Pecyn dogfennau cyhoeddus

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:
Ystafell Bwyllgora 3 - Y Senedd

Dyddiad:
Dydd Mercher, 2 Tachwedd 2011

Amser:
09:30

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

I gael rhagor o wybodaeth, cysylltwch a:

Llinos Dafydd
Clerc y Pwyllgor
029 2089 8403
HSCCommittee@wales.gov.uk

Agenda

1. Cyflwyniadau, ymddiheuriadau a dirprwyon

2. Ymchwiliad i'r cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru - Tystiolaeth gan BMA Cymru Wales, Cymdeithas y Meddygon Fferyllol a Choleg Brenhinol yr Ymarferwyr Cyffredinol (09.30 - 10.25) (Tudalennau 1 - 7)

HSC(4)-09-11 papur 1- BMA Cymru Wales
Dr David Bailey, Cadeirydd, Pwyllgor Ymarfer Cyffredinol Cymru
Dr Phillip White, Trafodwr Pwyllgor Ymarfer Cyffredinol Cymru

HSC(4)-09-11 papur 2 – Cymdeithas y Meddygon Fferyllol
Dr David Baker, Prif Weithredwr

HSC(4)-09-11 papur 3 – Coleg Brenhinol yr Ymarferwyr Cyffredinol
Dr Paul Myers, Cadeirydd Etholedig

Toriad 10.25 – 10.30

3. Ymchwiliad i Leihau'r Risg o Strôc - Tystiolaeth gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol (10.30 - 11.30) (Tudalennau 8 - 15)

HSC(4)-09-11 papur 4
Lesley Griffiths AC, y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Dr Tony Jewell, Prif Swyddog Meddygol
Chris Tudor-Smith, Pennaeth yr Is-adran Gwella Iechyd

4. Ymchwiliad i'r cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru - Tystiolaeth gan gynrychiolwyr y GIG (11.30 - 12.15) (Tudalennau 16 - 26)

HSC(4)-09-11 papur 5 – Bwrdd Iechyd Lleol Hywel Dda
HSC(4)-09-11 papur 6 – Bwrdd Iechyd Prifysgol Betsi Cadwaladr
HSC(4)-09-11 papur 7 – Bwrdd Iechyd Lleol Cwm Tâf

Chris Martin, Cadeirydd, Bwrdd Iechyd Lleol Hywel Dda
Berwyn Owen, Bwrdd Iechyd Prifysgol Betsi Cadwaladr a Cyfarwyddwr Rhaglen Cenedlaethol Rheolaeth Meddyginiaethau
Bernadine Rees, Cyfarwyddwr Gweithredol, Gofal Iechyd Sylfaenol, Iechyd Cymunedol ac Iechyd Meddwl, Bwrdd Iechyd Lleol Cwm Tâf

5. Papurau i'w nodi (Tudalennau 27 - 106)

Ymchwiliad i Leihau'r Risg o Strôc

HSC(4)-09-11 papur 8
Gwybodaeth gan Gymdeithas Cyfarwyddwyr Gwasanaethau Cymdeithasol Cymru

HSC(4)-09-11 papur 9
Gwybodaeth gan Gomisiynydd Pobl Hŷn Cymru

HSC(4)-09-11 papur 10
Gwybodaeth ychwanegol gan gynrychiolwyr Byrddau Iechyd

HSC(4)-09-11 papur 11
Ymateb gan y Gymdeithas Fferyllol Frenhinol

Ymchwiliad i'r cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru

HSC(4)-09-11 papur 12
Gwybodaeth ychwanegol gan y Gymdeithas Fferyllol Frenhinol

HSC(4)-09-11 papur 13 – Papur heb ei dderbyn
Gwybodaeth ychwanegol gan Fferylliaeth Gymunedol Cymru

HSC(4)-09-11 papur 14
Gwybodaeth ychwanegol gan Iechyd Cyhoeddus Cymru

Craffu ar Adroddiad Flynyddol Comisiynydd Pobl Hŷn Cymru

HSC(4)-09-11 papur 15
Gwybodaeth ychwanegol gan Gomisiynydd Pobl Hŷn Cymru

Fifth Floor, 2 Caspian Point, Caspian Way, Cardiff Bay, Cardiff, CF10 4DQ

Health and Social Care Committee
HSC(4)-09-11 paper 1
Inquiry into the contribution of community pharmacy to health services in Wales – Evidence from BMA Cymru Wales

September 2011

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the Health and Social Care Committees inquiry into the contribution of community pharmacy to health services in Wales

The British Medical Association represents doctors from all branches of medicine all over the UK. It has a total membership of almost 150,000 including more than 3,000 members overseas and over 19,000 medical student members.

The BMA is the largest voluntary professional association of doctors in the UK, who speak for doctors at home and abroad. It is also an independent trade union. BMA Cymru Wales represents some 7,000 members in Wales from every branch of the medical profession.

TERMS OF REFERENCE

The terms of reference for the inquiry are:

To examine the effectiveness of the Community Pharmacy contract in enhancing the contribution of community pharmacy to health and wellbeing services, including:

- The extent to which Local Health Boards have taken up the opportunities presented by the contract to extend pharmacy services through the provision of 'enhanced' services, and examples of successful schemes;
- The scale and adequacy of 'advanced' services provided by community pharmacies
- The scope for further provision of services by community pharmacies in addition to the dispensing of NHS medicines and appliances, including the potential for minor ailments schemes;
- The current and potential impact on demand for NHS services in primary and secondary care of an expansion of community pharmacy services, and any cost savings they may offer;
- Progress on work currently underway to develop community pharmacy services.

BMA CYMRU WALES RESPONSE

We recognise that there have been wholesale changes in retail pharmacy over the past decade, notably we have seen a move away from individual pharmacist contractors to the larger national companies which keep their network of pharmacies open using several employed pharmacists.

This has resulted in NHS Boards receiving an increased number of applications for community pharmacies in areas that were not previously viable for small businesses, and where patients have traditionally been served by a dispensing practice.

The growth in community pharmacies has evidently led to the increased availability of routine pharmacy services which is a welcome development but, perhaps on occasion this has been at the cost of the more 'personal service' - for example, the availability of the "local" pharmacist to attend out of hours in the event of an emergency to dispense essential medicines.

Dispensing can provide a sizeable proportion of practice resources, the abrupt loss of this presents considerable business continuity problems. It is vitally important to recognise that in many – mostly rural - areas, dispensing by general practitioners exists in order to support the provision of local services to patients. In these rural areas, owing to complex contractual calculations, dispensing income has become a vital stream of funding for the provision of primary care services in general.

Any moves that destabilise such dispensing practice may lead to a drastic reduction in the provision of general medical services in these areas. This service would be impossible to replace. We would therefore be totally opposed to any changes in the current control of entry regulations even if there were a perceived benefit to the provision of pharmacy services in isolation as the net effect on local health provision would still be overwhelmingly negative and must be a central consideration.

It is of note that the pharmacy application process does not recognise partners of the dispensing practice or the views of the local community. Therefore, practice partners are not given the opportunity to explain to the NHS Board the impact that the loss of dispensing status will have on the practice or their patients and the subsequent access to services. We are also concerned at the way in which the pharmacy contract uses category M pricing to free resources for other contractual changes with consequent effects on dispensing practices that they have no chance to ameliorate via the dispensing contract. This seems grossly inequitable.

With the advent of pre-packaging and the demise of preparing onsite, the role of the pharmacist has altered dramatically – moving away from the traditional role of the "chemist" (with unintended consequences in the rocketing price of "specials") but increasing the requirement for detailed advice made more complex by an ever widening range of drugs available.

We cautiously welcome the medication reviews and new medicine checks being undertaken at present but trust they will be targeted appropriately to ensure good value for money. Likewise, we also welcome the home delivery service now provided by many pharmacists.

We support the greater emphasis on compliance aids including the weekly dosing systems used to dispense medication for the frail and elderly, making it easier for carers to supervise medication. We recognise however that there are certain separate risks in terms of drug storage, recognition and wastage - and hope it will continue to be used appropriately for reasons of patient care rather than administrative convenience. We feel that this vital service should be adequately funded through the pharmaceutical contract.

We are concerned that in order to provide "additional services" there may be a fragmentation of existing services, with various provisions being delivered piecemeal. There is a risk that some

patients might take advantage of services provided outside their registered practice as there is no cohesive way of recording activity per patient done elsewhere. For example, the 'worried well' might have monthly cholesterol testing by going around all the pharmacies in their area, and as we assume such tests might attract a fee, this would lead to unnecessary expense. They might also travel from pharmacy to pharmacy to obtain medication. Another example may be patients who obtain emergency contraception - which we recognise is a vital service, but for which there is nothing to stop patients from repeatedly using this method instead of a more reliable and clinically appropriate means of contraception.

Experience shows that offering screening won't always attract the target audience as often those at risk are least likely to take advantage. Essentially, there is a danger of "over screening" some, thus wasting NHS resources, as currently there is no mechanism for activity outside general practice to be sensibly recorded – this issue applies to the example given above regarding emergency contraception, and is an concern which should be given detailed consideration should community pharmacists begin to provide other services (such as flu vaccines, travel medicines / immunisation etc).

The practice based primary care team provides fully integrated and recorded health care, and the standard of record keeping is exemplary. If outside agencies start to work at the edges, such activity will not be recorded and may lead to duplication at best, or a failure to make appropriate diagnosis at worst. Not to mention the potential for abuse of the system. We would then be faced with a difficult medico-legal situation, where the Defence Unions might argue that in setting up an "alternate care" pathway the LHB or pharmacist might be clinically responsible for any deficiencies. We are not sure what indemnity cover currently applies to our pharmacy colleagues, but this is an issue which is crucial.

There are great difficulties in recruiting and retaining doctors in Wales generally, unfortunately our country is not an attractive career choice for those wishing to practise medicine. However, in rural (and Valley) areas this problem is even more acute. The BMA is concerned about the sustainability of services in these areas and the resulting problems with access to healthcare for patients. The BMA has previously published a report on the nature of rural general practice in the UK[1], written by the general practitioners committee (GPC) of the BMA and the Institute of Rural Health (IRH). The joint report considered issues of dispensing and its implications on practice income on the retention of doctors in these hard-to-staff areas as a key component of healthcare delivery in rural settings. In addition - the vast majority of dispensing practices reinvest a portion of their dispensing income in other aspects of the practice such as employing additional staff and/or providing a wider range of services to their patients.

Finally, many are concerned that premises contracted to provide services to the NHS promoting healthy living, are also licensed to sell both alcohol and tobacco products (many retailers also have loyalty and reward schemes for customers who purchase these items). We find these roles incompatible. The sceptics amongst us think that were this to be an either healthcare or tobacco/alcohol choice, then we suspect which way the national companies would opt.

OPTIONS FOR THE FUTURE

Below are the key measures we would ask Government to consider to protect dispensing doctors and the provision of other services they provide:

- Legislative changes should be made to give some protection to dispensing status and to improve the pharmacy application system;

- There must be some degree of protection for dispensing status to allow for business continuity and to ease the transition where a practice does lose its right to dispense;

[1] http://www.bma.org.uk/images/rural_tcm41-20982.pdf

- It is essential that patients and dispensing doctors are allowed to participate in the pharmacy application process. Consistent with the NHS Reform Act patients must be consulted if there are proposed changes to their service delivery.

KEY MESSAGE

It is important for community pharmacies and GP Practices to work together; and in the majority of areas that is happening very effectively. However, in other – mainly rural areas - where community pharmacies are set up in localities which already have established dispensing doctors, the long-term future of the services provided by the GP Practice is, if not threatened – then severely compromised.

As with all things, pharmacy provision should be considered holistically – alongside its role and relationship to all other components in the patient pathway - including access to medical advice, assessment and to medicine.

BMA PUBLICATIONS

The following publications may be of interest to the Committees inquiry, please contact us if you would like a copy (some are these guides are only available for our members, and as such are not in the public domain, therefore we are unable to provide a hyperlink):

- **The community pharmacy - a guide for general practitioners and practice staff**
  This guide aims to support GPs and community pharmacists in developing more effective working relationships and in turn, improve primary care services for patients. This is a follow-up to the earlier workbook from the BMA and National Pharmacy Association called Improving communication between community pharmacy and general practice.

  14 April 2010

- **Improving communication between community pharmacy and general practice**
  The General Practitioners Committe of the BMA and the National Pharmacy Association have produced this workbook to help facilitate local dialogue between the two professional groups, helping to improve patient care.

  11 April 2008

- **Changes to the NHS Community Pharmacy Contractual Framework (CPCF) in England**
  Details of the New Medicine Service (NMS) feedback form.

  18 August 2011

- **The GP practice - a guide for community pharmacists and pharmacy staff**
  Guide to support GPs and community pharmacists in developing more effective working relationships and in turn, improve primary care services for patients.

  13 April 2010

- **Information for the public**
  This section of the 'Over the counter medication' report discusses the importance of information specifically for members of the public.

06 November 2007

- **Healthcare in a rural setting**

  In this report the key areas of medical education and training, recruitment and retention, and accessibility and sustainability of healthcare are examined in the rural context, with a focus on primary care. UK and international examples of good practice are included and recommendations for action made. The report is aimed at all healthcare professionals and organisations that can respond and improve healthcare in rural areas.

  January 2005
  CASE STUDIES

Case Study 1:

A dispensing GP Practice in Powys recently contacted us to highlight some serious issues of concern in the provision of pharmacy services to patients. This practice covers an area of 750 square miles; it has one main surgery and two smaller branches serving a total of 10,500 patients (a fourth branch practice was recently forced to close due to reductions in Minimum Practice Income Guarantee).

Only the patients living close to the main surgery have access to a pharmacists' expertise, other areas do not have a dense enough population base to be able to financially support a new pharmacy. Many patients therefore have a real need for access to a pharmacy / over-the-counter sales. The GP practice participates in the Dispensary Services Quality Scheme (DSQS) and employs a highly skilled pharmacy technician who is responsible for both managing dispensary services and medicines management – and who also undertakes home visits if necessary. The Practice is dependent on the income from dispensing to support the two branch surgeries:

"if we had our dispensing right removed we would have to assess the case to become a pharmacy on a least one site which would still leave our patients at the other end of the patch without a branch surgery or a pharmacist as it would be pointless running a surgery without any ability to provide medication nor would either end support a pharmacy. These patients would be 24-40 miles from a doctor or pharmacy… we have a good relationship with our local pharmacist but he has not taken up our offer to link more as we would really like medication reviews on our high-risk groups.

"It may be that for areas such as ours and our neighbouring practice an opening of the options that came with the New Pharmacy Contract would be the answer. If we could employ a pharmacist without altering our dispensing status and fund that position by gaining income from over-the-counter sales but also by performing services outlined in the New Pharmacy Contact, a pharmacist could be peripatetic on our patch available to patients on different sites on different days and working with our current technician in improving prescribing both in terms of cost and quality as well I am sure as giving valuable support to the dispensing team).

"We constantly hear rumours of dispensing being removed without any thought to how the pharmaceutical services are to replace them. It also does not seem the best way forward when there are GP sites which make ideal places to access pharmacists in areas which cannot support community pharmacies. Patients also like receiving medication from us and those living in (main practice area) who go to the pharmacist complain that it is inconvenient and on some days it closes for half of the day."

Case Study 2

A GP from a semi-rural dispensing practice in Denbigh contacted us recently to outline the impact of community pharmacies on their Practice:

"The introduction of the pharmacy contract has not helped us in any discernable way; there has been no reduction in our workload, we regularly receive multi-page medication reviews from the pharmacists, all advising patients to see their GP. This seems to be a duplication of work as we regularly review patients' medication.

"Recently there has been a switch from long term local pharmacists to large companies who move pharmacists around from location to location thus diminishing the possibility of any continuity of care. We are unaware of any positive benefits from the new pharmacy contract and would dispute whether any further channelling of monies in this direction is really money well spent.

"As a dispensing practice we pride ourselves in the quality of service that we provide to our patients and I know that most of our non-dispensing patients would prefer to have their medicines dispensed and, in many cases, delivered by the surgery. Both we and our pharmacy colleagues have seen a dramatic reduction in income together with supply difficulties due to manufacturers exporting medications to the continent.

"With the reduction in income, which has occurred as a result of the changes in drug tariff pricing, many smaller chemists seems to have been taken over by the larger chains. This has resulted in quite aggressive marketing to try and acquire business, particularly of the patients in nursing homes. We now have the ridiculous situation where pharmacies from more than 20 miles away are dispensing to patients in nursing homes. As a consequence, the local GP's are unable to build any sort of relationship with these organisations whereas previously it was a simple matter to liaise with a local pharmacist.

"We would urge the Welsh Government to look carefully before diverting any more funds into community pharmacies, especially in the days of financial restraint, to ensure that they are already getting value for the monies already invested in the community pharmacies. Of course, we would prefer to dispense to all my patients but am keen to ensure that those who are non-dispensing receive a service at least equal to that we are able to provide to our dispensing patients".

The Dispensing Doctors' Association
Low Hagg Farm
Starfitts Lane
Kirkbymoorside
North Yorkshire
YO62 7JF
Ffôn: 0751 430835 Ffacs 01751 430836
E-bost: Office@dispensingdoctor.org

Y Pwyllgor Iechyd a Gofal Cymdeithasol

HSC(4)-09-11 papur 2

Ymchwiliad i'r cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru - Tystiolaeth gan Gymdeithas y Meddygon Fferyllol

Rydym yn falch o gyflwyno'r ymateb canlynol i'r ymchwiliad hwn:

Mae Cymdeithas y Meddygon Fferyllol (DDA) yn cynrychioli buddiannau'r 1500+ o bractisiau fferyllol yn y DU ac yn hybu rhagoriaeth mewn rhoi cyffuriau ar bresgripsiwn er lles y 4 miliwn o gleifion fferyllol sy'n cael eu gwasanaethu gan y practisiau hynny. Mae tua 85% o bractisiau fferyllol ag aelodaeth gyswllt o'r Gymdeithas.

Mae 89 o bractisiau fferyllol yng Nghymru yn darparu gwasanaethau fferyllol i 200,011 o'u 530488 o gleifion. Gan hynny, mae gan bron 18% o bractisiau yng Nghymru ganiatâd fferyllol amlinellol (neu ei gyfwerth) ac maent yn dosbarthu 6.75% o'r holl eitemau presgripsiwn. (Mae'r ffigurau ar gyfer Lloegr yn debyg: y naill yn 16% a'r llall yn 7%).

Mae'n achos pryder i'r Gymdeithas bod datblygiad diweddar gwasanaethau fferyllol cymunedol wedi tueddu i ganolbwyntio ar y gwasanaethau hynny a ddarperir gan fferyllwyr mewn fferyllfeydd yn unig ac wedi eithrio bron yn gyfan gwbl y gwasanaethau hynny a ddarperir gan bractisiau fferyllol i'w cleifion yng nghefn gwlad.

Mae perygl, pe bai rhai gwasanaethau ond ar gael gan fferyllfeydd yn y dyfodol, y bydd dewis wedi ei leihau i'r claf yng nghefn gwlad a gall y pellter i'w fferyllfa agosaf nadu mynediad i'r gwasanaeth yn gyfan gwbl.

Efallai nad oedd y refeniw y mae practisiau yn ei dderbyn o ddarparu gwasanaethau fferyllol erioed wedi ei gynllunio i noddi darparu gwasanaethau meddygol cyffredinol, ond y gwir plaen amdani yn y rhan fwyaf o achosion yw ei fod yn gwneud hynny.

Gan hynny, pa bryd bynnag y symudir unrhyw wasanaethau a ddarperir oddi wrth y meddyg i'r fferyllydd, (neu i fod yn fwy cywir o'r feddygfa i'r fferyllfa) rhaid cymryd i ystyriaeth yr effaith y bydd symud o'r fath yn ei gael ar wasanaethau meddygol ehangach cyfredol os nad yw cleifion yn mynd i fod o dan anfantais.

Er ein bod o blaid integreiddio gwasanaethau fferyllol a meddygol ble bynnag y bo modd er mwyn mwyhau budd a hwylustod i'r claf, cydnabyddwn nad yw'r fframwaith sy'n rheoli ein gwaith yn ei gwneud hi'n hawdd i ni gyflawni hyn.

Mae'r DDA yn mynegi ei siom o beidio â bod yn rhan o'r trafodaethau hyn ar ddarparu gwasanaethau fferyllol yng Nghymru o'r cychwyn cyntaf a hyderwn y gallwn fel rhanddeiliaid gael ein cynnwys mewn unrhyw ymgynghoriadau yn y dyfodol.

Dr David Baker
Prif Weithredwr 21ain Medi 2011

Health and Social Care Committee

HSC(4)-09-11 paper 3

Inquiry into the contribution of community pharmacy to health services in Wales – Evidence from the Royal College of General Practitioners

Royal College of General Practitioners

WALES

September 2011

Inquiry into the contribution of community pharmacy to health services in Wales

Pharmacists have an important role to play in expanding the information given to patients by their GP. This helps in understanding what the treatment is for, how it works and results in increased compliance, reducing waste. There are also benefits in that patients can easily ask pharmacists for advice when they have problems and also pharmacists can monitor drug usage. Many GPs already have close working relationships with their local pharmacists and this should be encouraged. One example where this is especially relevant is the provision of "Just in case" boxes for patients at the end of life.

