part?
We expect that the findings of this study will help us to identify what pharmacists feel about offering the different sexual health services and to what extent they feel different competences are needed. We will be able to use this to help us build a competence framework that is relevant to the current and future roles of pharmacists and construct a method of demonstrating that pharmacists meet these competences.

Will my taking part in the study be kept confidential?
Yes. Your identity and contact details have been used only by us for this mailing, and will not be revealed to anyone else. Each mail out has been given a unique identification number in order for us to monitor patterns of responding. However, once completed questionnaires are received by us, we will remove the identification
number before entering them into the database, after which they can no longer be linked with a specific individual.

**What will happen to the results of the research study?**
The results of the study will be published in reports to be held at the University of Manchester. It is our expectation that the results will also be published in reports to be released into the public domain. These reports will be provided to participants on request. We also intend to produce summaries of our work for presentation either to the participants or to people representing them.

**What will happen if I don’t want to carry on with the study?**
As completed questionnaires will be anonymised on receipt, it will not be possible for us to identify your answers once they have been added to our database. For this reason we will be unable to remove any questionnaires from the study once we have received them.
If you choose not to respond to the questionnaire, this will have no impact on your ability to order learning programmes from CPPE or the University of Manchester.

**What if I need to make a complaint about the study?**
If there are any issues regarding this research that you would prefer not to discuss with members of the research team, please contact the Research Practice and Governance Co-ordinator by either writing to ‘The Research Practice and Governance Co-ordinator, Research Office, Christie Building, The University of Manchester, Oxford Road, Manchester, M13 9PT’, by emailing: Research-Governance@manchester.ac.uk, or by telephoning 0161 275 7583 or 275 8093.

**Who is organising and funding the research?**
The University of Manchester is providing sponsorship and funding for this study.

**Who has reviewed the study?**
This study was given a favourable opinion by the University of Manchester Senate Committee for Ethical Conduct.

**Where can I obtain further information if I need it?**
If you require further information then you are welcome to contact Matthew Shaw 0161 778 4015, email matthew@cppe.ac.uk

We would like to thank you for considering participating in this study, and for taking the time to read this information sheet.
Appendix H Confirmation of ethical approval

Secretary to the Ethics Committee  
Room 2.905 John Owens Building  
Tel: 0161 275 2206/2046  
Fax: 0161 275 5697  
Email: timothy.stibbs@manchester.ac.uk

ref: TPES/ethics/09208

Matthew Shaw,  
CPPE, Workforce Academy,  
School of Pharmacy and Pharmaceutical Sciences

3rd December 2009

Dear Matthew,

Committee on the Ethics of Research on Human Beings  
Shaw, Askcroft: An investigation into the competencies required for community pharmacies offering sexual health services (ref 09208)

I write to follow up my email of 3rd December and to confirm that the further information that you submitted satisfies the concerns of the Committee and that the project therefore has full ethical approval.

The general conditions remain as set out in my letter of 12th October.

We hope the research goes well.

Yours sincerely,

Timothy Stibbs  
Secretary to the Committee