The use of computerised reminders for prescription review by the GP mean that there is often little added value in Pharmacist led medication review for the many patients having regular treatment for a straightforward long term condition (such as hypothyroidism). Patients with complicated drug regimes often have multiple co-morbidities and these patients will be seeing their GP regularly in any case. There may be a place for medication reviews of patients in nursing homes, in reducing over-prescribing, but again, these patients are also regularly seen by their GP and this may result in duplication of effort and cost. Governance of medication reviews is particularly important and information must be fed back to the GP in a confidential and timely manner.

We question the value of pharmacist initiated investigations, especially those which are clinically unnecessary and only serve to raise alarm in the "worried well", increasing the burden on GPs (to explain the significance of any results) and resulting in cost to the NHS.

GPs have a unique role in managing their patients in a holistic way. Seemingly trivial appointments for medication reviews with the GP are an important part of the way in which this care is provided. Symptoms which would not be mentioned at a pharmacist led review may be raised with the GP and can be identified and pro-active action taken. This is often of benefit to both the patient and the NHS in the long term. There is a danger that increasing use of pharmacists and other non-medical professionals leads to a fragmentation of care, to the ultimate detriment of the patient and resulting in increased eventual cost to the NHS.

Yours faithfully

Dr Bridget Osborne
Chair
RCGP Wales

Y Pwyllgor Iechyd a Gofal Cymdeithasol
HSC(4)-09-11 papur 4
Ymchwiliad i Wasanaethau Lleihau'r Risg o Strôc - Tystiolaeth ysgrifenedig gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol

1. Mae'r papur hwn yn rhoi tystiolaeth i'r Pwyllgor ynghylch: epidemioleg strôc / pwl o isgemia dros dro (TIA) yng Nghymru; polisïau ehangach i geisio lleihau'r risg o gael strôc; camau i fynd i'r afael â risgiau allweddol ar gyfer strôc; gweithgareddau codi ymwybyddiaeth; a datblygiadau yn y dyfodol.

Strôc a TIA yng Nghymru

2. Strôc yw un o brif achosion anabledd ymhlith oedolion yng Nghymru ac mae'n un o'r achosion marwolaeth mwyaf cyffredin. Er mai clefyd sy'n effeithio ar bobl hŷn yn bennaf yw strôc, gall effeithio ar bobl o unrhyw oedran.

3. Mae dros 65,000 o gleifion ar gofrestr strôc / TIA meddygon teulu Cymru, sy'n cyfateb i ryw 2% o'r boblogaeth[1]. Yn 2009/10, 118.08 i bob 100,000 o'r boblogaeth oedd nifer y derbyniadau brys i ysbytai yng Nghymru â strôc fel prif ddiagnosis. Gostyngodd y nifer rhwng 2002/03 a 2007/08 (o 151.89 i 122.70), cododd yn 2008/09 (130.76), ond gostyngodd eto yn 2009/10 (118.08).

4 Mae'n galonogol gweld o'r ffigurau marwolaethau fod tuedd ar i lawr o ran nifer y rhai sy'n marw o strôc. Yn 2009, bu farw 97 o bob 100,000 o bobl 65-74 oed o strôc. Mae hyn gryn dipyn yn is na'r targed Cynnydd mewn Iechyd o 135 o bob 100,000 erbyn 2012.[2]

Camau ehangach Llywodraeth Cymru i leihau'r risg o gael strôc

5. Mae lleihau'r risgiau o gael strôc yn dal yn flaenoriaeth i Lywodraeth Cymru ac mae'n elfen allweddol o'n strategaeth ehangach i fynd i'r afael â risgiau clefyd cardiofasgwlaidd. Er enghraifft, mae Fframwaith Gwasanaeth Cenedlaethol Cymru ar gyfer Clefyd y Galon (2009) yn nodi'r gofynion yn glir o ran atal, asesu risg a rheoli clefyd cardiofasgwlaidd.

6. Yn ddiweddarach, gofynnodd Llywodraeth Cymru i Iechyd Cyhoeddus Cymru fapio'r gwasanaethau presennol ar draws Cymru sy'n asesu pobl y mae perygl iddynt gael clefyd cardiofasgwlaidd, megis strôc, a rheoli'r ffactorau risg hyn. Gan ddefnyddio canlyniad yr ymarfer hwn, gofynnwyd i Iechyd Cyhoeddus Cymru argymell ffyrdd o wneud y

[1] Ffynhonnell: Y Fframwaith Ansawdd a Chanlyniadau, Contract ar gyfer Gwasanaethau Meddygol Cyffredinol: Ystadegau'r Fframwaith Ansawdd a Chanlyniadau, 2010-11
[2] Ffynhonnell: Adroddiad Blynyddol y Prif Swyddog Meddygol 2010

gwasanaethau hyn yn fwy systematig a chydgysylltiedig. Cyflwynwyd yr argymhellion hyn yn ddiweddar ac mae fy swyddogion yn paratoi cyngor yn eu cylch i mi gael ystyried y ffordd ymlaen.

7. Mae'r rhaglen 1000 o Fywydau a Mwy hefyd yn cyfrannu drwy ei gwaith i wella gwasanaethau TIA a hysbysu data clinigol allweddol. Bydd rheoli pobl sy'n cael TIA neu fân strôc yn effeithiol ac yn brydlon yn lleihau nifer y strociau yng Nghymru. Dangosodd archwiliad clinigol cenedlaethol diweddar na fydd pobl yn cael ymyriadau llawfeddygol yn dilyn TIA ac rydym yn paratoi i gydweithio â Byrddau Iechyd Lleol i roi sylw i hyn. Disgwyliaf weld gwelliannau sylweddol dros amser.

8. Mae gwaith mwy cyffredinol ar wella iechyd a lles pobl hŷn, yn codi o'r Strategaeth ar gyfer Pobl Hŷn, yn chwarae rhan hefyd. Er enghraifft, mae Llywodraeth Cymru'n cefnogi'r Rhaglen Heneiddio'n Iach a ddarperir gan Age Cymru. Rhaglen gwella iechyd ydyw sy'n cefnogi ac yn darparu mentrau megis *Gofal Piau Hi y Gaeaf Hwn*, a rhaglenni gweithgarwch corfforol ac ymwybyddiaeth o feddyginiaeth. Mae'r mentrau hyn yn amlwg yn cyfrannu at leihau'r risgiau o strociau mewn pobl hŷn.

<u>Y Cynllun Gweithredu i Leihau'r Risg o Strôc</u>

9. Yng Nghylchlythyr Iechyd Cymru (2007) 58, a gyhoeddwyd gan Lywodraeth Cymru, pwysleisiwyd bod mynd i'r afael â strôc yn un o brif flaenoriaethau'r gwasanaeth iechyd yng Nghymru. Gofynnwyd i Fyrddau Iechyd Lleol adolygu gwasanaethau strôc a pharatoi cynlluniau gweithredu ffurfiol i fapio'r daith tuag at gydymffurfio â safonau cenedlaethol erbyn 2015.

10. Yng Nghylchlythyr Iechyd nesaf Cymru ((2007) 082), mynnwyd bod asesiad yn cael ei gynnal o fylchau yn yr adnoddau neu'r gwasanaethau a oedd ar gael yn lleol ac yn genedlaethol i geisio lleihau'r ffactorau risg ar gyfer strôc. Roedd y Rhaglen Gwella Gwasanaethau Strôc a sefydlwyd yn sgîl hynny yn cynnwys cam i fynd i'r afael â'r risg o gael strôc ac fe'i rhoddwyd ar waith gan Wasanaeth Iechyd Cyhoeddus Cenedlaethol Cymru fel un o ffrydiau gwaith y rhaglen honno.

11. Paratowyd adroddiad y ffrwd waith, "Hybu Iechyd Cardiofasgwlaidd: Y Cynllun Gweithredu i Leihau'r Risg o Strôc", yn 2010, er mwyn tynnu'r camau presennol at ei gilydd a'u cryfhau. Roedd yn canolbwyntio ar atal sylfaenol ond yn ystyried bod lleihau'r risg yn fater i'r holl lwybr gofal strôc.

12. Roedd y Cynllun yn ymdrin â'r boblogaeth gyfan, ac yn cynnwys camau i godi ymwybyddiaeth y cyhoedd o'r ffactorau risg ar gyfer pwysedd gwaed uchel, ffibrilio atrïaidd, TIA a strôc. Roedd y cynllun hefyd yn cyfeirio at ymyriadau penodol ar lefel yr unigolyn, megis y Cynllun Cenedlaethol i Atgyfeirio Cleifion i Wneud Ymarfer Corff, ac yn cynnwys cyfraniad fferyllfeydd cymunedol at redeg ymgyrchoedd iechyd y

cyhoedd, at gyfeirio at wasanaethau lleihau'r risg ac at gynnal adolygiadau o feddyginiaeth lle y bo'n briodol. Roedd holl gamau'r cynllun i gael eu cyflawni erbyn Mawrth 2012.

13. Mae'r cynnydd o ran cyflawni camau'r Cynllun Gweithredu i Leihau'r Risg o Strôc wedi bod yn gadarnhaol ar y cyfan, gyda nifer fawr o fentrau'n cyfrannu at y darlun cyffredinol. Mae nifer fach o gamau wedi'u gohirio neu wedi'u disodli gan ddatblygiadau diweddarach. Mae nifer o gamau wedi parhau ac wedi datblygu ar ôl y dyddiad cyflawni gwreiddiol.

Camau Llywodraeth Cymru i leihau Ffactorau Risg Penodol ar gyfer Strôc

14. Mae fframwaith strategol Llywodraeth Cymru ar gyfer iechyd y cyhoedd, *Ein Dyfodol Iach*, yn nodi'r agenda a'r camau sydd eu hangen i wella iechyd a lles yng Nghymru. Mae gan bump o'r deg canlyniad sydd wedi'u blaenoriaethu yn *Ein Dyfodol Iach* gydberthynas uniongyrchol â lleihau'r ffactorau risg ar gyfer clefyd cardiofasgwlaidd a strôc:
    - Llai o bobl yn ysmygu;
    - Mwy o bobl yn cymryd rhan mewn gweithgarwch corfforol;
    - Llai o bobl yn bwyta'n afiach;
    - Gwell iechyd yn y gwaith; a
    - Lleihau annhegwch ym maes iechyd.

15. At hynny, mae'r Rhaglen Atal a Hybu Genedlaethol wedi nodi meysydd gweithredu iechyd y cyhoedd sy'n gallu cael effaith sylweddol ar y defnydd o adnoddau iechyd a gofal cymdeithasol dros gyfnod o dair i bum mlynedd. Mae'r meysydd hyn yn cynnwys lleihau'r baich a achosir gan ddefnyddio tybaco a chamddefnyddio alcohol a rheoli'r risg fasgwlaidd yn effeithiol – mae'r rhain i gyd yn berthnasol i leihau'r risg o gael strôc.

16. Adlewyrchir y blaenoriaethau hyn ar gyfer iechyd y cyhoedd yng nghamau penodol y Cynllun Gweithredu i Leihau'r Risg o Strôc. Fodd bynnag, mae'r gweithgarwch i fynd i'r afael â'r ffactorau risg hyn yn estyn y tu hwnt i gamau'r Cynllun Gweithredu ac amlinellir rhai datblygiadau allweddol isod.

Pwysedd gwaed

17. Nododd Arolwg Iechyd Cymru 2010 fod nifer yr achosion cofnodedig o bwysedd gwaed uchel wedi cyrraedd 20%. Mae gweld y meddyg teulu yn gyfle i nodi a rheoli pwysedd gwaed uchel a ffactorau risg eraill megis ysmygu, lefelau colesterol a rhythmau afreolaidd y galon. Mae'r Fframwaith Ansawdd a Chanlyniadau (QOF) ar gyfer Meddygon Teulu yn hybu ac yn gwobrwyo gofal systematig rhagweithiol yn y meysydd hyn. Bydd Byrddau Iechyd Lleol yn sicrhau ansawdd y broses QOF ac yn

cydweithio â phractisau meddygon teulu i leihau gwahaniaethau a gwella canlyniadau. Mae nifer y cleifion yr edrychir ar bwysedd eu gwaed yn parhau i gynyddu, ac mae gan dros 88%[3] o gleifion sydd wedi cael strôc neu TIA yn y gorffennol gofnod fod pwysedd eu gwaed yn cael ei reoli i'r lefel a dargedwyd. Roedd y Set Wybodaeth Gofal Sylfaenol yn rhoi gwybodaeth gymharol i Fyrddau Iechyd Lleol i nodi cyfleoedd i wneud mwy o waith yn y maes hwn.

18. Yn ôl canllawiau'r Sefydliad Cenedlaethol dros Iechyd a Rhagoriaeth Glinigol, gall rhoi'r canllawiau pwysedd gwaed uchel ar waith arwain at arbedion sylweddol[4]. Bydd cadw at yr argymhellion yn costio mwy mewn cyffuriau, ond bydd y nifer ddisgwyliedig o ddigwyddiadau cardiofasgwlaidd (trawiadau ar galon a strociau) a gaiff eu hatal os rheolir pwysedd gwaed uchel yn well yn gorbwyso hynny.

Tybaco

19. Nododd Arolwg Iechyd Cymru 2010 fod tua chwarter o oedolion (23%) yn dweud eu bod yn ysmygu ar y pryd. Bydd cysylltiad â thybaco yn cynyddu'r risg o gael amrywiaeth o gyflyrau, gan gynnwys strôc a chlefyd cardiofasgwlaidd. Bydd y risg yn cynyddu gyda phob sigarét a ysmygir. I lawer, rhoi'r gorau i ysmygu yw'r peth gorau y gallant ei wneud i wella'u hiechyd.

20. Mae cymryd camau i fynd i'r afael â'r niwed a achosir gan ysmygu yn dal yn flaenoriaeth i Lywodraeth Cymru. Un o brif themâu *Ein Dyfodol Iach* yw lleihau nifer y rhai sy'n ysmygu ac yn dod i gysylltiad â mwg ail-law. I wireddu hyn rydym newydd ymgynghori ar Gynllun Gweithredu drafft ar Reoli Tybaco, sy'n adeiladu ar ein rhaglen o gamau i atal pobl ifanc rhag dechrau ysmygu ac i helpu ysmygwyr sydd am roi'r gorau i'r arfer. Mae hefyd yn hybu amgylcheddau di-fwg, ond y nod penodol yw diogelu plant a lleihau annhegwch ym maes iechyd. Nod y Cynllun Gweithredu yw gostwng y lefelau ysmygu i 16% erbyn 2020. Rydym wrthi ar hyn o bryd yn ystyried yr ymatebion i'r ymgynghoriad ar Gynllun Gweithredu drafft Cymru ar Reoli Tybaco a byddwn yn lansio'r Cynllun diwygiedig ym mis Rhagfyr.

21. Mae Llywodraeth Cymru yn cefnogi'r gwasanaeth Dim Smygu Cymru, sy'n cael ei gyflenwi gan Iechyd Cyhoeddus Cymru. Gall ysmygwyr sydd am roi'r gorau gysylltu â Dim Smygu Cymru i gael arweiniad, cyngor, gwybodaeth a mynediad am ddim i gwnsela a grwpiau cymorth ledled Cymru. Nodwyd yn adroddiad blynyddol 2010/11 Dim Smygu Cymru fod tua 16,000 o bobl wedi cysylltu â'r gwasanaeth yn ystod y flwyddyn honno.

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[3] Contract ar gyfer Gwasanaethau Meddygol Cyffredinol, Ystadegau'r Fframwaith Ansawdd a Chanlyniadau ar gyfer Cymru 2010-11 (Medi 2011)

[4] http://www.nice.org.uk/usingguidance/benefitsofimplementation/costsavingguidance.jsp

Gordewdra (gan gynnwys deiet / yr halen a fwyteir a gweithgarwch corfforol)

22. Nododd Arolwg Iechyd Cymru 2010 fod tua 3 o bob 5 oedolyn (57%) dros bwysau neu'n ordew, a bod tua 1 o bob 5 (22%) yn ordew. Nododd yr Arolwg hefyd mai tua 3 o bob 10 oedolyn (30%) a ddywedodd eu bod wedi bodloni'r canllawiau o ran gweithgarwch corfforol yn yr wythnos ddiwethaf.

23. Mae Llwybr Gordewdra Cymru Gyfan yn amlinellu'r pedair haen o wasanaethau sy'n anelu at atal a rheoli pwysau a gordewdra. Cefnogir y gwaith ataliol gan *Newid am Oes*, yr elfen marchnata cymdeithasol o ymateb ehangach Llywodraeth Cymru i helpu pobl i gyrraedd a chynnal pwysau iach. Rhaglen gwbl integredig yw *Newid am Oes*, a'i nodau yw creu'r amodau cywir i newid ymddygiad, targedu gwybodaeth yn gywir at deuluoedd mewn perygl a meithrin perthynas barhaus â hwy. I gychwyn, targedodd *Newid am Oes* deuluoedd â phlant ac mae dros 13,000 o deuluoedd wedi'u cofrestru yng Nghymru. Ym mis Hydref eleni, bydd *Newid am Oes* yn cael ei hestyn i ymdrin ag oedolion yn fwy cyffredinol ac rwyf yn cynnig ei bod yn ymdrin â chamddefnyddio alcohol o Wanwyn 2012.

24. Mae Llywodraeth Cymru yn parhau i ddarparu ymyriadau i geisio gwella deiet y boblogaeth, gan gynnwys lleihau'r halen a'r braster dirlawn a fwyteir. Mae'r gwaith sy'n cael ei wneud ar hyn o bryd yn cynnwys datblygu canllawiau ar ddarparu bwydydd a diodydd iachach ar gyfer lleoliadau sector cyhoeddus megis ysbytai, canolfannau hamdden a lleoliadau ieuenctid – bydd y rhain yn cael eu cyhoeddi cyn bo hir.

25. Mae'r Cynllun Cenedlaethol i Atgyfeirio Cleifion i Wneud Ymarfer Corff (NERS) yn cynnwys cleifion gordewdra a strôc, yn unol â Chanllawiau Clinigol Cenedlaethol Coleg Brenhinol y Ffisigwyr ar gyfer Strôc (2008) sy'n argymell y canlynol yn yr adran ar adsefydlu: 'After stroke, all patients should participate in aerobic training unless there are contraindications unrelated to stroke.' Atgyfeiriwyd dros 23,000[5] o gleifion rhwng 1 Ebrill 2010 a 31 Mawrth 2011. Mae'r gwerthusiad o NERS a gyhoeddwyd yn 2010 yn cadarnhau cost-effeithiolrwydd y cynllun. Gan ddefnyddio Blynyddoedd Oes yr Addaswyd eu Hansawdd (QALY) i fesur effeithiolrwydd, cafwyd cost fesul QALY o £12,111, sy'n is o lawer na throthwy NICE o £20,000-£30,000.

Alcohol

26. Gall alcohol fod yn ffactor risg ac yn ffordd o atal strôc. Bydd goryfed mewn pyliau ac yfed llawer o alcohol yn cynyddu risg rhywun o gael pwysedd gwaed uchel a strociau isgemig a gwaedliniol. Fodd bynnag, gall yfed ychydig bach o alcohol neu yfed alcohol yn gymedrol gael

[5] Seiliedig ar wybodaeth reoli'r rhaglen NERS

effaith gadarnhaol ar y risg o gael strôc drwy gynyddu'r colesterol HDL a lleihau tuedd y gwaed i glotio.

27. Nododd Arolwg Iechyd Cymru 2010 fod tua 2 o bob 5 oedolyn (44%) yn dweud eu bod wedi yfed mwy nag a argymhellir ar o leiaf un diwrnod yn yr wythnos ddiwethaf, a bod tua chwarter (27%) yn dweud eu bod wedi goryfed mewn pyliau. Mae ein Strategaeth Camddefnyddio Sylweddau i Gymru – Gweithio Gyda'n Gilydd i Leihau Niwed 2008-2018 – yn rhoi blaenoriaeth uchel i fynd i'r afael â chamddefnyddio alcohol. Mae'r cynllun cyflawni yn cynnwys ystod o gamau sydd wedi'u targedu'n benodol at fynd i'r afael â'r niweidiau sy'n gysylltiedig ag alcohol. Yn rhan o'r Cynllun Cyflawni, mae Llywodraeth Cymru yn darparu ymyriadau ar lefel y boblogaeth yn ogystal ag ar lefel yr unigolyn, megis ymyriadau byr i fynd i'r afael â'r niwed a achosir gan alcohol.

28. Mae gwerthusiadau o ymyriadau byr wedi dangos yn gyson eu bod yn un o'r ffyrdd mwyaf effeithiol o leihau yfed problemus. Bydd Llywodraeth Cymru yn parhau i hybu cyfleoedd ar gyfer ymyriadau byr mewn perthynas ag alcohol mewn gofal sylfaenol ac eilaidd.

Ffibrilio Atrïaidd

29. Mae'r rhaglenni sgrinio cenedlaethol sydd ar gael yng Nghymru, a gweddill y DU, ar gyfer y boblogaeth yn seiliedig ar gyngor arbenigol a ddarperir gan Bwyllgor Sgrinio Cenedlaethol y DU (NSC y DU). Polisi NSC y DU ar hyn o bryd yw nad yw'n argymell sgrinio ar gyfer ffibrilio atrïaidd. Fodd bynnag, mae'r polisi hwn yn cael ei adolygu a bydd un newydd yn barod erbyn Mawrth 2012. Mae Llywodraeth Cymru ac Iechyd Cyhoeddus Cymru yn aelodau o NSC y DU a chânt wybod am ddatblygiadau.

30. Fodd bynnag, dengys y dystiolaeth fod rheoli Ffibrilio Atrïaidd yn brydlon yn llesol i gleifion ac yn lleihau'r risg o gael strôc. Yn rhan o 1000 o Fywydau a Mwy, mae'r Gwasanaeth Ansawdd a Gwybodaeth Gofal Sylfaenol wedi llunio canllaw ar arferion fel y gellir darparu gofal yn unol â'r dystiolaeth gyfredol orau sydd ar gael. Mae'r gwaith hwn yn cynnwys mynd ati'n gynnar i nodi a rheoli ffibrilio atrïaidd symptomatig ac ansymptomatig.

31. Mae practisau'n cael eu gwahodd i gymryd rhan yn y gwaith o wella Ffibrilio Atrïaidd, yn rhan o gyfres o ddigwyddiadau dysgu sy'n cael eu cynnal yn lleol.

<u>Ymgyrchoedd a gweithgareddau i godi ymwybyddiaeth o ffactorau risg clefyd cardiofasgwlaidd a strôc</u>

32. Mae'r angen i godi ymwybyddiaeth ymhlith y boblogaeth o'r risgiau sy'n gysylltiedig â chlefyd cardiofasgwlaidd, gan gynnwys strôc, yn elfen

allweddol o weithgarwch Llywodraeth Cymru. Adlewyrchir hyn yn y Rhaglen Lywodraethu, sy'n cynnwys ymrwymiad i gynnal ymgyrch flynyddol dros gyfnod y Llywodraeth hon, i fynd i'r afael â'r pum blaenoriaeth fwyaf ar gyfer iechyd y cyhoedd yng Nghymru (gordewdra, ysmygu, beichiogrwydd yn yr arddegau a chamddefnyddio cyffuriau ac alcohol).

33. Mae nifer o fentrau eisoes wedi'u sefydlu i godi ymwybyddiaeth o'r prif risgiau. Yn Ebrill 2008 cynhaliodd y Gymdeithas Strôc ymgyrch Gymru gyfan, i gefnogi Her Iechyd Cymru, yn rhan o'i hymdrechion i godi ymwybyddiaeth y cyhoedd o symptomau strôc. Cyhoeddwyd hysbysebion mewn ugain wythnosolyn yn annog pobl i weithredu'n gyflym, gan ddefnyddio'r prawf FAST, os byddent yn amau bod rhywun yn cael strôc. Dywedodd y Gymdeithas Strôc fod 3.5 gwaith yn fwy o bobl yn gyfarwydd â'r prawf FAST yn dilyn yr ymgyrch un wythnos. At hynny, nod yr ymgyrch radio 'Pwyso a Mesur eich Risg', a gynhaliwyd yn Ionawr 2009, oedd tynnu sylw at y ffaith fod cadw pwysau eich corff yn iach yn gallu gostwng pwysedd gwaed a lefelau colesterol uchel, gan leihau'r risg o strôc.

34. Ym Mawrth 2011 cynhaliwyd yr ymgyrch 'Gofynnwch Gyntaf' mewn partneriaeth â'r Gymdeithas Strôc i godi ymwybyddiaeth y cyhoedd. Roedd yr ymgyrch yn cynnwys hysbysebion radio a digwyddiadau profi yng ngweithleoedd rhwydwaith y Safon Iechyd Gorfforaethol, yn ogystal â phosteri mewn fferyllfeydd, arosfannau bysiau a phractisau meddygon teulu.

35. Rydym hefyd wedi nodi nifer o faterion codi ymwybyddiaeth sydd wedi'u hanelu at gynulleidfaoedd penodol:

<u>Gweithleoedd</u>

36. Mae Llywodraeth Cymru ac Iechyd Cyhoeddus Cymru yn rhoi gwybodaeth i gyflogwyr ar y risg o glefyd cardiofasgwlaidd drwy Gymru Iach ar Waith, sy'n trefnu digwyddiadau ymgysylltu â chyflogwyr ac yn cyhoeddi e-gylchlythyrau ac e-fwletinau. At hynny, cyfeirir cyflogwyr at ddeunyddiau cymorth cyrff sy'n bartneriaid, gan gynnwys Sefydliad Prydeinig y Galon a'r Gymdeithas Strôc.

37. Yn rhan o'r ymgyrch 'Gofynnwch Gyntaf', cynhaliwyd 15 o ddiwrnodau atal strôc gyda chyflogwyr, gan gynnwys Grŵp Yswiriant Admiral, Tata Steel, HSBC, John Lewis, Lloyds TSB a GE Aviation, a grwpiau pobl dduon a lleiafrifoedd ethnig ar draws Cymru. Profwyd 500 o unigolion am bwysedd gwaed uchel a Ffibrilio Atrïaidd.

<u>Lleoliadau Addysgol</u>

38. Y peth gorau, os ydym am newid ymddygiad, yw cyflwyno negeseuon ataliol sylfaenol yn gynnar, a rhaid i'r amgylchedd ategu'r negeseuon

hynny. Mae'r Cynlluniau Ysgolion Iach – Rhwydwaith Cymru (WNHSS) yn cynnig fframwaith ar gyfer ymagwedd ysgol gyfan at iechyd, sy'n cynnwys gweithredu ar y ffactorau risg ar gyfer strôc. Mae dros 99% o ysgolion a gynhelir yn rhan o WNHSS ac rydym wrthi ar hyn o bryd yn estyn y dull i leoliadau cyn-ysgol.

Datblygiadau yn y Dyfodol

39. Mae polisïau cyfredol Llywodraeth Cymru wedi ceisio lleihau'r risgiau sy'n gysylltiedig â chlefyd cardiofasgwlaidd, gan gynnwys strôc, drwy ganolbwyntio ar y prif ffactorau risg, gan gynnwys tybaco, deiet, gweithgarwch corfforol, alcohol a phwysedd gwaed.

40. Mae lleihau'r risg o gael strôc yn dal yn flaenoriaeth i Lywodraeth Cymru yng nghyd-destun gwella iechyd cardiofasgwlaidd yn gyffredinol ac iechyd a lles pobl hŷn. Er bod cynnydd sylweddol wedi'i wneud, cydnabyddwn y bydd angen cymryd mwy o gamau yn y blynyddoedd nesaf – adlewyrchir hynny yn y Rhaglen Lywodraethu.

41. Er enghraifft, mae Llywodraeth Cymru wedi ymrwymo i gychwyn rhaglen o archwiliadau iechyd blynyddol, dan arweiniad meddygon teulu, nyrsys practis, fferyllwyr a phroffesiynolion iechyd eraill, ar gyfer pawb dros 50 oed. Gallai archwiliadau iechyd fod yn ffordd bwysig o nodi a delio'n gynharach â phroblemau posibl yng nghyd-destun lleihau'r risg o gael strôc. Mae swyddogion wrthi'n cyflawni gwaith cwmpasu cychwynnol a chyn bo hir byddaf yn ystyried yr opsiynau cyntaf ar gyfer cyflenwi archwiliadau iechyd i bobl dros 50.

42. At hynny bydd materion yn ymwneud ag atal a lleihau'r risg o strôc yn rhan bwysig o ddatblygiadau yn y dyfodol, a byddant yn ymddangos yn y Cynllun Cyflawni Cenedlaethol ar gyfer Strôc, y mae Llywodraeth Cymru wrthi'n ei ddatblygu ar gyfer y cyfnod 2011-12 hyd 2015-16. Bydd hyn yn nodi'r canlyniadau a ddymunwn ar gyfer poblogaeth Cymru o ran mynd i'r afael â strôc, ac yn arwain ac yn cyfarwyddo'r camau a gymerir gan y GIG. Yn rhan o'r gwaith hwn, byddaf yn edrych yn ofalus i weld pa arweiniad strategol a gwaith partneriaeth y bydd eu hangen yn y dyfodol i helpu'r GIG i gyflawni fy nodau ar gyfer lleihau niferoedd y strociau a gwella ansawdd gofal strôc.

Health and Social Care Committee

HSC(4)-09-11 paper 5

Inquiry into the contribution of community pharmacy to health services in Wales – Evidence from Hywel Dda Health Board

Jenny Pugh-Jones Head of Medicines Management (Acting) Hywel Dda Health Board
September 2011.

- **the effectiveness of the Community Pharmacy contract in enhancing the contribution of community pharmacy to health and wellbeing services;**

The Community Pharmacy contract has the potential to really make an impact on this area as Community Pharmacies are in a unique situation where both patients and the wider members of the public pass through their door. To date the effectiveness of the contract is less than ideal due to a number of issues:

- Lack of support/signposting at a national level for raising awareness of the services that Community Pharmacy offers.
- Requires greater working partnerships with other Healthcare Professionals. Often other healthcare professionals are not aware of the contract although this is improving.
- Public Health campaigns because of no funding often rely on 'available material' rather than clear strategic direction of travel. This is improving as Health Boards become more coordinated with their own Public Health Wales teams within organisations and linking in with internal communication teams.
- The essential services around signposting and self care are not easy to determine clear patient outcomes and would benefit from a clearer focus. Documenting advice in this area is time consuming and often pharmacies struggle to demonstrate compliance with these services although it is well known that they perform a vital function in being the gateway to other services for all the public (not just patients)
- Lack of clear steps that can be taken within the contract to withhold payment/or fine pharmacies for essential services where compliance is an issue.
- At the moment the main remuneration aspect of the contact is dispensing, a rework of the contract is required to move this focus onto provision of further services.
- There is no provision for domiciliary services – a significant proportion of patients will be delivered to hence never see the pharmacy/pharmacist, this potentially is a vulnerable group of patients who would benefit from the community pharmacy services but cannot or do not attend the pharmacy.

- **the extent to which Local Health Boards have taken up the opportunities presented by the contract to extend pharmacy services through the provision of 'enhanced' services, and examples of successful schemes;**

- Hywel Dda had in place prior to national roll out both EHC and NRT (Level 2). The Health Board also supports provision of needle exchange and substance misuse enhanced services. The Just in Case boxes enhanced service is due to be implemented in the next few months.
- Hywel Dda also has a limited advice to care homes service and also a rota service in certain areas which require it.
    - In additional to the above the Health Board supports Medication Administration Scheme which is in place in one of the Counties and is currently due to be rolled out across all of Hywel Dda.
    -
    - The Health Board is also exploring additional services such as influenza vaccination (collating data at present on type of patients presenting at Pharmacies to access private schemes)

    - **the scale and adequacy of 'advanced' services provided by community pharmacies;**

    - There continues to be concern over the adequacy of the MUR and medicines intervention schemes for a number of reasons. The Health Board supports the MUR in principle and recognises the expertise and unique position of the Community Pharmacist to provide this service however concerns are raised as a consequence of target setting and include:
- There is no audit trail of the quality of the MUR (the Health Board has no access to audit the MUR)
- The target of 400 is inflexible, many small pharmacies do not have the opportunities without the need to undertake MURs on the same patients- even though this is annual the benefits are often reduced by repetition of this service.
- Some Pharmacies have the capacity to do more than 400 MURS but are unable to do so.
- A target of 400 has lead to 'anecdotal' evidence of MURs being undertaken in patients that are unlikely to have any benefit, and questions whether this is an appropriate use of significant resource.
- Targeting MURs towards specific patient groups is of benefit but at present the Health Boards have no mechanism to enforce this measure.
- There is a need for MURs to be quality checked with regard to safety and value for money this would enhance the reputation of community pharmacists and MURs in the eyes of other healthcare professionals

- **the scope for further provision of services by community pharmacies in addition to the dispensing of NHS medicines and appliances, including the potential for minor ailments schemes;**

- The minor ailments scheme in principle is supported but there are concerns on the resource implications of these schemes as although GPs time may be freed up by patients accessing the scheme inevitably there is another patient who requires the appointment so no overall cost efficiencies are seen within General Practice.
  There is likely to be increase in paperwork for Community Pharmacy. The self care agenda should be promoted more effectively encouraging people to take responsibility for their ailments, perhaps supported by a scheme where a small payment is made to avoid patients not even considering purchasing often inexpensive remedies?
- Community Pharmacy has a place in the provision of other items such as appliances, enteral feeds, dressings etc and this needs further development as currently there is a trend for outside companies to provide such items direct to patients.

Some suggestions:

- Weight management and offer additional support
- Pain management service- to provide additional support and monitoring of patients to ensure appropriate use of mild to moderate analgesia at an appropriate step in the pain pathway.
- Support the structured lifestyle requirements of NICE in partnership with GP practices
- HF follow up clinics from Pharmacy- needs to be independent prescriber- good example of pilot in Hywel Dda
- Expansion of the stop smoking enhanced service to include provision of all therapies and also behavioural support at the pharmacy (all in one service).
- If services are to be moved closer to the patient's home there is an increasing need for a motivated clinically driven workforce within CP which requires investment and support to ensure that pharmacist time is appropriately utilised and that MURs reflect the agenda.

- **the current and potential impact on demand for NHS services in primary and secondary care of an expansion of community pharmacy services, and any cost savings they may offer;**

- Waste reduction is key to improving efficiencies within the Health Service and medicines are no different to other areas of health.
- With £50million estimated of wasted medicines each year a concerted effort needs to be made to reduce this wastage, this may include;
    - Increase public awareness.

- Review of GP repeat prescribing procedures.
- Review of Managed repeat services.
- Increase use of 'green bags perhaps look at issuing from Community Pharmacies?

- **progress on work currently underway to develop community pharmacy services.**

- Along with the previously mentioned services that are in operation across Hywel Dda the following services are being developed:
- Just in case boxes enhanced service currently to be rolled out
- Medicines on discharge service
- Medication Administration Scheme also being rolled out across Hywel Dda
- Pilot of HF review in Pembrokeshire Pharmacy.
- Influenza service in 2012-13 following collation of data in this year (2011-12)

Health and Social Care Committee

HSC(4)-09-11 paper 6

Inquiry into the contribution of community pharmacy to health services in Wales – Evidence from Betsi Cadwaladr University Health Board

Betsi Cadwaladr University Health Board
Pharmacy & Medicine Management Clinical Programme Group

- **the effectiveness of the Community Pharmacy contract in enhancing the contribution of community pharmacy to health and wellbeing services;**

The current community pharmacy contract has enhanced the contribution of community pharmacy to the health and wellbeing of population. There is a need to further develop this contribution by reviewing the current contract requirements and services. The financing of the contract is also in need of review as it is still predominantly focused on the item of service fees attracted by dispensing. A contract funding pharmacies to meet patients' pharmaceutical needs and deliver outcomes would be preferable to the existing reimbursement for medicine supply.

- **the extent to which Local Health Boards have taken up the opportunities presented by the contract to extend pharmacy services through the provision of 'enhanced' services, and examples of successful schemes;**

The North Wales Local Health Boards took advantage of the enhanced services level of service with in the contract. The commissioned services have been public health rather than medicines management led such as EHC, Smoking Cessation, Supervised consumption and NSP.
Barriers to commissioning medicines management type services include overlap between GMS and Pharmacy services, i.e. GMS is funded to provide the service, but, because GMS money is ring-fenced moving resources to fund a pharmacy scheme is difficult, e. g. minor ailments. Difficulties can also occur where the Health Board's and contractors' opinions differ in regards to what is considered

contractual and what is an enhanced level of service e.g. public health campaigns and enhanced service interventions, multidisciplinary audit.

The EHC, Smoking Cessation, and NSE have all proved to be successful services and are all planned for national roll-out. Smoking cessation is currently producing quit outcomes rates comparable to Stop Smoking Wales.

- **the scale and adequacy of 'advanced' services provided by community pharmacies;**

The local uptake of advanced services is variable. Nearly all pharmacies in BCU are able to offer MUR, however few reach their full allocation. The independent contractors and smaller multiples seem to have been less concerned with quantity of MURs completed and to have focused more on the quality of the MUR being undertaken. In contrast, it appears that the larger multiples have developed a target driven culture to increase MUR uptake, while being less focused on the quality of the reviews undertaken.
In England, targeting MURs at specific patient groups would theoretically improve the return on the MUR spend, If this approach were to be adopted in Wales, it would also be beneficial if localities were given to opportunity to contribute to the process for deciding target groups, or the authority to set local patient target groups. This would help to target locally identified pharmaceutical needs.

No single pharmacy in BCU has applied to provide the AUR advanced service; this is probably largely due to a lack of knowledge and confidence to provide this service.

- **the scope for further provision of services by community pharmacies in addition to the dispensing of NHS medicines and appliances, including the potential for minor ailments schemes;**

The scope for community pharmacy to deliver a wider range of services is dependent on the structure and funding arrangements of the current GMS and Community pharmacy contract.
A national minor ailments scheme would require WG funding.. The scope of future services should be more focused on the delivery of evidence based pharmaceutical care planning and interventions rather than the provision of pharmaceuticals. There is a big difference between patients having possession of and taking medicines properly to maximise outcomes.

It is well documented that the more medicine you take the less likely you are to take them correctly, and the more likely the risk of side-effects. Also the more medicines are prescribed, the greater the chance of having multiple co morbidities, to be house-bound and have less contact with GPs and pharmacists. It follows that domiciliary patients on multiple medicines are at much higher risk of harm from unwanted side-effects than any benefits. Community pharmacists are in an ideal position to intervene with these patients and reduce waste and harm.

- **the current and potential impact on demand for NHS services in primary and secondary care of an expansion of community pharmacy services, and any cost savings they may offer;**

See paragraph above. Many admissions and demands for services (e.g. falls) are due to poor outcomes from medicines or as a consequence of poor medicines management. It is well known from the evidence, which medicines are most likely to cause harm. Taking the GMS contract for example Near Patient Testing (NPT) enhanced services have been commissioned to improve the management of these high risk medicines e. g. DMARDS management.

One way to improve medicines management and improve outcomes for patients would be to identify these high risk drugs and have community pharmacies targeting MUR at these patients and supporting them in the community.

- **progress on work currently underway to develop community pharmacy services.**

Current work on enhanced services is focused on consolidation of service provision across the new Health Boards, and the launch and development of national enhanced services. There is some new service development being piloted, for these pilot services support should be sought from PHW to evaluate them effectively and develop the evidence base for further service development.

There are also a number of pilot schemes being undertaken by the primary care pharmacy team, that involve the identification of vulnerable domiciliary patients, and developing and delivering a pharmaceutical care package for the individual patient, in their own home. These schemes utilise more fully the skills of pharmacists and technicians' to improve outcomes for patients and reduce waste on medicines and hospital admissions.

These pilots should be evaluated and any outcomes used to inform the development of community pharmacy services, community pharmacy is as well placed to identify patients in need of support and to work with primary care pharmacists and GPs to improve outcomes for patients. They are also the largest proportion of the pharmacy workforce so have a greater potential capacity to deliver these of services.

BCUHB Pharmacy & Medicines Management 23.8.11

Health and Social Care Committee

HSC(4)-09-11 paper 7

Inquiry into the contribution of community pharmacy to health services in Wales – Evidence from Cwm Tâf Health Board

To assist with its enquiry into the contribution of community pharmacy to health services in Wales, the committee sought views on a range of points. There are addressed below.

The effectiveness of the Community Pharmacy contract in enhancing the contribution of community pharmacy to health and wellbeing services

The Community Pharmacy contract has the potential to make a significant impact on Health Care delivery. Community Pharmacists are well placed to deliver services due to their unique open access in the Community. There is scope to improve the effectiveness of the current contract arrangements:

- Currently the contract is driven by dispensing volume. A shift in the balance between dispensing fees and other elements of remuneration would enhance the effectiveness of the contract.
- Improving public awareness of the professional services that Community Pharmacies offer.
- Improving working partnerships with other Healthcare Professionals, including referral to specialist services e.g. Dietitians.
- An improved framework for performance monitoring and contractual compliance would help demonstrate outcomes.
- The benefits of patient registration with community pharmacies (compare with Scottish model) could be explored.

The extent to which Local Health Boards have taken up the opportunities presented by the contract to extend pharmacy services through the provision of 'enhanced' services, and examples of successful schemes

- Cwm Taf has the following enhanced services in place: (uptake %)
    - Smoking cessation – Levels 2 & 3 (38%)
    - Needle exchange – (27%)
    - Home Medication Administration Scheme - MAR charts - (47%)
    - Waste reduction scheme – (25%)
    - Substance misuse/supervised consumption – (91%)
    - Out of Hours pharmacy rota – (9%)
    - Online Non-Prescription Ordering Service (dressings) – (n/a)
    - Emergency Hormonal Contraception – (53%)

- The Health Board is evaluating the current arrangements for influenza vaccination and may consider alternative models involving community pharmacy in the future.

The scale and adequacy of 'advanced' services provided by community pharmacies

- In Cwm Taf 67/77 (87%) of community pharmacy premises are accredited for Medication Usage Reviews. Uptake of MURs continues to increase year on year. Current predictions for 2011-12 are 15,000 MURs. This represents 65% of the maximum allowable.
- There is no national mechanism to determine the quality of MURs completed (the Health Board has no access to the MURs).
- There is no data available to assess GP acceptance of MUR recommendations.
- The target of 400 MURs per contracted pharmacy is inflexible. Many small pharmacies do not have the capacity to undertake all 400 MURs. Some Pharmacies have the capacity to do more than 400 MURS but are unable to do so as they are constrained by current regulations.
- An outcome-based performance monitoring arrangement would allow LHBs to assess the benefits of MURs and to allow LHBs to direct community pharmacists to specific patient groups.

The scope for further provision of services by community pharmacies in addition to the dispensing of NHS medicines and appliances, including the potential for minor ailments schemes

- There is scope for the further provision of services by community pharmacies. Examples are shown below:
  - Formulary compliance/management within primary care (replicating arrangements already in place in secondary care) and supporting the LHB's prescribing position on key therapeutic areas.
  - Alternative supply arrangements for the provision of other items such as appliances, enteral feeds, dressings etc.
  - Coordinated work with social services and the voluntary sector (e.g. Parkinson's Society).
  - Chronic condition management (e.g. Asthma review service/pain management etc).
  - Medicines governance (e.g. medication review/patient safety/safe storage and disposal of medicines).
  - Optimise the benefits from the use of high risk and/or high costs medicines through activities such as patient reported outcome measures (PROMS).
  - Explore and implement the use of technological advancements in pharmacy (e.g. dispensing automation as an adjunct to improving safety and releasing professional time for the provision of extra services).

  - Key enablers are:

- Access, via IT, to the individual health record, with appropriate safeguards and governance processes.
- Electronic access to the pharmacy dispensing record on admission of patients into hospital and contributing to the pharmacy record on discharge from hospital.
- Dove-tailing and integration of primary care contracts (community pharmacy and GMS) to avoid potentially conflicting elements of each contract.
- Integration of community pharmacy into LHB service planning models.
- To increase the number and scope of activity of community-pharmacy based pharmacist independent non-medical prescribers.

The current and potential impact on demand for NHS services in primary and secondary care of an expansion of community pharmacy services, and any cost savings they may offer

- Increased access to services through community pharmacists is aligned to WG policy (e.g. Setting the Direction)
- Refocusing community pharmacy remuneration on professional services would remove the potential conflict between volume based dispensing income and other services that could reduce medicines expenditure within primary care (e.g. medicines waste).

Progress on work currently underway to develop community pharmacy services

- The implementation of Just-in-Case Boxes for palliative care patients in the community is being planned.
- Work is ongoing on the implementation of new pharmacy services (e.g. Discharge Medication Review Service).

Concluding remarks

Community pharmacy is an under-used resource to the NHS in Wales.

The community pharmacy contractual framework has the potential to support a more integrated and clinical role.

This requires a re-balancing between the fee per item dispensing services and clinical services.

Howard Rowe
Head of Medicines Management

Dr. Brian Hawkins
Chief Pharmacist
Medicines Management Practice Unit

Eitem 5

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:	**Ystafell Bwyllgora 3 - Y Senedd**
Dyddiad:	**Dydd Iau, 20 Hydref 2011**
Amser:	**09:45 - 11:55**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

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Cofnodion Cryno:

Aelodau'r Cynulliad:	**Mark Drakeford (Cadeirydd)** **Mick Antoniw** **Rebecca Evans** **Vaughan Gething** **William Graham** **Elin Jones** **Darren Millar** **Lynne Neagle** **Lindsay Whittle** **Kirsty Williams**
Tystion:	**Lesley Griffiths, Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol** **Gwenda Thomas, Y Dirprwy Weinidog Plant a Gwasanaethau Cymdeithasol** **David Sissling, Llywodraeth Cymru** **Chris Hurst, Llywodraeth Cymru** **Steve Milsom, Llywodraeth Cymru**
Staff y Pwyllgor:	**Llinos Dafydd (Clerc)** **Naomi Stocks (Clerc)** **Catherine Hunt (Dirprwy Glerc)** **Stephen Boyce (Ymchwilydd)** **Victoria Paris (Ymchwilydd)**

1. Cyflwyniadau, ymddiheuriadau a dirprwyon

1.1 Ni chafwyd unrhyw ymddiheuriadau na dirprwyon.

2. Ymchwiliad i ofal preswyl ar gyfer pobl hyn - cytuno ar y cylch gorchwyl

2.1 Cytunodd y Pwyllgor ar welliannau i'r cylch gorchwyl drafft, ac ar y ffaith y bydd yr ymgynghoriad yn cael ei lansio ar 24 Hydref.

3. Cyllideb ddrafft 2012 -13: craffu ar y Gweinidog Iechyd a Gwasanaethau Cymdeithasol a'r Dirprwy Weinidog Plant a Gwasanaethau Cymdeithasol

3.1 Bu'r Gweinidog Iechyd a Gwasanaethau Cymdeithasol yn ateb cwestiynau gan aelodau'r Pwyllgor ynghylch cyllideb ddrafft 2012-13.

3.2 Cytunodd y Gweinidog i roi gwybodaeth ychwanegol i'r Pwyllgor am gyllid sydd wedi'i neilltuo ar gyfer gwasanaethau iechyd meddwl, a manylion ynghylch sut y bydd yr £83 miliwn ychwanegol yn cael ei ddyrannu i fyrddau iechyd.

3.3 Cytunodd y Gweinidog i ddarparu gwybodaeth i'r Pwyllgor am effaith y system presgripsiynau am ddim.

3.4 Bu'r Dirprwy Weinidog Plant a Gwasanaethau Cymdeithasol yn ateb cwestiynau gan aelodau'r Pwyllgor ynghylch cyllideb ddrafft 2012 -13.

3.5 Cytunodd y Dirprwy Weinidog i rannu â'r Pwyllgor adroddiad gan awdurdodau lleol ar ddigonolrwydd lefel y cyllid sydd ar gael ar gyfer y pecyn gwella camau cyntaf, pan fydd yr adroddiad ar gael.

4. Cynnig o dan Reol Sefydlog 17.42(vi) i benderfynu gwahardd y cyhoedd o'r cyfarfod ar gyfer eitem 5

4.1 Cytunodd y Pwyllgor ar y cynnig.

5. Cyllideb ddrafft 2012-13: trafod y dystiolaeth

5.1 Bu'r Pwyllgor yn ystyried y dystiolaeth a gafwyd.

TRAWSGRIFIAD

Gweld trawsgrifiad o'r cyfarfod.

Leading Social Services in Wales
Yn arwain Gwasanaethau Cymdeithasol yng Nghymru

ADSS Cymru Response to Inquiry into Stroke Risk Reduction

October 2011

Association of Directors of Social Services Cymru (ADSS Cymru)

1. ADSS Cymru is the acknowledged professional leadership organisation for Social Services in Wales. It represents the interests of the 22 statutory Directors of Social Services and the heads of services that support them in delivering Social Services responsibilities and accountabilities, across the twenty-two Councils in Wales. Its primary purpose is to provide a national voice as a champion for the well-being, protection and care of vulnerable adults and children in Wales, by working in partnership with the Welsh Government, the Welsh Local Government Association and other key stakeholder in the Public Sector.

2. We welcome the opportunity to respond to the consultation on the Terms of Reference for the Committee for the Inquiry into Stroke Risk Reduction.

3. The response from our members (heads of adult social services) is structured around the Terms of Reference put to us by the Chair of the Health & Social Care Committee, Mark Drakeford, A.M.

Response to Consultation Questions

Q1 – 'What is the current provision of stroke risk reduction services and how effective are the Welsh Government's policies in addressing any weaknesses in these services?

Answer:

This question is about prevention and Local Authorities work in partnership with health colleagues and the voluntary sector- who we fund to provide a range of services which may impact on stroke prevention- i.e exercise classes in day centres, walking and therapeutic support provided by Age Concern for example.

The immediate impact for people who have had a stroke is for speedy health care with specialist support available at this acute time of need. Social Care services impact at the discharge phase to support with care packages in the community, occupational therapy support- equipment, reablement and changes to environment and buildings. We also offer support to carers.

Q2 'What are your views on the implementation of the Welsh Government's Stroke Risk Reduction Action Plan and whether action to raise public awareness of the risk factors for stroke has succeeded?

Answer:
We would put the Action Plan in the context of the standard for stroke services in Wales is contained in the National Service Framework for Older People (2006). The framework states:

"The NHS, working in partnership with other agencies where appropriate, will take action to prevent strokes, and to ensure that those who do suffer a stroke have access to diagnostic services, are treated appropriately by a specialist stroke service, and subsequently, with their carers, participate in a multidisciplinary programme of secondary prevention and rehabilitation and appropriate longer term care."

In addition, the Welsh Health Circular 58 (2007) emphasised the requirement that Local Health Boards and local government work in partnership to ensure that the three main aims of the Framework are implemented: That is:

1. Preventing stroke
2. Improving stroke survival rates
3. Maximising post-stroke independent living and quality of life

Stroke continues to be a major concern for Social Services, and the work done so far locally has certainly raised the profile of stroke and what's needs to be done locally to reduce its incidence and impact. Local stroke and falls groups are evident with all the relevant agencies and voluntary organisations contributing. New models of service deliver focus on prevention and reablement which are positive interventions. However, our demographic landscape will mean that we will need to invest significant in intermediate care service which during these difficult times economically, will be a challenge.

The Local Health Boards have continued opportunity to address the barriers for stroke risk prevention in primary prevention by making improvements in the effective management of risks across a whole range of patient registers for disabetes, obesity, hypertension etc. These are all factors that increase the likelihood of a person having a stroke, particularly those over 55 years of age. Stroke risk reduction, as we all accept, applies to the entire stroke care pathway.

Q3 What are the particular problems in the implementation and delivery of stroke risk reduction actions?

Answer:

We need to focus on the health prevention agenda and start to push on the education of individuals, to reduce smoking and obesity, which means linking in with primary care who have a key role to play here. Telemedicine may have a significant impact on reduction of stroke if it was available everywhere.

ADSS Cymru calls for a broader strategy that places emphasis on the rehabilitation phase along the reablement route with clear outcomes for the patient/service services user.

Q4 'What evidence exists in favour of an atrial fibrillation screening programme being launched in Wales?

Answer:

We believe that this is a discussion and decision for our health colleagues- however the monitoring of this may require additional resources or telemedicine as above. There are some robust research studies e.g. Stroke Risk Management Changes in Mainstream Practice by L. Kalra, MD, PhD, FRCP; I. Perez, MD; ;A. Melbourn, RGN , Clinical and Health Services Studies Unit, King's College School of Medicine and Dentistry, London, UK. which indicate that significant number of ischemic events remain potentially preventable.

Finally,

We welcome the priority given the reduction of stroke risk by the Welsh Government, and ADSS Cymru assures the Welsh Government of its support to the Health & Social Care Committee to progress this agenda. We would be happy to discuss these issues further.

Thank you.

Nygaire Bevan,
Chair of the ADSS Cymru Heads of Adult Services Group

For further information please contact:

Latha Unny
Research & Policy
ADSS Cymru Business Unit
Torfaen County Borough Council
County Hall
Cwmbran
NP44 2WN

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Health and Social Care Committee

HSC(4)-09-11 paper 9

Inquiry into Stroke Risk Reduction – Information from the Older People's Commissioner for Wales

Dear Mr Drakeford

Re: Health and Social Care Committee – Inquiry into stroke risk reduction

Thank you for contacting the Older People's Commission for Wales with your enquiry received on 29 September 2011. The Commissioner, Ruth Marks, has asked that I respond on her behalf.

My apologies for the delay in responding; however, I wished to share your email within the Commission in order to gather information for a fuller response. Having discussed your request with members of the Commission's Policy team, I can report back that the Commission has not had any specific evidence brought to us with regard to stroke risk reduction.

Having searched our records, it appears that the only contact we have relating to the issue of strokes has been from the secretary of a regional stroke club raising concerns about the local authority's withdrawal of funding to the Stroke Association. This has resulted in the cutting of a local stroke support service that provided physical and psychological support in the local area. Despite acknowledging current budgetary constraints faced by local authorities, the Commission shares the enquirer's concerns that cutting these types of service has a lasting impact on stroke victims and their families. As the enquirer pointed out to us, since the cuts came into being, over 100 people in the area, who had suffered strokes, had been discharged from hospital without any form of continued support. Despite talk of implementing a volunteer service in the area, the enquirer questions the viability and effectiveness such a service would provide as the kind of support required needs specialist knowledge and training.

Again, my apologies for not having responded sooner; however, I would like to thank you again for bringing the inquiry to the Commission's attention. In addition, we would be very interested in receiving information and updates as to the outcome of the Committee's inquiry into stroke risk reduction.

If you have any questions or comments, please do not hesitate to contact me directly.

Yours sincerely

Robert Ellis

Information and Enquiries Officer
Older People's Commission for Wales/Comisiwn Pobl Hŷn Cymru

GIG CYMRU NHS WALES
Bwrdd Iechyd
Aneurin Bevan
Health Board

Our Ref: DL/lb

26 October 2011

Catherine Hunt
Deputy Clerk
National Assembly for Wales
Cardiff

Dear Ms Hunt

Further to the Health & Social Care Committee I attended two weeks ago to present evidence on the Stroke Risk Reduction Plans, Aneurin Bevan Health Board's response was given at the Committee and is contained in the transcript.

As a result of this, Lynne Neagle AM has asked specifically about the ownership of the Stroke Risk Reduction Plans and what structures do the Health Boards/Public Health in Wales have within organisations to take their Stroke Risk Reduction Plans forward.

All LHB's across Wales are committed to meet the 2012 timescales in each of their plans although the actions to reduce the risk of stroke will obviously need to continue beyond that date.

Within ABMU Local Health Board they have a stroke development group that is taking forward work on Af, Tia, smoking cessation etc. This meets monthly and has an action plan that is constantly being taken forward. The ABMU public health priorities include tackling obesity, smoking cessation and alcohol consumption. Where they think they need to do even better is in reduction of hypertension. They have engaged their pharmacists in Tia work and are currently examining how they introduce dabigatran. They are in the early stages of considering how we develop interventional neuro-radiology. They are involved in research with Swansea University to examine the theoretical basis of formation of blood clots. They are hopeful that they will gain research funding with Ceri Phillips to examine meteorological effects on stroke, they would then want to work with partners in local authorities to see how housing and heating can be improved to reduce stroke.

Pencadlys
Bloc A, Tŷ Mamhilad,
Ystad Parc Mamhilad,
Pontypŵl, Torfaen. NP4 0YP
Ffôn: 01873 732732 (prif switsfwrdd)
e-bost: abhb.enquiries@wales.nhs.uk

Headquarters,
Block A, Mamhilad House,
Mamhilad Park Estate,
Pontypool, Torfaen. NP4 0YP
Telephone: 01873 732732 (main switchboard)
e-mail: abhb.enquiries@wales.nhs.uk

The stroke risk reduction plan in Cardiff & Vale includes Primary prevention & Secondary prevention strategies. Primary prevention (smoking cessation, healthy life style, obesity prevention/reduction, lowering cholesterol. reduced salt intake, blood pressure control, anticoagulation for AF etc) strategy is driven by Public Health & Primary Care. Secondary prevention (control of blood pressure, lowering cholesterol, anticoagulation for AF, antiplatelet therapy, carotid endarterectomy, smoking cessation, life style modification etc) is mainly driven by secondary & primary care. The QOF targets incorporate most of the stroke risk factors.

Once patients are admitted with TIA or Stroke they follow the Health Boards secondary prevention pathway. In Cardiff & Vale, there is a formal link between Primary & Secondary care and they meet regularly through the Stroke Steering Group. At present they do not have a representative from Public Health, which they ought to have in their steering group. The South East Wales Stroke Group has been mainly involved in developing thrombolysis service until now, but theye need to have discussions about regional Stroke risk reduction strategies in future meetings. They currently report all activities to the Delivery Support Group, with whom they work very closely.

Hywel Dda have a Stroke Steering Group and a Stroke Delivery Group who are responsible for implementing the stroke action plan. The Stroke Risk Reduction Plan is part of their stroke action plan and is taken forward and monitored by these groups.

The actions within the Stroke Risk Reduction Plan forms part of the work programme of the local Public Health Team. There is also a Primary Care Vascular Risk Reduction Group to which some of the actions have been assigned. Primary Care are represented on the Steering Group by Prof Jonathan Richards, GP and Locality Clinical Director.

The lead for the Cwm Taf Stroke Risk Reduction Plan sits with the Director of Public Health, who is represented on the Cwm Taf Stroke Steering Group by a Consultant in Public Health (currently Dr Dyfed Huws). He is responsible for reporting on progress with implementation at the bi-monthly Steering Group meetings.

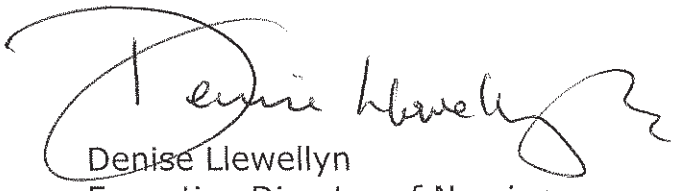
Betsi Cadwaladr Health Board utilises the arrangements in place to identify disease, treat, and manage risk factors which are associated with stroke under the quality and outcomes framework within the General Medical Services Contract. In addition the Health Board has commissioned a specific Cardiovascular Risk Assessment Enhanced Service within primary care, aimed at identification and early engagement with patients at risk of developing cardiovascular disease.

The Health Board is actively utilising its resources to promote health in all settings of care and has prioritised smoking cessation as a key intervention, which will have a direct impact in stroke risk reduction. Health Social Care and Wellbeing Strategies agreed with Local Authority partners identify risk factors such as diet, exercise, smoking and alcohol consumption for multi-agency action. The Stroke Forum will be reviewing the public health focus of its activities as part of the Board's planning for 2012/13.

These are the responses I have received from the other LHB's in answer to Lynne Neagle's enquiry at the Committee.

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

Yours sincerely



Denise Llewellyn
Executive Director of Nursing

ROYAL CYMDEITHAS PHARMACEUTICAL FFERYLLOL SOCIETY FRENHINOL
Wales Cymru

2 Ashtree Court, Woodsy Close
Cardiff Gate Business Park
Cardiff CF23 8RW

Tel: 029 2073 0310
wales@rpharms.com
www.rpharms.com

Health and Social Care Committee

HSC(4)-09-11 paper 11

Inquiry into Stroke Risk Reduction – Response from The Royal Pharmaceutical Society

18th October 2011

Introduction

The Royal Pharmaceutical Society (RPS) welcomes the opportunity to provide a written contribution to the inquiry into stroke risk reduction.

The RPS is the professional body for pharmacists in Wales and across Great Britain. We are the only body that represents all sectors of pharmacy.

The RPS promotes and protects the health and well-being of the public through the professional leadership and development of the pharmacy profession. This includes the advancement of science, practice, education and knowledge in pharmacy. In addition, it promotes the profession's policies and views to a range of external stakeholders in a number of different forums.

The role of pharmacy in stroke risk reduction

We advocate that the pharmacy profession has an important role to play in contributing to stroke risk reduction through targeted and opportunistic interventions. We acknowledge the Welsh Government's policy intentions for stroke risk reduction as outlined in the Stroke Risk Reduction Action Plan but recommend that stroke risk reduction strategies should form part of a wider approach to tackle the risk factors associated with the wide range of vascular diseases, ensuring the effective use of financial resources and health professional time. We have outlined how pharmacy could contribute to such an approach in Appendix A.

We believe that the issues outlined in our written response and oral evidence to the Committee's inquiry into community pharmacy are of relevance to this inquiry and refer members of the Committee to those issues[1]. We would however like to take this opportunity to highlight the following points pertinent to this inquiry:

- **Getting more from the Community Pharmacy Contractual Framework:** We believe that a great deal more can be achieved in the reduction of stroke and other vascular conditions by utilising the provisions of the community

[1] **National Assembly for Wales Health and Social Care Committee Inquiry into Community Pharmacy, September 2011:**
http://senedd.assemblywales.org/ieListDocuments.aspx?CId=227&MID=501

pharmacy contractual framework. **We propose that a national enhanced service for the treatment and provision of advice to individuals with vascular disease risks may offer some solutions for reducing vascular risks**. Local enhanced services may also offer solutions in addressing any gaps in local service provision to meet local population health needs and contribute to a reduction in vascular risks. These enhanced provisions could include medicines assessment and compliance support, clinical medication review, and chronic conditions management through local community pharmacy services.

- **Targeting and supporting those at highest risk:** Targeted Medicines Use Reviews (MURs) also offer opportunities for individuals to be supported by their community pharmacist to understand more about their medicines. MURs can have both a primary and secondary prevention role, supporting individuals to get the best from their medicines and helping them to reduce their risk factors. Community pharmacists in Wales have obtained professional accreditation and adapted their premises to incorporate private consultation areas to ensure MURs can be delivered effectively. **We propose that this advanced service should be used to help target and support individuals with hypertension and/or a diagnosis of stroke.**

- **Medicine safety**
  Pharmacists are the experts in medicines, providing pharmaceutical care and advice across care settings. The drugs used in the secondary and primary prevention of stoke, Atrial Fibrillation and vascular disease are often high risk drugs that require a targeted approach to ensure national guidelines are followed and individuals who have had a stroke receive the best pharmaceutical care. **We propose that robust mechanisms are put in place by each LHB to ensure the consistent implementation of clinical guidelines and National Patient Safety Alerts on the use of high risk drugs for all vascular conditions.**

- **Vascular risk screening services**

We propose that the development of national vascular screening services that encompass stroke and cardiovascular disease could offer a number of opportunities for risk reduction of vascular conditions. Such an approach would require seamless integration and coordination of activities within and between community health services, primary care and secondary care to improve the level of detection of those at risk and also to improve the clinical effectiveness and efficiency of service delivery. We believe that the prioritisation of resources to achieve this should help to reduce vascular risks as well as contributing to efforts to reduce health inequalities across Wales.

We advocate that pharmacists should play a role in national vascular screening services, working alongside and in partnership with other health professional colleagues in primary care, community and hospital settings. We have outlined the opportunities provided by pharmacy in this context as well as some recommendations for action at Appendix A.

We trust that this contribution is helpful and look forward to the progress of the inquiry. If you require any further information please do not hesitate to contact us.

Yours sincerely

Mrs Mair Davies
Chair, Welsh Pharmacy Board

Patron: Her Majesty The Queen Chief Executive: Helen Gordon
Enquiries T 0845 257 2570 E support@rpharms.com

Appendix A

Vascular Risk Assessment in Wales

Making use of Community Pharmacy

Why Pharmacy?

- Pharmacists have a key and unique role to play in modernising the delivery of patient care across Wales. As the NHS expert in medicines they are a valuable community resource, seeing people who are generally fit and well, those who may have health risks, those who are not in touch with any other health professional, and addressing the health and wellbeing needs of people already diagnosed with minor ailments and chronic conditions
- Most adults in the UK use community pharmacies, whether in local communities, on the high street or in supermarkets, and it is estimated that there over 1.6million daily visits to UK pharmacies
- Community pharmacies are used by groups of people who may be infrequent users of other health care services such as men and women who work long hours, those aged over 35 and those with chronic conditions
- Pharmacists play a key role in improving access to health information, advice and healthcare interventions
- Working in our communities, within GP surgeries, LHBs, secondary and tertiary care, pharmacists are well placed to deliver a range of clinical patient services, manage a safe and efficient medicines supply system and provide support on safe and effective prescribing to other healthcare professionals
- Pharmacists are well placed to help identify people who may benefit from health checks, for example by targeting vulnerable and high risk groups and those presenting with potentially high risk symptoms of diseases that are undiagnosed
- Local community pharmacies are well placed to deliver significant improvements in health care provision in rural as well as more urban areas across Wales

The key roles of pharmacists in vascular health

- Contributing to illness prevention and the wider public health agenda
- Providing healthy lifestyle information and advice to the general public and to targeted patients with particular risk factors
- Providing point of care testing (i.e. analytical tests performed outside the conventional laboratory setting)
- Counselling patients on the implications of test point of care test results
- Managing chronic conditions such as CHD and diabetes
- Supporting self-care and self-management of a range of chronic conditions and minor ailments
- Overseeing medicines management and monitoring patient's conditions
- Signposting patients to other health, social care and voluntary sector services
- Referring patients requiring further investigations to their GP

Key service challenges for including community pharmacists in vascular risk assessment in Wales (See table 1)

- Integrating community pharmacists into wider programme for vascular screening
- Utilising the Community Pharmacy Contractual Agreement and ensuring appropriate remuneration for pharmacy-led services
- Utilising the skills of the pharmacy workforce more appropriately – staffing, training, education and competence
- Utilising community pharmacy premises as part of NHS hub and spoke services
- Including community pharmacy in a whole systems approach supported by secure IT and web based systems

Table 1: Key service challenges for including community pharmacists in vascular risk assessment

Key issues for Wales	Opportunities provided by community pharmacists	Recommendations
Integrating community pharmacists into programmes for vascular risk assessment	▪ Including community pharmacists in vascular risk assessment programmes can enhance access to care and assessment in communities across Wales ▪ Community pharmacists are able to undertake near patient testing including checking blood pressure, measuring height, weight and waist circumference measurements, as well as blood glucose and cholesterol testing. ▪ Community pharmacy interventions such as support for weight reduction, smoking cessation and the management of medications, can help to prevent, reduce and, in some cases, reverse the onset of vascular disease. ▪ Working closely with the primary care team and other appropriate health professionals in the community, pharmacists can provide individuals with advice to help reduce the risks of vascular disease, refer them to their GP for further investigation, provide GPs and other health professionals with timely	▪ Early engagement of community pharmacists with GPs and other appropriate health professionals to ensure effective planning and smooth implementation of vascular risk assessment programme in the community ▪ Encouraging GPs and community pharmacists to work together to ensure robust and efficient referral processes are in place for individuals identified at high cardiovascular risk. ▪ Ensuing appropriate mechanisms are in place (i.e. via IM&T systems) to exchange patient information in a secure way between community pharmacies and GP practices to improve continuity of care and improve the efficiency of healthcare services. ▪ The role of community pharmacists should be clearly identified in pathways of care for vascular disease assessment activities and interventions ▪ Systematic and integrated processes must ensure all health professionals, including community pharmacists, work to agreed service protocols to reduce duplication of

	information about high risk individuals, and provide advice to health professionals and individuals on medicines management issues where appropriate. ▪ By identifying individuals at risk of developing vascular disease and improving access to health assessment, advice and support, community pharmacists can contribute to the wider public health agenda and the national agenda of reducing health inequalities across Wales including socio-economic, ethnic and gender inequalities. ▪ Promoting and 'marketing' vascular risk assessment consistently in community pharmacies across Wales	effort, streamline service delivery and ensure cost effectiveness. ▪ The role of all health professionals, including community pharmacists, should be clearly articulated to the public via a coordinated information campaign.
Utilising the Community Pharmacy Contractual Agreement and ensuring appropriate remuneration for pharmacy-led services	▪ The Community Pharmacy Contractual Agreement provides key opportunities to actively engage community pharmacists in the public health agenda. ▪ Through the contract, community pharmacists can provide a valuable source of healthy lifestyle support to members of the public, those with risk factors and people with diagnosed health conditions. Due to accessibility of community pharmacies across Wales, lifestyle advice can be provided in all types of communities, urban and rural, to support individuals with making important lifestyle changes to improve their health and well-being. Examples of preventative community	▪ Ensure service descriptions for vascular risk assessment clearly specify the role required by community pharmacists ▪ Agree the costs of the service and negotiate the remuneration to community pharmacists, ensuring cost-effectiveness at all times. ▪ Ensure adequate funding and start-up grants for community pharmacies to cover: ➢ Training, educational needs and accreditation ➢ Equipment and premises adaptation requirements ➢ Record keeping requirements ➢ The degree of patient follow up required ➢ Interventions to target specific hard to reach groups

	pharmacy services include vascular risk assessment, obesity management services and smoking cessation support. ▪ Utilising the contract can ensure the integration of community pharmacists into healthcare teams and support the drive for improved access to healthcare services and quality of care delivered across the NHS. ▪ The contract can be used to engage community pharmacies in structured ways as part of local services to deliver targeted and opportunistic patient education, medicines management, improving disease control, testing and monitoring support as part of integrated patient care pathways. ▪ The contract can be used as an effective lever to encourage community pharmacists to get actively involved in opportunistic and routine diagnostic testing.	➢ The skill mix required by the community pharmacy ▪ Encourage/incentivise greater partnership working between GPs and community pharmacists to ensure continuity of care and ease of access to health services in local communities.
Utilising the skills of the pharmacy workforce more appropriately: staffing, training, education and competence	▪ Community pharmacists are professionally eligible and competent to undertake a range of simple diagnostic tests in local communities across Wales. They include blood pressure checks, blood glucose checks, and cholesterol checks, all of which are key aspects in identifying vascular and related problems. ▪ By undertaking specific training and participating in continuing professional development, community pharmacists and their staff can deliver an effective service as part of a vascular risk assessment programme.	▪ Structured and ongoing Continuing Professional Development should be made available to pharmacists and community pharmacy staff involved in vascular assessment ▪ Encourage multidisciplinary training to all healthcare professionals involved in the vascular risk assessment programme to ensure improved partnership working ▪ Ensure service delivery takes a flexible approach to working, manpower and skill mix. ▪ Explore opportunities for reducing professional isolation through access to a network of more specialist advice and expertise, decision making support tools and evidence based information.

Utilising community pharmacy premises as part of NHS hub and spoke services	▪ Utilising community pharmacy premises as part of an overall estates strategy will help to reduce overlap and duplication in the delivery of innovative models of vascular risk assessment ▪ Utilising community pharmacy premises as part of a whole system approach to vascular risk assessment can contribute to local strategies to provide assessment to targeted areas and in multiple locations.	▪ Explore opportunities for bringing currently disparate services together and promoting sharing of facilities. e.g. community hospitals, community pharmacies, social services. ▪ Encourage investment in community pharmacy premises to develop them as outlets for a range of professional services in line with overall strategic models of care including vascular risk assessment in Wales. ▪ Clarify the governance arrangements that need to be put in place for using multiple locations in vascular risk assessment
Including community pharmacy in a whole systems approach supported by secure IT and web based systems	▪ Including community pharmacists as part of a multi-disciplinary team approach to vascular risk assessment will help to increase the identification of individuals with high risks and those requiring specific healthcare interventions. ▪ Effective communication between pharmacists, GPs and other health professionals will help to ensure that individuals receive the right care in the right place and at the right time. ▪ Community pharmacists undertaking opportunistic and routine diagnostic testing can record, store and transfer patient information to GPs and other relevant health professions as appropriate to help inform care planning and ensure continuity of care. ▪ Community pharmacists can utilise secure IT systems to transfer information and speed up referral times for individuals identified with high risk factors of vascular and related disease.	▪ Explore the options for ensuring quality assurance in recording and storing patient data and information in both electronic and paper forms as part of a vascular risk assessment process. ▪ Ensure secure IT systems are in place to allow the confidential transfer of patient information between community pharmacists, GPs and other healthcare professionals as appropriate. ▪ Develop clear protocols for transferring patient identifiable information and making referrals to other health professionals.

	▪ Community pharmacists can be engaged in audit processes for vascular risk assessment in Wales through the use of IT systems.	

ROYAL CYMDEITHAS PHARMACEUTICAL FFERYLLOL SOCIETY FRENHINOL
Wales Cymru

2 Ashtree Court, Woodsy Close T 029 2073 0310
Cardiff Gate Business Park E wales@rpharms.com
Cardiff CF23 8RW W www.rpharms.com

Health and Social Care Committee
HSC(4)-09-11 paper 12
Inquiry into the contribution of community pharmacy to health services in Wales – Additional information from the Royal Pharmaceutical Society

Mark Drakeford AM
Chair, Health and Social Care Committee

17 October 2011

Dear Mr Drakeford,

Thank you for the opportunity of presenting information to the Health and Social Care Committee inquiry into community pharmacy on 28th September. I am pleased to provide below further information as discussed and requested during the session.

1. The pharmacy contract in Scotland

We were asked a number of times about the community pharmacy contract in Scotland and asked for further information. The following information is taken from the NHS Scotland Community Pharmacy website (http://www.communitypharmacy.scot.nhs.uk/index.html) where much more detailed information can be found if required.

i) Minor Ailments Service

The Minor Ailment Service (MAS) allows eligible individuals to register with and use a community pharmacy as the first port of call for the treatment of common illnesses on the NHS. A patient registers with the community pharmacy of their choice in order to use MAS. Once registered they can present at any point with symptoms and the pharmacist, having ascertained whether the patient is still eligible to use the service, will treat, advise or refer them to another health care practitioner where appropriate.

ii) Acute Medication Service

The Acute Medication Service (AMS) introduces the Electronic Transfer of Prescriptions (ETP) and supports the provision of pharmaceutical care services for acute episodes of care and any associated counselling and advice.

iii) Chronic Medication Service

The Chronic Medication Service (CMS) allows patients with long-term conditions to register with a community pharmacy of their choice for the

provision of pharmaceutical care as part of a shared agreement between the patient, community pharmacist and General Practitioner (GP). It introduces a more systematic way of working and formalises the role of community pharmacists in the management of individual patients with long term conditions in order to assist in improving thepatient's understanding of their medicines and optimising the clinical benefits from their therapy.

iv) Public Health Service

The Public Health Service (PHS) element of the contract aims to encourage the pro-active
involvement of community pharmacists and their staff in supporting self care, offering suitable interventions to promote healthy lifestyles and establishing a health promoting environment across the network of community pharmacies by participating in national and local campaigns. It comprises the following services:

- the provision of advice to both patients and members of the public on healthy living options and promotion of self care;
- the provision of NHS or NHS approved health promotion campaign materials, other health education information and additional support materials to patients and members of the public;
- the participation in national health promotion campaigns which are on display and visible in the pharmacy for agreed periods of time, including the display of materials in a window of the pharmacy, or in the absence of a suitable window space, another space in the pharmacy;
- the participation in local health promotion campaigns where agreed between the local NHS Board and community pharmacist;
- the provision of a smoking cessation service, comprising of advice and supply of nicotine replacement therapy (NRT) and other smoking cessation products over a period of up to 12 weeks, in order to help people give up smoking; and
- the provision of a sexual health service comprising of the supply of emergency hormonal contraception (EHC), a Chlamydia testing service and a Chlamydia treatment service.

2. **The Joint Statement by the Royal Pharmaceutical Society and the Royal College of General Practitioners**

   I am pleased to attach the joint statement between RPS and the RCGP. This can also be accessed electronically at http://www.rpharms.com/public-affairs-pdfs/RPSRCGPjointstatement.pdf. This document was prepared by the RPS and the RCGP in England, and in Wales we are currently working with RCGP Cymru on the priority areas we want to take forward.

3. **Men's Health**

   The attached document (Commissioning a Health and Wellbeing Service from Community Pharmacy) is a document prepared in England by a number of pharmacy bodies to highlight the benefits of such a service from community pharmacy. It contains the following case study;

"Knowsley PCT targeted men aged 50-65 with their free health checks in 10 pharmacies across the region. After conducting the check, Knowsley PCT surveyed participants to evaluate the service. The study found that 96 per cent of men said they have made at least one lifestyle change as a result of the check-up, while almost 100 per cent said they were either very or quite likely to attend a follow-up health check and would recommend the checks to other men".
Source: NHS Improvement Programme, 2009

4. **The number of pharmacies with a consultation area**
   We have been informed by the Pharmacy and Prescribing Branch of the Welsh Government that the number of community pharmacies accredited to provide Medicines Use Reviews in 2010 was 613, or 87% of all premises. A consultation area is one of the requirements of accreditation.

I trust this information is helpful. If you need any additional information or would like to discuss any issues in further details, please do not hesitate to get in touch. We look forward to the results of the inquiry with interest.

Yours sincerely,

Mair Davies
Chair, Welsh Pharmacy Board
Royal Pharmaceutical Society

(Enc.)

JOINT STATEMENT

Breaking down the barriers – how community pharmacists and GPs can work together to improve patient care

Introduction

This joint statement sets out the background, summarises the evidence and makes recommendations for the benefits to patients of improved liaison between community pharmacists and general practitioners.

1. Over the last 20 years successive policy changes have moved the pharmacist's role from primarily one of dispenser towards a generic health care provider advising patients on their use of prescribed medicines, self care and lifestyle as well as delivering other innovative services. However, these changes often seem to have been introduced in isolation from other primary care services, especially general practice, thereby reducing opportunities for enhanced patient benefit.

2. General practitioners are similarly taking on a broader role, particularly in England, involving commissioning services as part of the Coalition Government's NHS reforms. GPs are also working with a range of primary care practitioners to deliver services to their local communities and recognising the skills and experience of the full range of healthcare professionals is key to the thinking in this statement.[1]

3. Patients may be surprised when they discover that their community pharmacist[2] and their GP do not share the same clinical record and that the local community pharmacist is not always an integral part of the primary care team (while recognising that patients have free choice of pharmacy and may use many pharmacies whilst being registered with a single practice). Pharmacists play a key role in the long-term management of patients with chronic disease and can see the patient as often as a member of the general practice team. Many members of the public and patients see the pharmacist as a first port of call for advice, not just on their medicines but also on their underlying health problems. This is particularly true for men seeking advice on health issues.

4. Whilst many GPs do work closely with their local pharmacist, a culture change is recommended between GPs, pharmacists and the public to allow the collaborative partnership between general practice and community pharmacy to deliver its potential.

5. Both bodies recognise and are committed to how GPs and pharmacists can learn with and from each other starting at undergraduate level and continuing throughout their professional careers. Both bodies will work together to explore continued opportunities for joint learning.

6. Both bodies welcome the joint work being undertaken to roll out the RCGP's Research Ready model to pharmacists.[3]

Building Blocks for Change

7. Some key building blocks need to be agreed to underpin new working relationships. This should be with the aim of offering patients a high quality, safer, more consistent and cost effective service These should include:

    - Better transfer and sharing of patient information facilitated by improved inter professional IT links and clear safeguards for consent and confidentiality

    - Shared standards and ways of working to ensure consistency of services and information to the public (for example in areas such as screening and diagnosis and pharmacy-led treatments and advice)

    - Joint education and training at undergraduate and postgraduate level, which could facilitate greater trust and understanding of the professions' respective and complementary roles, skills and expertise

    - Standard setting and clinical guidance on the provision of over-the-counter medicines where these medicines have doubtful value

    - Acknowledging the opportunity for joint working to improve medicines utilisation, cost-effectiveness and minimise waste.

Working together can improve patient care and safety

8. The benefits to patients of joint working between general practices and pharmacists are not in doubt This statement draws on a separate paper drafted by the Royal Pharmaceutical Society with input from the RCGP

9. Better use of Medicines Use Reviews (MURs)[4] by pharmacists and the practice team can reduce duplication of effort by the primary care team as well as improve patient care through reducing errors and improving adherence to treatment[5].

10. Pharmacist prescribers, working closely with GPs and practice nurses, can similarly contribute to better patient management and can also help improve the quality and outcome of patient management in a range of long-term conditions.[6]

11. By working together more closely, general practices and pharmacists will be able to deliver better healthcare to vulnerable groups such as those in care homes or elderly patients who are taking a large range of medicines, including anti-psychotic medicine.

12. Community pharmacists working with general practices and specialist palliative care teams can ensure reliable and prompt medicine supply, and supportive

advice (especially about analgesia) for patients, lay carers and other members of the health care team.

13. Pharmacists with the appropriate expertise, working with drug misusers, can increase retention within treatment programmes by a structured supportive approach, and those with prescribing and drug misuse qualifications can contribute to community detoxification by adjusting doses.
14. GPs and their practice teams, together with pharmacists can support lifestyle change and encourage self care.
15. GPs and pharmacists should be aware of the evidence base and efficacy of the products they promote and supply and be aware of the tension between clinically evidenced supplies and non-evidence-based products.

Managing long-term conditions

16. Patients can already benefit from being able to receive timely and accessible help from pharmacies in understanding and using medicines. Access to this should be promoted and resources should be more effectively targeted to patient need. An example of how this can work is the New Medicine Service[7] being introduced in England.
17. Improvements should be made to improve the sharing of information between the pharmacist and general practice. This will be achieved through improved IT links and through ensuring appropriate arrangements for protecting patient confidentiality and obtaining patients' consent to information-sharing.
18. Patients should have a choice of where medicine reviews[8] take place, with consultation between the professions and communications systems in place to support this process.
19. Locally agreed protocols relating to medicine reviews should reflect agreed standards. From the patient perspective, care should be delivered to the same standard by whomever is undertaking the task.
20. The same quality standards should be used for GPs and pharmacists when undertaking medicine reviews. These quality standards do not yet exist and the RPS and RCGP will work together to develop and agree them.
21. There should be better use of 'repeat dispensing'[9] to increase efficiency, reduce practice workload and increase patient convenience as well as value for money.
22. GPs and carers should consider benefiting patients with long-term conditions and complex medication regimes by utilising the pharmacist independent prescriber[10] jointly working with the GP and patient working in collaboration.
23. In England, in conjunction with the patient's GP, pharmacists should be able to refer to services commissioned by clinical commissioning groups within agreed care pathways.
24. Pharmacists should be able to refer patients to local GPs and pharmacists with special interest services. Pharmacists referring across to the patient's GP should do so in accordance with agreed local care pathways/protocols.
25. There should be national arrangements for patients and carers to be able to access a supply of their regular medicine(s) in an emergency.[11]

26. Building on the guidance for general practice[12] community pharmacists and staff should recognise the front-line role they have in identifying carers and ensuring that carers are signposted to appropriate support and that GP surgeries are apprised so they may involve carers in patient care and provide ongoing support.[13]

Care home residents and the house-bound

27. There should be improved joint working between GPs and pharmacists for patients who reside in care homes; for example, pharmacists could attend care homes alongside GPs to undertake joint medicine reviews, and review medicines being prescribed to patients who reside in care homes.
28. Pharmacists should participate in medicine reviews for housebound patients.

End-of-life care

29. Patients and their carers should have better access to medicines required for palliative care. This includes working with out-of-hours providers to ensure access throughout the whole 24 hours.
30. Pharmacists should form part of the out-of-hours team for palliative care, though inclusion in a pharmacy on-call rota.
31. The sharing of information between GP, palliative care service and community pharmacist throughout end-of-life care should be improved.

Care for drug misusers

32. Drug misusers should continue to have convenient access to supervised administration of substitution treatments and be encouraged to make greater use of these interactions for other health interventions.
33. Pharmacists with the appropriate expertise should have opportunities to contribute more to care planning and review of treatment objectives, building on the knowledge of the drug misuser acquired through daily contact.
34. Consideration should be given to using pharmacist prescribers' working within a locally agreed shared care protocol to titrate doses, including during dose induction and detoxification.
35. Pharmacists should use the opportunities afforded by supervised administration to promote other health interventions, including blood-borne virus testing and immunisation,[14] influenza immunisation and appropriate counselling.

Preventing ill health

36. GPs and pharmacists should collaborate in providing cardiovascular risk assessment, including, when not duplicating what has already been done, on-site cholesterol monitoring.
37. Pharmacists should ensure convenient public access to evidence-based preventive interventions including, for example, 'Stop Smoking' services, emergency hormonal contraception, chlamydia testing and treatment[15] and

vaccinations. All such interventions should be delivered to the same quality standards wherever they are provided.

38. Pharmacists with appropriate expertise could become providers of travel immunisations and malaria prevention treatments and make recommendations as to what travel immunisations are required / recommended. Furthermore, pharmacists could provide advice on ailments contracted abroad, including traveller diarrhoea and sexually transmitted disease. This service must be supported by suitable communications between pharmacists and GPs to ensure that patient records are updated accordingly.
39. Better publicity for the public on how to access services (e.g. emergency hormonal contraception) should be provided.

Supporting self care

40. Patients should be able to access advice and or treatment for common minor illnesses conveniently, including outside the opening times of their general practices or community pharmacist.
41. Where possible GPs, nurses, practice staff and pharmacists and their teams should work together as part of a coordinated team across practices.
42. Provided funding can be identified a pharmacy NHS Minor Ailments Service[16] should be available to support GPs in urgent care and out-of-hours provision.
43. More effective promotion to the public and others should be implemented, to encourage use of pharmacies for minor ailments and advice on self care.

Levers and incentives

44. Further work needs to be carried out to establish what levers and incentives may be appropriate in order to expedite the changes described above. These should be applicable at various levels as appropriate, including individual pharmacy and practice level, local professional group level, and national level

National level

45. It is essential for patient safety that relevant patient information should flow both ways between general practices and pharmacies and IT systems in England and Wales should enable this while ensuring clear safeguards for consent and confidentiality and that patient information is not available to counter staff without appropriate training.[17]
46. Ethical issues in sharing patient information should be identified and resolved with input from patients and service users. A joint code of ethics addressing issues such as consent and confidentiality must be agreed by both professional bodies to facilitate this.
47. Joint national guidance should be produced with input from patients and the public on evidence-based recommendations for non-prescription (OTC) medicines by all health professionals.
48. Outcomes and methods of measurement should be identified for assessing the pharmacy contribution to patient care.

49. New models of commissioning pharmacy input which requires joint working with general practice (e.g. the Chronic Medication Service in Scotland) should be explored.

50. Stakeholders should be consulted on how best to achieve continuity of pharmacy care, including the concepts of patient registration at pharmacies and shared records.

Local level

51. Examples and models of shared practice should be shared and disseminated.

Communication at local and national levels

52. Better ways of communicating between GPs and pharmacists should be explored. For example, the following may be considered:

    - Meetings between Local Pharmaceutical Committee (LPC) and Local Medical Committee (LMC)
    - RCGP Faculties and RPS local practice fora discussion of health needs and how joint working can improve the provision of healthcare and encourage better self care
    - Shared learning events for the primary health care team, including pharmacists
    - Shared critical event analysis
    - Periodic joint practice level meetings where this is feasible.

53. Professional bodies for general practice and pharmacy should meet regularly and provide leadership on joint working for members.

Sharing information

54. There should be a consultation process on the following areas:

    a) The extent to which pharmacists or qualified and appropriately trained staff involved in the provision of care to the patient should have access, with consent, to the patient's medical record

    b) pharmacist access to the Summary Care Record.[18]

55. A mechanism should be identified for the pharmacist to be able to record, and with the patient's consent share with the patient's practice, clinically significant over-the-counter sales, NHS Minor Ailment scheme consultations and public health interventions such as immunisation.

Shared standards and ways of working

56. Pharmacies and GP practices should work to common quality standards for screening and diagnostic testing.

57. Shared formularies for prescribing and supply for common conditions should be jointly developed.

58. Patient feedback should be used systematically to assure the adequacy of privacy and facilities in pharmacy consultation areas.[19] Pharmacists need to ensure they can provide confidential places to consult.

59. It should be recognised that continuity of care is particularly important when locums are involved.

Education and training

60. Ongoing CPD/ training using joint e-learning modules, case reviews and significant event meetings should be encouraged.

61. Through education and training ensure that a basic level of life support training is available in general practice and community pharmacy settings so that vulnerable patients with long term conditions are protected.

Moving forward

62. Action is now needed from individual clinicians, local professional groups, NHS organisations, national bodies and patients to shape how local care develops. The Royal College of General Practitioners and the Royal Pharmaceutical Society will start this process by:

    a) bringing together an invited multi-stakeholder group to explore the recommendations in this paper and identify the actions that are needed

    b) setting up a joint working group including patients and service users to take an agreed work programme forward.

    c) The initial scope of the working group will focus on the development of quality standards for medicine reviews

Notes

[1] This Statement applies to Great Britain only.

[2] Community pharmacists are responsible for controlling, dispensing and distributing medicine. They work to legal and ethical guidelines to ensure the correct and safe supply of medical products to the general public. They are involved in maintaining and improving people's health by providing advice and information as well as supplying prescription medicines.

Community pharmacists also sell over-the-counter medical products and instruct patients on the use of medicines and medical appliances. Some pharmacists will also offer specialist health checks, such as blood pressure monitoring and diabetes screening, run smoking cessation clinics and weight reduction programmes and are able to prescribe as well as dispense medicines.

Community pharmacists work in high street pharmacies, supermarkets, local healthcare centres and GP surgeries. http://www.prospects.ac.uk/community_pharmacist_job_description.htm

[3] Research Ready is an online self-accreditation tool covering the basic requirements for undertaking primary care research in the UK. Developed in conjunction with the NIHR Clinical Research Network and the Primary Care Research Networks, it is aligned with the latest Research Governance Frameworks. (For more information, see http://www.rcgp.org.uk/clinical_and_research/circ/research__knowledge_transfer/research_ready.aspx

[4] A Medicines Use Review involves a review of a patient's medicines, including items that are regularly prescribed, used only when necessary and those obtained for the purpose of self care. Its aim is to improve understanding of how, why and when medicines should be taken.

[5] MURs are only available in England and Wales through the community pharmacy contractual framework

[6] Evaluation of supplementary prescribing in nursing and pharmacy. Bissell et al 2008; Evaluation of nurse and pharmacist independent prescribing. Latter et al 2011

[7] http://www.psnc.org.uk/data/files/PharmacyContract/Contract_changes_2011/summary_of_cpcf_changes_may_2011.pdf

[8] Medicine reviews are: 'a structured critical examination of a patient's medicines with the objective of reaching an agreement with the patient about treatment, optimising the impact of medicines, minimising the number of medication-related problems.' Room for Review. A guide to medication review; the agenda for patients, practitioners and managers, published by Medicines Partnership ISBN 09544028 0 4.

[9] Part of the Community Pharmacy Contractual Framework in England and Wales, and of the Chronic Medication Service in Scotland

[10] Pharmacists who have completed the appropriate training and can prescribe any licensed medicine for any medical condition within their competence.

[11] Scotland already has a national scheme for patients to obtain an emergency supply of NHS medicines.

[12] Supporting Carers in General Practice
http://www.rcgp.org.uk/professional_development/continuing_professional_devt/carers.aspx

[13] For more information see the RCGP Supporting Carers in General Practice e-learning programme
http://www.rcgp.org.uk/professional_development/continuing_professional_devt/carers.aspx

[14] Immunisations are already provided by pharmacies in some areas (eg Isle of Wight 'Pharmacy Fix' service) with underpinning training and arrangements for dealing with anaphylaxis.

[15] Supply of emergency hormonal contraception and provision of Chlamydia testing are part of the Public Health component of the pharmacy contract in Scotland and provided by all pharmacies in Scotland.

[16] A national Minor Ailments Service has been in place in Scotland since 2006. Currently 60% of PCTs in England commission such a service.

[17] The Chronic Medication Service in Scotland includes electronic communication between the patient's nominated pharmacy and his or her GP practice.

[18] Emergency Care Summary in Scotland

[19] The Pharmacy Regulator the General Pharmaceutical Council is currently updating guidance on confidentiality.

High Impact Changes and Public Health:

Commissioning a Health and Wellbeing Service from Community Pharmacy

Key Messages:

- Community pharmacy is a valuable and under-utilised resource that should be part of the solution to reduce health inequalities and improve the wellbeing of our communities.
- Community pharmacy provides a range of health and wellbeing services that improve public health. These include NHS Health Checks, stop smoking, weight management and alcohol interventions.
- Community pharmacy's health and wellbeing services are well established and are an efficient mechanism to effectively roll out new public health initiatives.
- Community pharmacists and their teams see many people who are not registered with GPs; they can provide accessible and personalised services that can reach the individuals that GPs are missing.
- This is more than a policy briefing; it is a call to action for you to:
    - **Engage with your Local Pharmaceutical Committee** to discuss how community pharmacy can help improve public health services in your area; and
    - **Maintain and develop your relationships** with community pharmacy to ensure a smooth transition of health and wellbeing services into the new public health landscape.

High Impact Changes:

The Department of Health has previously identified a number of High Impact Changes that highlight practical measures that can be implemented at local level. These have been extensively used across the NHS and local government and include:

- Working in partnership;
- Influencing change through advocacy;
- Appointing a champion;
- Developing integrated activities to reduce variation and align priorities;
- Personalising services by providing more help to encourage people to improve their lifestyle;
- Improving the effectiveness and capacity of services; and
- Amplifying national social marketing priorities.

High Impact Changes that Community Pharmacy can deliver:

Community pharmacy is ideally placed to implement these High Impact Changes and help drive the Government's new public health agenda. We can do this by providing:

- Greater patient choice;
- Personalised services and enhancing patient involvement and understanding of their care: 'no decision about me, without me';
- Accessible care closer to home, in pharmacies at the heart of local communities;
- Early intervention and effective outcomes; and
- A positive patient experience in an open and friendly environment.

THE COMMUNITY PHARMACY HEALTH AND WELLBEING SERVICE

There are over 10,500 community pharmacies across England, including in areas of significant social deprivation, under-doctored areas and in rural communities. Department of Health data shows that 99 per cent of the population, even those living in the most deprived areas, can get to a pharmacy within 20 minutes by car. An estimated 1.6 million people visit a pharmacy each day, of which 1.2 million do so for health related reasons (Department of Health, 2009).

The convenient locations of community pharmacies, where people live, work and shop, and their extended opening hours make them the most accessible point of contact for health services. Accordingly, community pharmacy is better able to reach all members of the community and, in particular, make it easier for certain groups to choose to access services locally.

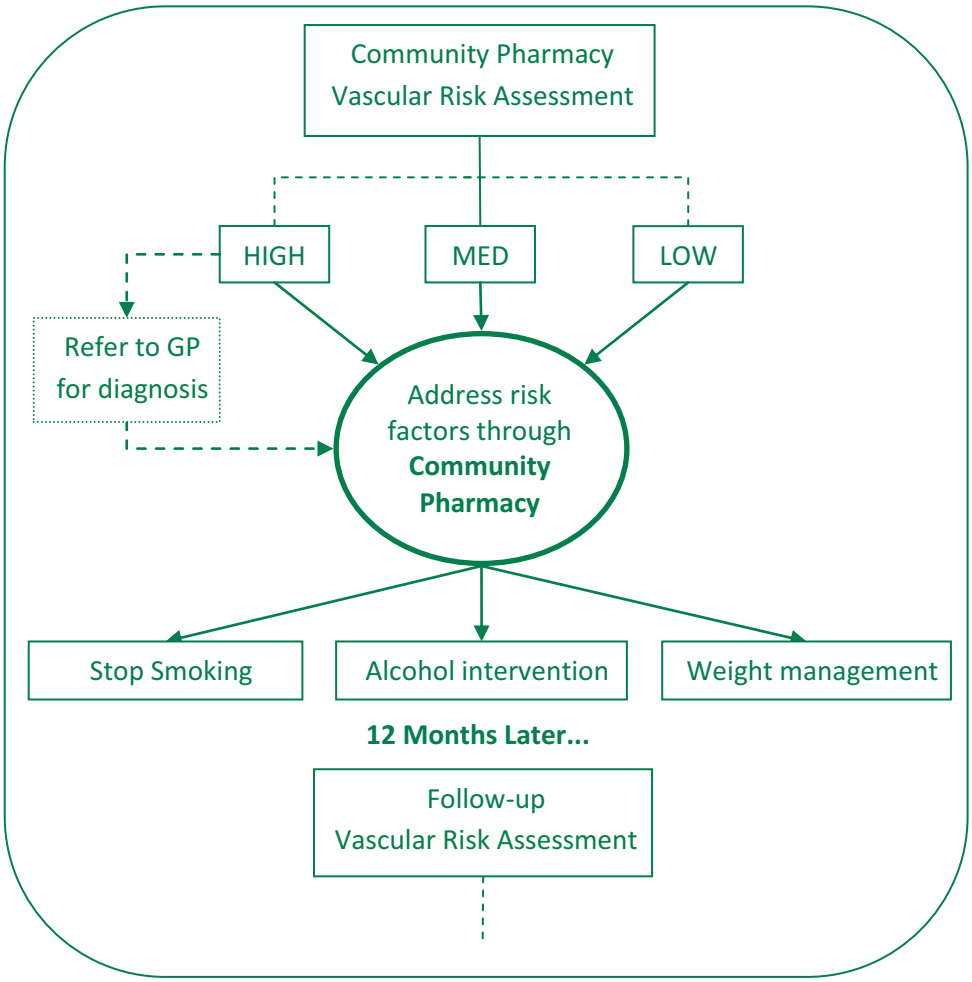
Community pharmacies are ready, willing and able to deliver a package of health and wellbeing health services for commissioners; Healthy Living Pharmacies are one vehicle for this that is currently working particularly effectively.

HIGH IMPACT CHANGE:

Develop integrated activities to reduce variation and align priorities.

The Health and Wellbeing service pathway is illustrated in Figure One. We highlight each of the potential elements of such a package in the rest of this briefing.

FIGURE ONE: HEALTH AND WELLBEING SERVICE PATHWAY



CASE STUDY:

Healthy Living Pharmacies (HLPs) are making a real difference to the health of people in Portsmouth, with 10 pharmacies awarded HLP status by NHS Portsmouth. HLPs have to demonstrate consistent, high-quality delivery of a range of services such as stopping smoking, weight management, emergency hormonal contraception, chlamydia screening, advice on alcohol and reviews of the use of their medicines.

They proactively promote a healthy living ethos and work closely with local GPs and other health and social care professionals. Early indications show that HLPs have greater productivity and offer higher-quality services. Early evaluation results include a 140% increase in smoking quits from pharmacies compared with the previous year; and 75% of the 200 smokers with asthma or chronic obstructive pulmonary disease who had a medicines use review accepted help to stop smoking.

Source: NHS Portsmouth, 2010.

NHS HEALTH CHECK PROGRAMME

The NHS Health Check Programme is a national initiative which aims to identify and reduce cardiovascular risk in people aged 40-74 (NHS Improvement Programme, 2008).

The burden of vascular disease falls disproportionately on people living in deprived circumstances and on particular ethnic groups and it accounts for the largest part of the health inequalities in our society (NHS Improvement Programme, 2008).

Vital Signs national outturn results for 2009/10 show that around 1 million people were offered an NHS Health Check, and almost 800,000 NHS Health Checks were delivered (Boyle, 2010).GPs have been responsible for conducting the vast majority of checks to date; however, a study of 338 patients by Pfizer revealed that two-thirds of those at risk said they would not access screening at their GP (Hunt, 2010). In the Pfizer community pharmacy-based pilot, 26 per cent of people accessing the service had not visited their GP in more than a year, and 66 per cent said they were unlikely to have a similar screening appointment at their GP practice (PrimaryCareToday, 2010).

Results from a GP–led pilot study suggest that GPs are missing a large number of at-risk individuals (Polak, 2010). Consultations were undertaken at a major supermarket in south east London, screening over 1,000 people. On average, each consultation was only four minutes 23 seconds. The study revealed that 425 participants needed a follow-up, 261 were previously undiagnosed, while 106 had abnormal results in a previously undiagnosed condition.

The lead GP in the study said, '...my practice worked really well and our QOF targets were great...so where are these people?' This indicates that if people are unwilling or unable to present to the practice during normal working hours then healthcare providers must go out and find them opportunistically.

Community pharmacy can provide these quality services, reaching people who would otherwise not access GP services. Community pharmacy, as an additional provider of NHS Health Checks, can identify individuals who are at risk of developing vascular disease and can support them to reduce their risk through lifestyle modifications. Community pharmacy provides an opportunity for greater patient choice and access to one-to-one professional assessment, advice and support.

CASE STUDY:

Birmingham South PCT commissioned a 'Heart MOT' pilot, a cardiovascular risk-based assessment, in 30 community pharmacies in Birmingham. The results of the pilot show that males who would not normally see a GP can be targeted; and in addition that individuals from deprived areas and with a minority ethnic background can be targeted.

Of those assessed, 60 per cent were male, 65 per cent were from the average, less deprived, and most deprived quintiles, and 7.4 per cent and 24.8 per cent were from Black and Asian communities respectively. Importantly, it highlights that a significant number of individuals can be identified for whom intervention for vascular disease risk or other risk factors is required; around 70 per cent of those assessed were referred to their GP.

Source: NHS Improvement Programme, 2009

Individuals are allowed to take ownership of their treatment and condition and this enhances the likelihood of improved health outcomes. Community pharmacy is able to maintain ongoing relationships with these individuals through an effective personalised service which encourages adherence with lifestyle modification programmes.

HIGH IMPACT CHANGE:

Personalise services by providing more help to encourage people to improve their lifestyle.

CASE STUDY:

Knowsley PCT targeted men aged 50-65 with their free health checks in 10 pharmacies across the region. After conducting the check, Knowsley PCT surveyed participants to evaluate the service. The study found that 96 per cent of men said they have made at least one lifestyle change as a result of the check-up, while almost 100 per cent said they were either very or quite likely to attend a follow-up health check and would recommend the checks to other men.

Source: NHS Improvement Programme, 2009

ALCOHOL INTERVENTIONS

The Alcohol Learning Centre (2010a) describes Identification and Brief Advice (IBA) as opportunistic case finding followed by the delivery of simple alcohol advice (in the research literature, this is referred to as 'Alcohol Screening and Brief Interventions').

These are effective interventions directed at people consuming alcohol at increasing or higher-risk levels who are

CASE STUDY:

In the North West of England pharmacy is playing a key role in the provision of alcohol intervention and brief advice (IBA). Around 125 pharmacies across Wirral, Blackpool, Knowsley, Oldham, Liverpool and Warrington are involved in service provision. The service can be targeted to those who may be at high risk such as those who present for treatment of hangovers, gastric problems and falls. Pharmacy sees a different demographic of people from those who may visit a GP practice, especially in areas of health inequality.

The initial reports for NHS Blackpool showed that of the 138 interventions made, 39 per cent of people screened were found to be drinking either at increasing or c high risk. Based on these results the potential cost savings could be significantly greater than those estimated by the Department of Health, which makes an assumption that only one in four people would be identified at increasing or high risk.

Source: Stafford. 2010.

not typically complaining about or seeking help for an alcohol problem.

A Cochrane Collaboration review (Kaner et al., 2007) provides substantial evidence for the effectiveness of IBA. There is a large body of evidence supporting IBA in primary care, including at least 56 controlled trials (Moyer et al., 2002). Indeed, these authors suggest that for every eight people who receive simple alcohol advice, one will reduce their drinking to within lower-risk levels.

This compares favourably with smoking where only one in twenty will act on the advice given, increasing to one in ten with nicotine replacement therapy (Silagy & Stead, 2003). People who received IBA in A&E made 0.5 fewer visits to the A&E during the following 12 months (Crawford et al., 2004), leading to significant cost savings.

In this regard, NHS East of England (2009) reflected that IBA services delivered through the Direct Enhanced Services to 50 per cent of new GP practice registrants by 2011/12 would cost £873,000, but would deliver benefits of £3 million through reducing A&E attendances by 8,500 and hospital admissions by 3,300 annually.

Using a model adapted from the Alcohol Learning Centre's 'Ready-Reckoner' tool (2010b), and based on pharmacy identifying one in four people at high risk (as assumed by the Department), the net cost saving to the NHS works out as follows:

- 100 pharmacies – net cost saving to NHS: £215,107 per annum
- 400 pharmacies: £860,427
- 800 pharmacies: £1,720,853
- 1,000 pharmacies: £2,151,067

Community pharmacy has a significant opportunity to be better utilised to deliver alcohol awareness programmes, give brief advice, and provide intervention services relating to safe alcohol consumption.

HIGH IMPACT CHANGE:

Improve the effectiveness and capacity of services.

CASE STUDY:

Hampshire and Isle of Wight LPC ran a community pharmacy IBA service in 2009. A total of 794 opportunistic and pro-active interactions and 801 interventions were made. Of these, 47 per cent reported low risk, 26 per cent increasing risk, 13 per cent higher risk and 3 per cent possible dependence. Information was offered to 58 per cent of participants, 37 per cent were given brief advice and 5 per cent were referred for further support.

Source: HubCAPP, 2009.

STOP SMOKING SERVICES

Community pharmacy is now an established and trusted provider of stop smoking services and these are widely commissioned by PCTs.

CASE STUDY:

The Isle of Wight has recognised that stop smoking services play an integral part of cardiovascular disease prevention programmes. Their programme engaged 11 community pharmacies within the target area to provide up to three hours a week of one-to-one stop smoking support. At the time of evaluation, of the 53 smokers that engaged with the pharmacy-led smoking cessation service at least 18 had not been smoking for over a month.

Source: NHS Improvement Programme, 2009

The healthcare benefits achieved by stopping smoking are irrefutable, as are

the benefits of offering stop smoking services in community pharmacy. In 2009/10 757,537 people set a quit date through NHS Stop Smoking Services in England. At the four week follow-up 373,954 people had successfully quit - 49 per cent of those who set a quit date. Stop Smoking services within a community pharmacy setting helped 140,000 set a quit date in 2009/10, and at week four 62,000 people had successfully quit compared to 55,000 in 2008/09; an increase of 15 per cent (NHS Information Centre, 2010).

WEIGHT MANAGEMENT

It has been estimated that those who are overweight or obese cost the economy £7 billion in treatment, benefits, loss of earnings and reduced productivity. If no action is taken, the total costs to society are expected to rise to £50 billion by 2050 (Foresight, 2007). Pharmacies can provide additional services to help tackle obesity in the community through innovative weight management programmes.

SAVINGS BY MOVING PATIENTS FROM THE GP SURGERY TO COMMUNITY PHARMACY

Not only will community pharmacy Health and Wellbeing Services help to provide greater access and capacity, it will also be of greater added value to commission these services from community pharmacy than from GPs. An average GP surgery consultation last 11.7 minutes and costs £32, while the same 11.7 minute consultation in community pharmacy would cost £17.75 (PSSRU, 2008).

The initial VRA in community pharmacy ought to take between 20 and 30 minutes meaning the disparity and hence savings would be even greater, and GP capacity could be freed-up to deal with more complex cases.

CASE STUDY:

The weight management service in Central Lancashire is a structured behavioural change programme over 12 months based on setting achievable interim goals, supported by holistic lifestyle advice including diet and exercise.

An evaluation by the University of Central Lancashire revealed that after 12 months, the average reduction in BMI was 2.4. The service was also found to be more cost effective than prescribing Orlistat over 12 months, at £160 per patient compared to £419.51 per patient. There was also found to be an average reduction in blood pressure of 9/6 mmHg.

The evaluation found significant support from the service users who appreciated the informal pharmacy environment and the flexibility for drop-in appointments.

Source: Vohra, 2010.

SUMMARY

- All of the elements that make up health and wellbeing services are already commissioned as individual services by community pharmacies.
- Combining these elements into a health and wellbeing package would be more effective than commissioning and pricing individual services.
- Community pharmacy staff already have the competencies to deliver all elements of the service efficiently and effectively with minimal additional training.
- The existing infrastructure and staff capabilities will enable quick roll-out of services and delivery of the programme within short timescales.
- Pharmacy is ready and willing to provide a package of health and wellbeing services.

Notwithstanding the above, the purpose of this paper is not just to highlight the benefits of commissioning a health and wellbeing package of services from community pharmacy. It is a call to action to ensure pharmacy is at the forefront of commissioners' thinking as the new public health landscape develops.

CALLS TO ACTION

Primary Care Trusts	1. Ensure the communication lines are open: as commissioning processes change it will be crucial that commissioners are fully aware of the impact being made by community pharmacy on the ground. Regular engagement with LPCs will facilitate this understanding, so we ask that full and frequent communications with your LPC are maintained. 2. Publish the list of people involved in forming shadow boards who will have interim responsibility for commissioning in the same way as SHAs have published the bridging arrangements. 3. Publish contact details for the Directors of Public Health and key members of their team.
Local Authorities	1. Identify and establish communications with the responsible persons in PCTs and shadow GP consortia for commissioning public health services. 2. Identify the process and responsibility for ensuring the public health requirements within Joint Strategic Needs Assessment and Pharmaceutical Needs Assessments are integrated and updated. 3. Publish contact details for the Joint Directors of Public Health and key members of their team. 4. Engage community pharmacy and other primary care professional bodies in the process of identifying effective representation in the formation of Health and Wellbeing Boards.
Local Pharmaceutical Committees	1. Invite Directors of Public Health to meet and discuss how local community pharmacies can make a significant contribution to reducing health inequalities by providing health and wellbeing services. 2. Contact Local Authorities: commissioning of most public health services will be the responsibility of the Health and Wellbeing Board. Contact the individuals within local authorities to ensure pharmacy remains well and truly on the radar of these commissioners-to-be.

NOTES:

The CCA, NPA and AIMp are members of Pharmacy Voice, bringing together all pharmacy owners. For further information on Pharmacy Voice please contact the NPA press office on 01727 795901 or email communications@npa.co.uk

For a copy of this document or further information please email office@thecca.org.uk.

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Health and Social Care Committee
HSC(4)-09-11 paper 14
Inquiry into the contribution of community pharmacy to health services in Wales – Additional information from Public Health Wales

It was good to be able to attend the HSCC and take questions from the Committee. There were a few areas where we agreed to send additional information. Please find attached:

1. A paper I've written reporting research evidence on those *Factors which influence a person's decision when managing a minor ailment v1.0*. Within that paper I refer to some research undertaken on behalf of the PAGB and members may be interested to read the whole paper- I would certainly recommend that. There is a hyperlink in my paper

2. A PowerPoint presentation *Uptake of MURs* comprising of two slides, one ranking the 22 local authority areas by proportion of the maximum number permitted MURs undertaken, the other, the deprivation ranking of the 22 areas.

3. A literature review I undertook earlier in the year which I thought members might be interested in following their questions on the uptake of MURs and reasons why MURs were not taken up *Medicines use review by community pharmacists v1.0*

4. A link to the MPharm indicative syllabus http://www.pharmacyregulation.org/education/approval-courses/accreditation-guidance
   To qualify as a pharmacist the person must hold a MPharm degree (4 years) + pass the pre-registration year and pre-registration exam. They can then apply for membership of the General Pharmaceutical Council (GPhC), which entitles the person to work as a pharmacist. Every year pharmacists must undertake continuing professional development activities sufficient to satisfy the requirements of the GPhC. Hopefully this information will help to address questions around those activities pharmacists are competent and qualified to do by virtue of being qualified as pharmacists.

5. Regarding competence to deliver enhanced services the WCPPE website describes the role of WCPPE in delivering training and assessing pharmacists competence www.wcppe.org.uk/assessment/enhanced-services-assessments and members can view some of the training provided by WCPPE in the latest programme *WCPPE Autumn 2011 (2).pdf http://www.wcppe.org.uk/learning* See page 3 for enhanced service accreditation and page 19-23 for some of the pharmacy contract specific courses available.

If there is anything else I agreed to supply and I've forgotten please let me know.

Anne Hinchliffe MRPharmS FFPH

Ymgynghorydd mewn Iechyd Cyhoeddus Fferyllol, Iechyd Cyhoeddus Cymru

Consultant in Pharmaceutical Public Health, Public Health Wales

Factors which influence a person's decision to consult with their GP for a minor ailment or visit a community pharmacy

Author: Anne Hinchliffe, Consultant in Pharmaceutical Public Health

Date: 14 October 2011 **Version:** 1.0

Publication/ Distribution:

- To members of the Health and Social Care Committee, National Assembly for Wales

Review Date: N/A

Purpose and Summary of Document:

This document has been prepared in response to a request from the above Committee for research evidence about those factors which influence a person's decision to consult with their GP for a minor ailment or to visit a community pharmacy.

Evidence is provided from six UK studies, published during the past decade. A comprehensive literature review has not been undertaken.

1. **Proprietary Association of Great Britain (2009) *Making the case for the self care of minor ailments*** Available at http://www.pagb.co.uk/information/PDFs/Minorailmentsresearch09.pdf [Accessed 13th October 2011]

- People in Wales are more likely to consult their GP with a minor ailment than people in England (p29)
- People in Wales are significantly less likely to have tried over-the counter (OTC) medicine before visiting GP/nurse (29% v 48%)(p29)
- People are more likely to visit their GP with a minor ailment because they want reassurance than because they want free medication (p41)
- People in Wales are more likely to lack the confidence to self care than people in England (p43)

Members may be interested to read the full report as it describes many more points on the management of minor ailments from the perspective of doctors, nurses and the public.

2. **Hammond T, Clatworth J and Horne R. 2004. Patients' use of GPs and community pharmacists in minor illness: a cross-sectional questionnaire-based study. Family Practice 21 (2), pp.146-49**

- Study to explore the prevalence of visits to the GP that GPs felt could be managed by a pharmacist, and to explore patients' reasons for such visits
- 13 GP practices in West Sussex, consultations over a one week period
- GPs considered 7% (260/3984) consultations could have been managed by a community pharmacist
- Skin and musculoskeletal problems were the most common causes of 'unnecessary' visits to the GP
- The majority of patients making 'unnecessary' visits (59%) disagreed with their GP and felt that the pharmacist was 'not appropriate for this problem'

- Other reasons for not attending the pharmacist were:
    - Didn't think of it (15%)
    - Entitled to free prescriptions (6%)
    - Too embarrassed/ lack of privacy (6%)

3. Hassell K. et al. 2001. Managing demand: transfer of management of self limiting conditions from general practice to community pharmacies. British Medical Journal 323 (7305), pp.146-47

- During the six months of the trial, all patients seeking general practice appointments or telephone prescriptions for 12 conditions at one general medical practice were offered a consultation at a local community pharmacy instead
- The pharmacist prescribed treatments from a limited formulary and patients exempt from the prescription charge received medicines free of charge, thus removing any financial disincentive
- Overall 38% consultations for the 12 conditions were transferred from the GP to the pharmacy
- Transfer rates were higher for head lice, indigestion, thrush and constipation. Patients with earache, cough or sore throat were more likely to want to consult a GP

4. McIntyre J. et al. 2003. Use of over-the-counter medicines in children. International Journal of Pharmacy Practice 11, pp. 209-15

- A postal questionnaire was used to explore reasons for over-the-counter use in children and the sociodemographic factors influencing self-care rather than GP consultation
- The results were based on 424 returned questionnaires (61%)
- Reasons for seeing GP rather than pharmacist:
    - Want advice from GP (50%)
    - Medicine only available on prescription (24%)
    - Can get medicine free on prescription (22%)

  - Unable to get to a pharmacy (18%)
  - Cost of OTC medicine is not affordable (12%)
- Cost was more likely to be a barrier in areas of greater deprivation

5. **Boardman H. et al. 2005. Use of community pharmacies: a population-based survey. Journal of Public Health 27 (3), pp. 254-62**

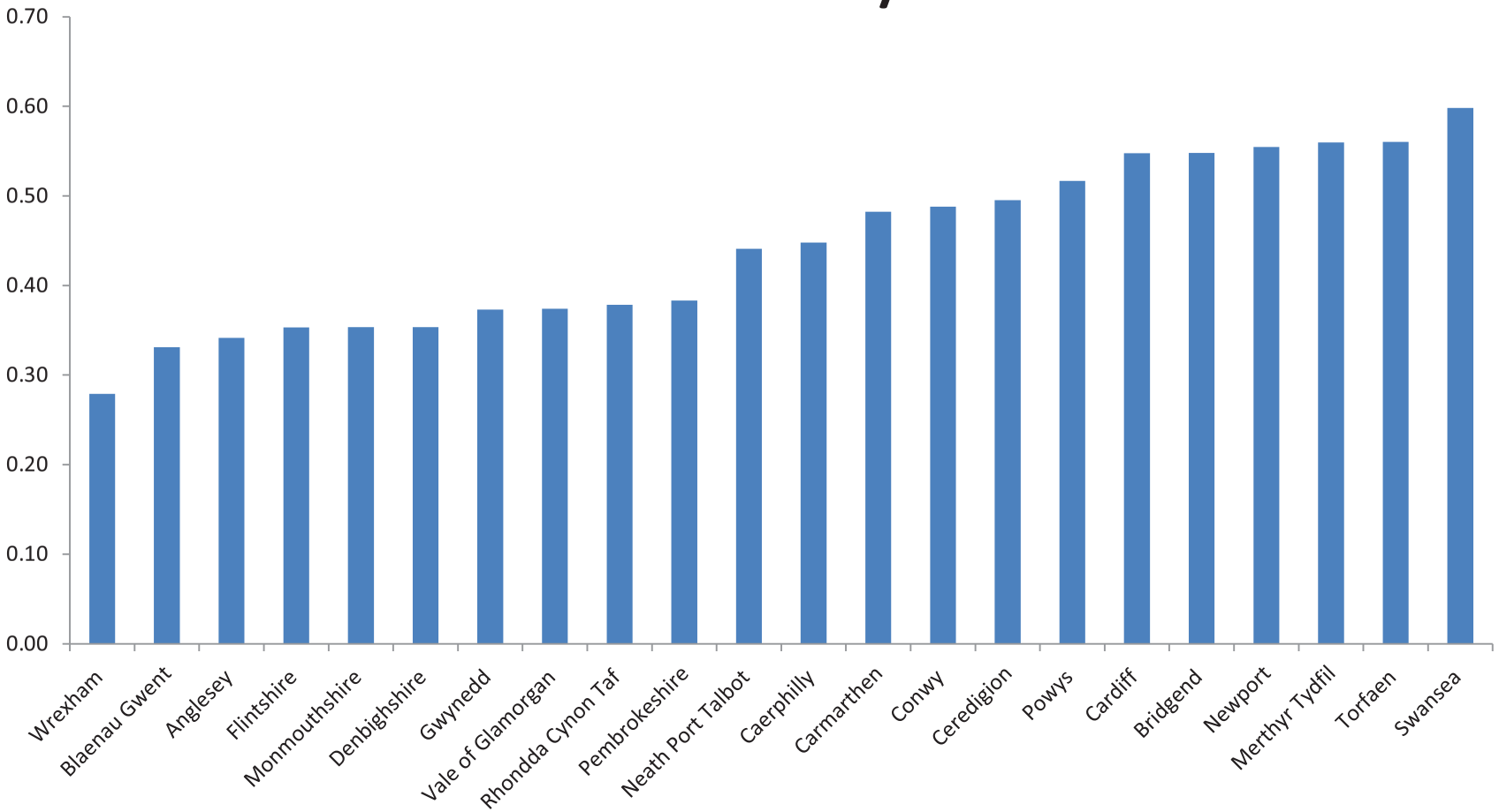
   - A cross-sectional survey of 10,000 adults aged 35 years or over. Response rate 67%
   - 40% had purchased an OTC medicine and 12% had asked for advice from a pharmacy in the previous month
   - Purchasers of OTC medicine were more likely to be younger and from higher socio-economic classes

6. **Hughes D. et al. (2008) Investigating factors influencing user choices to visit either general practitioners or community pharmacists in the management of minor ailments – piloting a discrete choice experiment** Available at www.pprt.org.uk/Documents/Publications/Investigating_factors_influencing_user_choices.pdf [Accessed 13 October 2011]

   - A literature review identified a number of factors that potentially impact decisions regarding if and when to use general practice or community pharmacy services including:
     - convenience factors
     - information, reassurance and anxiety
     - altruistic concerns to alleviate pressure on stretched services
     - previous experience and the ability to self-care
     - specific features of professionals e.g. lay beliefs concerning professional boundaries
     - organisational features of services e.g. privacy concerns, availability of to provide advice

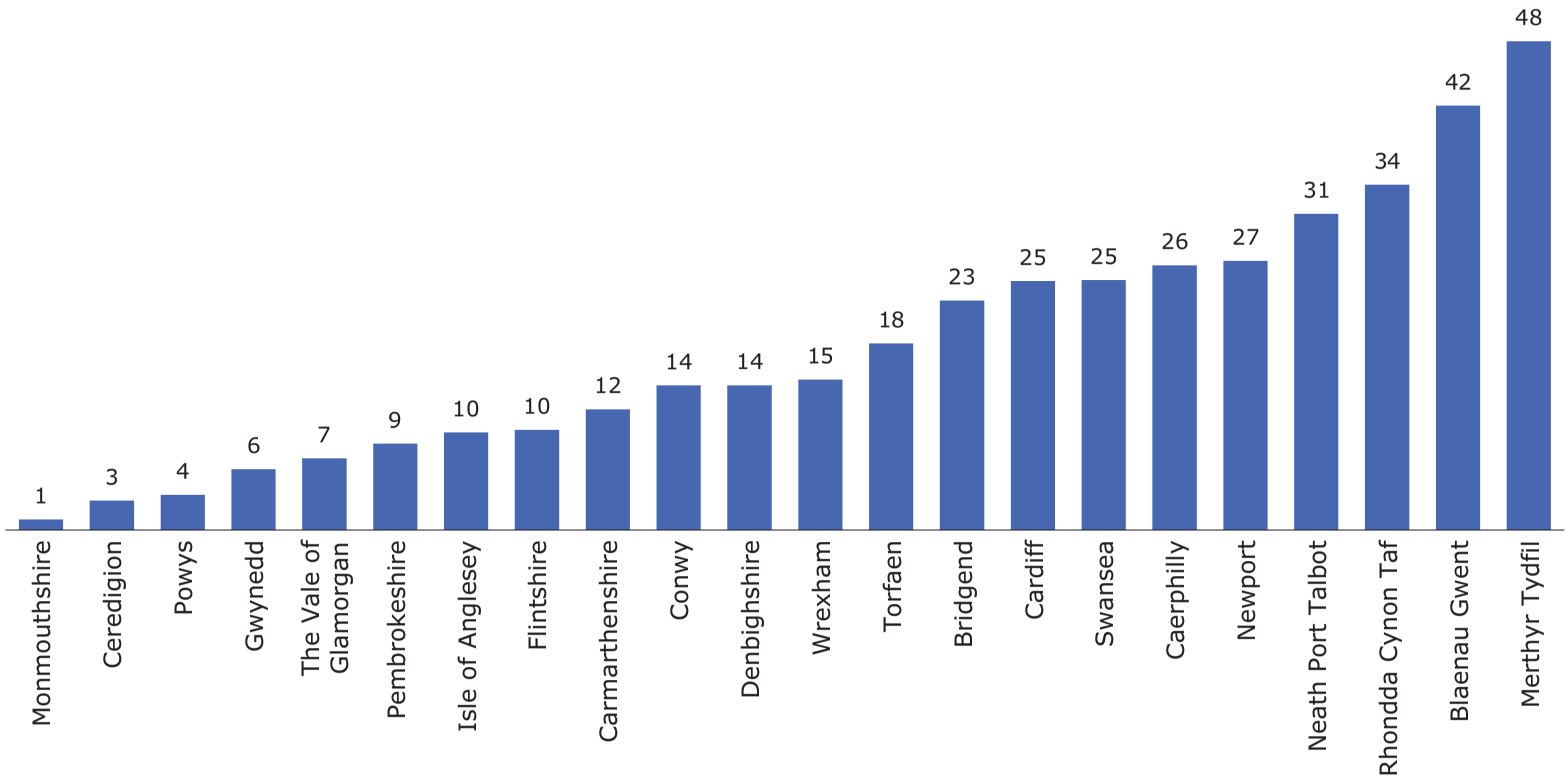
  - material concerns e.g. the affordability of medicines
  - medicine related concerns e.g. relative efficacy of prescription and non-prescription medicines, concerns over inappropriate and/or over-utilisation of medicines
- Discrete choice experiment (DCE) methodology was then used to determine which factors were most influential
- The DCEs found respondents preferred consultations that were:
  - Lengthier
  - More accessible
  - Lower cost
  - With the GP rather than the pharmacist

Proportion of maximum permitted MURs undertaken by local authority area 2010/11



Data source: NWIS 2011

Proportion of population living in most deprived fifth of Wales



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Medicines use review by community pharmacists

Author: Anne Hinchliffe, Consultant in Pharmaceutical Public Health

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Purpose and Summary of Document:

To review the published literature on medicines use review (MUR) by community pharmacists, following the introduction of the MUR advanced service into the community pharmacy contractual framework.

A number of research projects and evaluations have quantified MUR activity and sought to understand those factors which influence uptake, both patient and pharmacist/pharmacy factors.

Little evidence was found on clinical outcomes post MUR. Studies evaluating directed MUR services, focusing on a particular disease, were most likely to report clinical outcomes.

In developing MUR services there are opportunities to learn from experiences of MUR to date. These include:

- Developing strategies to encourage uptake/ delivery of MURs to patients who need them the most
- The need for quality assurance of MURs
- The need to evaluate clinical outcomes from MUR services
- Improving communication between pharmacists and GPs
- Improving GP enthusiasm for community pharmacy MUR services

The review has been presented as evidence tables for easy reference.

Contents

Table 1: Generic MUR services

Ref	Study	Population/ setting	Intervention/ aim	Outcomes/results	Design	Evidence level
Factors influencing MUR delivery						
1.	Bradley F et al. Determinants of the uptake of medicines use reviews (MURs) by community pharmacies in England: A multi-method study. *Health Policy* 2008; 88: 258-68	England, 2006 Survey of all Primary Care Organisations (PCOs), (n=303) Case study investigations of 10 PCOs, involving interviews with 43 key stakeholders	To explore and identify the key determinants influencing the uptake of MURs	Survey response rate =74% • Ownership category of the pharmacy was the most significant determinant of MUR uptake ($p<0.001$). Rates of provision by multiple pharmacies were almost twice that of independent pharmacies (108 vs. 56 MURs per pharmacy during 2006) • Pharmacies with higher levels of prescription items dispensed were more likely to undertake MURs ($p<0.001$) • Higher levels of deprivation and proportion of patients with limiting long-term illness within the PCO were associated with significantly lower levels of MURs (both $p<0.001$) • MUR training opportunities and the motivation of pharmacists were the main drivers to implementation	Quantitative analysis of national MUR activity data	2+

Ref	Study	Population/ setting	Intervention/ aim	Outcomes/results	Design	Evidence level
				• Lack of support from GPs was cited by 62% respondents as a barrier. Other barriers included accreditation of premises and pharmacist lack of confidence to perform MURs • Communication between community pharmacists and GPs was identified as an issue with MURs having the potential to adversely affect GP/ pharmacist relationships • Concerns regarding the quality of MURs were expressed by PCO staff		
2.	Mc Donald R et al. *The impact of incentives on the behaviour and performance of primary care professionals. Report of the National Institute for Health Research Delivery and Organisation programme 2010*. SDO project	• General medical practice • Community pharmacy • General dental practice in England Of relevance to this report, 70 community	To explore and explain the impact of incentives in primary care on professional behaviours and performance	MURs- qualitative analysis (see p124-7, 146-52, 207-8, 220 for quotations and discussion) • Pharmacist locums reported little desire or pressure to conduct MURs • Owners struggled to conduct MURs whilst maintaining dispensing volumes • Salaried pharmacists experienced varying degrees of pressure and motivation to conduct MURs	Multi-method approach, including qualitative and quantitative components	2-

Ref	Study	Population/ setting	Intervention/ aim	Outcomes/results	Design	Evidence level
	(08/1618/158) www.sdo.nihr.ac.uk/files/project/158-final-report.pdf	pharmacists		• Some pharmacists felt unease about financial incentives and asking patients to sign MUR forms as they thought this may alter patient perception from a service which had patients' best interests at heart to something financially driven • Most pharmacists said they undertook MURs in accordance with the spirit (as opposed to the letter) of the MUR guidance. Only a small number admitted undertaking 'tick box' MURs • GPs generally had negative views of pharmacist MURs		

Ref	Study	Population/ setting	Intervention/ aim	Outcomes/results	Design	Evidence level
General evaluation of MUR services						
3.	Royal Pharmaceutical Society QI4PD medicines use review audit reports http://www.qi4pd.org.uk/index.php/Reports-update.html Annual report 2009/10	Ongoing UK national multidisciplinary audit, developed by the RPS, RCGP and the Clinical Audit Support Centre Ltd. The audit involved four groups: • Community pharmacy • General practice, Primary • PCOs • Patients who had recently had a MUR.	To review the effectiveness of MURs from the different perspectives of: • Community pharmacy • General practice • Patients • PCOs and, where appropriate, to improve the quality of MURs	*Pharmacy report* - 54 pharmacies - 551 MURs • 75% MURs were undertaken in large multiple pharmacies • 84% MURs were initiated by pharmacists • <1% MURS were initiated by GPs • In 80% MURs, recommendations were made to the patient. Adherence, lifestyle changes and 'other' were the most popular categories • The pharmacist contacted the GP post MUR in 19% MURs *Patient report* 3016 submissions from 316 pharmacies across 14 PCOs • 49% patients reported receiving recommendations to change how they take their medicines, and of these 90% were likely to make the change(s) • 77% had their medicines knowledge improved by the MUR • 97% patients thought the place where the MUR was conducted was sufficiently confidential • 85% patients scored the MUR 4 or 5 on a usefulness scale where 1 was not useful	Multi-disciplinary audit	2-

Ref	Study	Population/ setting	Intervention/ aim	Outcomes/results	Design	Evidence level
				and 5 very useful *GP report* 240 GP practices participating in MUR service across 13 PCOs • 52% considered the MUR service beneficial • 48% thought it increased patients' understanding of their medicines • 40% considered it improved patient compliance with their medicine regime • 18% thought it supported the management of long-term conditions		
4.	MUR statistics (England) reported at www.psnc.org.uk/pages/mur_statistics.html					

Ref	Study	Population/ setting	Intervention/ aim	Outcomes/results	Design	Evidence level
Pharmacist views						
5.	Blenkinsopp A et al. Community pharmacists' experience of providing medicines use reviews: findings from the national evaluation of the community pharmacy contractual framework *Int J Pharm Pract* 2007; Suppl 2: B45-6	All community pharmacists in 31 PCOs in England and Wales, (n=1080), 2006 Focus groups with 25 community pharmacists	To explore community pharmacists' experience of providing MURs and future plans of those not currently providing them	Community pharmacist survey response rate 71% • 70% had a counselling area that met the requirements for MUR accreditation • 59% were providing MURs and only 16% were not planning to do so in the future • 'Company policy' (40%) and 'own decision' (40%) were the main drivers for providing the service • 23% had employed pharmacy locums to conduct MURs or to provide cover • Large multiples (>30 stores) were more likely to provide MURs than other types of pharmacy • Mean number of MURs per pharmacist =63 • Mean time to provide a MUR = 51 minutes (22 min face-to-face with patient) • 77% pharmacists identified patients for MUR • Only two pharmacists said GPs were the	Postal survey and focus groups	2-

Ref	Study	Population/ setting	Intervention/ aim	Outcomes/results	Design	Evidence level
				main source of selecting patients for MUR • Only 26% reported having received feedback from GPs on MURs • Only 12% thought that providing MURs had improved their relationship with GPs • Lack of a consultation area and pressures of other work were the main reason for not providing MUR • Pressure from employers, and the desire to use the MUR funding to pay for second pharmacist cover to release time to both provide MUR and allow time to catch up on paperwork, were the main reasons for providing the service • Challenges included the time taken to prepare and provide the MUR and patients not attending for appointments		
6.	Bradley F et al. Commissioning and delivery of services from community pharmacy: a national study. Manchester; The University of Manchester, 2007.	PCTs in England, 2006,	National survey of PCTs Interviews with commissioners and providers of NHS services from community pharmacies at 10 PCT	The results cover a range of community pharmacy services following the introduction of the new community pharmacy contractual framework. The following pages provide some comments specifically on MUR. • MURs have not contributed positively to integration of pharmacists into the	Postal questionnaire Semi-structured interview either face-to-face or by telephone	2-

Ref	Study	Population/ setting	Intervention/ aim	Outcomes/results	Design	Evidence level
	www.pharmacy.manchester.ac.uk/cip/CIPPublications/commissionedreports/commissioning_and_delivery_final_report.pdf		case study sites	primary healthcare team (p32-3) • Training for MURs was generally considered useful although some thought it was too clinically orientated and had raised an expectation that the MUR should be more clinically focused than is the case (p42-3) • Attitudes towards delivery of MURs varied and were influenced by employers (p45-6, 53-5)		
7.	Latif A, Boardman H. Community pharmacists' attitudes towards medicines use reviews and factors affecting the numbers performed *Pharm World Sci* 2008, 30: 536-43	280 pharmacists employed by one UK community pharmacy chain April/ May 2006	To investigate: • Factors that influence the number of MURs performed by community pharmacists • Community pharmacists' attitudes towards the service	60% (167/280) pharmacists completed the questionnaire 27% (44/167) had not performed any MURS 43% (71/167) had conducted one to 14 31% (51/167) had conducted ≥15 The following affected the number of MURs undertaken: • Job title (store based pharmacists did more than locums) • Weekly working hours (those working ≥21 hours per week did more MURs than those with shorter working hours • Availability of a consultation area The following had no significant affect on the number of MURs undertaken: • Pharmacist gender	Postal questionnaire Convenience sample	2-

Ref	Study	Population/ setting	Intervention/ aim	Outcomes/results	Design	Evidence level
				• Years qualified • Clinical diploma held by pharmacist • Pharmacy size There were high levels of agreement with the following statements: • MURs are an opportunity for an extended role (93%) • MURs make better use of pharmacists' professional skills (86%) • MURs will enhance pharmacists understanding of their patients' views about medicines (96%) • MURs will improve patients' use of medicines (93%) There were high levels of disagreement with the following statements: • MURs are a waste of pharmacists' time (90%) • I would not like to see more advanced services introduced in the future (69%) • MURs will not improve patient compliance (86%) • MURs will not improve the cost-effectivness of prescribed medication (66%) • 43% respondents expressed doubts as to whether GPs thought the service was valuable to patients with a further 35% giving a neutral response • 74% felt they had insufficient supporting staff to conduct MURs satisfactorily		

Ref	Study	Population/ setting	Intervention/ aim	Outcomes/results	Design	Evidence level
				• 74% did not have enough time to carry out MURs • Opinion was split over whether pharmacists needed access to the patient's medical notes for a fully beneficial review		
8.	Latif A, Mahmood K, Boardman H. Medicines Use Reviews- how have pharmacists' views changed *Royal Pharmaceutical Society conference 2010* abstract 69 www.rpharms.com/rps-conference-pdfs/rpsconf2010abstractbook.pdf	300 pharmacists employed by one UK community pharmacy chain September 2009	To determine pharmacists' views of MURs and compare them with a similar study (ref 7)	63% (189/300) questionnaires were returned Compared with the 2006 survey results the following were noted: • A reduction in those that viewed the service as 'a great opportunity for an extended role' (82% vs. 93%) • An increase in those that considered MURs a waste of pharmacists' time (7% vs. 2%). Pharmacists expressed similar views about the perceived benefits of MURs to patients and their positive impact on cost-effectiveness and the use of medicines. The following barriers were still identified by many pharmacists: • Lack of time (58% vs. 74%) • Adequate support staff (56% disagreed they had sufficient support vs. 74%) • Negative GP views of the service By 2009 most pharmacies had a consultation area so this was no longer an issue.	Postal questionnaire	Abstract only available

Ref	Study	Population/ setting	Intervention/ aim	Outcomes/results	Design	Evidence level
9.	Cowley J et al. Exploring community pharmacists' experience and opinions of Medication Review services in England, Wales and Scotland *Royal Pharmaceutical Society conference 2010* abstract 91 www.rpharms.com/rps-conference-pdfs/rpsconf2010abstractbook.pdf	Thirty community pharmacists, - Scotland (15) - England (10) - Wales (5) November 2009	To explore barriers and facilitators to MUR provision	Interviewees perceived that MUR services: • Enhanced the relationship between the pharmacist and patient • Improved the image of the profession • Allowed pharmacists to meet patients' pharmaceutical needs • Increased pharmacists' job satisfaction • Were unnecessarily bureaucratic • Were difficult to deliver due to workload and the need for privacy • Were inappropriately linked to remuneration rather than patient needs	Qualitative-recorded interview	Abstract only available
10.	National Pharmacy Association and Primary care Pharmacists Association. *Medicines use review support and*	4 PCOs in England	Evaluation of an educational intervention and structured support programme to improve the quality of MURs	Pharmacists reported improved time management and an increase in confidence, both of which had been barriers to implementing MURs Written recommendations to GPs were of variable quality indicating a need to improve	Qualitative Community pharmacy evaluation forms, feedback	2-

Ref	Study	Population/ setting	Intervention/ aim	Outcomes/results	Design	Evidence level
	evaluation programme report 2010 www.npa.co.uk/Documents/Docstore/PCO_LPCs/MUR_support_evaluation.pdf			pharmacists' written communication skills	sessions with facilitator, patient satisfaction survey, sample of completed MUR forms	
GP views						
11.	Celino G et al. General practitioners' experiences of medicines use review: qualitative findings from the national evaluation of the community pharmacy contractual framework in England and Wales *Int J Pharm Pract* 2007; Suppl 2: B20-1	All GPs in one LHB (Wales) and three PCTs (England) n=397	To explore GP experiences of the community pharmacy MUR service	20 GPs were interviewed, all from different practices and representing the four areas • GPs were happy with the focus of MUR as described to them by PCIOs and community pharmacists before the service began, i.e. helping patients to understand their medicines • Many GPs had experienced MURs with inappropriate or ill-informed clinical recommendations and were less happy with this • GPs had some concerns over the types of patients reviewed by pharmacists and lack of integrations with the work of the practice	Semi-structured telephone interview	Abstract only available
12.	Wilcock M, Harding G. General	GPs attending one of three	To explore GPs' perceptions of	90% (52/58) GPs completed the questionnaire. 60% described their working	Self-administered	2-

Ref	Study	Population/ setting	Intervention/ aim	Outcomes/results	Design	Evidence level
	practitioners' perceptions of medicines use reviews by pharmacists. *Pharm J* 2007; 279:501-3 www.pjonline.com/files/rps-pjonline/pdf/pj_20071103_perceptions.pdf	locality-based prescribing meetings held in March and April 2007. Cornwall and Isles of Scilly PCT	community pharmacist MURs	relationship with their local community pharmacist as good. Although 60% thought the pharmacists' recommendations were generally useful, in the free text response to a question about how the GP thought their practice partners perceive the usefulness of MURs, the majority of comments were negative. The paper gives examples of GPs' views of useful and less useful MURs. These are: *Really useful MUR* • Single sheet of paper with brief relevant action points • Close working relationship with practice • Information on patients with compliance problems or adverse drug reaction (ADR) issues or drug interactions • Ensuring patients understand more about their medicines • Targeting MURs to particular groups of patients *Waste of time MUR* • Pages of information and having to hunt for (unhelpful) advice • Asking GP to check BPs etc when these reviews have already been done • MURs on patients whose medicines are stable and known to be compliant • When the practice has recently conducted a medication review	questionnaire	

Ref	Study	Population/ setting	Intervention/ aim	Outcomes/results	Design	Evidence level
				• One that highlights known problems that the GP is working on or has solved to their best ability • Discussing adverse effects that are inevitable and which the GP will have balanced against the clinical need for the drug		
Patient views						
13.	Iqbal S, Wood K. Exploring patient opinions of MURs *Royal Pharmaceutical Society conference 2010 abstract 19* Available at www.rpharms.com/rps-conference-pdfs/rpsconf2010abstractbook.pdf	23 patients who had a MUR in the previous four weeks. Patients selected from four branches of a large multiple community pharmacy chain, East Midlands, England February 2010	To explore patient opinions of MURs Comparison of pharmacist interventions as recorded on the MUR form and patient recall of recommendations made to them during the MUR	• 13 patients said they found the MUR beneficial and they were more informed about their medication as a result of the MUR • A further five said the MUR was reassuring as it confirmed existing knowledge of their medicines • Seven patients stated they had a poor or minimal relationship with their GP, of which four thought the MUR was useful • Only three could recall all the recommendations made by the pharmacist • 21 would have another MUR the following year • 8 thought the consultation room was too small • No one expressed concern that they were being overheard	Semi-structured telephone interviews Service evaluation	Abstract only available

Ref	Study	Population/ setting	Intervention/ aim	Outcomes/results	Design	Evidence level
14.	Latif A, Pollock K, Boardman H. Why do patients accept or decline the invitation for a Medicines Use Review? *Royal Pharmaceutical Society conference 2010 abstract 20* www.rpharms.com/rps-conference-pdfs/rpsconf2010abstractbook.pdf	Patients accepting or declining an offer for a MUR in one of two pharmacies, England.	To investigate reasons why patients accept or decline the offer of a MUR	54 MURs were observed and 34 patients interviewed either face-to-face or by telephone about their experience Most patients were approached 'ad-hoc' and were asked if they had time to spare to 'go through their medicines'. Patients generally accepted the invitation because they were asked by the pharmacist or staff with whom they had good relations. Some felt they were helping the pharmacist in some way by agreeing to a MUR. Most patients thought the 'ad-hoc' approach was acceptable as long as they did not have other commitments. A few accepted because they were curious or acknowledged that it was a 'good thing to keep up their knowledge' Eight patients declined the invitation for a MUR, three of which were subsequently interviewed by telephone. Observation found that two declined due to a lack of time and three refused without giving a reason. Of the three patients who declined and were interviewed, one declined because he thought the MUR would result in more medication and two because they had previously had a review with the doctor.	Observation and patient interviews	Abstract only available

Ref	Study	Population/ setting	Intervention/ aim	Outcomes/results	Design	Evidence level
15.	Youssef S, Hussain S, Upton D. Do patients perceive any benefit from medicines use reviews offered to them in community pharmacies? *Pharm J* 2010; 284:165-6 www.pjonline.com/content/papers_patients_perceive_benefit_murs_community	All patients who had a MUR at one community pharmacy in Derby, England betweenAugust and October 2008 n=152	To determine whether patients benefit following MURs and whether certain groups of patients derived more benefit than others. Three outcome measures were used: • Patients' perceived benefit • Pharmacists' interventions • Public health initiatives arising as a result of MURs	Response rate to the questionnaire was 53% (81/152) 55 (68%) respondents reported the MUR had increased their knowledge of their medicines and 47 (58%) were more aware of the side-effects from them 15 pharmacist interventions were made of which five were found to have been implemented on examining the PMR 83 (55%) patients were asked about their smoking status and 11 were found to be smokers. These 11 patients were offered support to stop smoking. Four enrolled onto the 'Fresh start' programme and successfully quit smoking	Postal questionnaire Service evaluation	2-

Table 2: Directed MUR services

Ref	Study	Population/ setting	Intervention/ aim	Outcomes/results	Design	Evidence level
Asthma						
16.	Portlock J, Holden M, Patel S. A community pharmacy asthma MUR project in Hampshire and the Isle of Wight. *Pharm J* 2009; 282: 109-112 www.pjonline.com/files/rps-pjonline/pdf/pj_20090131_hampshire.pdf	47/315 community pharmacies in the Hampshire and Isle of Wight Local Pharmaceutical Committee area July- December 2007	Targeted MUR with the aim of improving inhaler technique and increasing adherence, leading to improved outcomes Pharmacists recruited suitable patients with asthma for a MUR. Pharmacy staff received training on how to deliver a successful asthma MUR which included: • Checking inhaler technique • Assessing inspiratory flow • Calculating adherence based on number of prescriptions collected in past 12 months	965 asthma MURs undertaken • 37% (358/965) patients demonstrated primary non adherence i.e. collected <75% intended asthma prescriptions in previous 12 months • A further 31% (300/965) had secondary adherence issues, i.e. were not taking their medicines in the way they had been intended Pharmacists made 1,787 interventions (mean 1.8 per MUR consultation) of which: • 41% device checks • 10% GP or nurse referral • 49% educational Patient feedback response rate 24% (230/965). Of these, 65% (147/226) patients thought a follow-up visit to the pharmacy would benefit them. Respondents thought the advice given by the pharmacist was useful (98%) and they understood more about using their medication since using the service (91%). • Pharmacist feedback response rate 61%	Analysis of community pharmacies' asthma MUR interventions (evalution by GSK) Service evaluation via patient questionnaire and healthcare professional feedback form (evaluation by LPC) Pharmacist feedback form	2+

Ref	Study	Population/ setting	Intervention/ aim	Outcomes/results	Design	Evidence level
			The project was supported by GSK Plus	(28/47). • Almost two-thirds (64%, 18/28) agreed that participation in the MUR service had developed their professional working relationship with other healthcare professionals • All respondents thought they had an important role to play in the management of patients with asthma and all but one said they would like to participate in similar services in the future Healthcare professional feedback response 33% (15/46)- all GPs 86% (12/14) agreed community pharmacists have an important role to play in managing patients with asthma and 79% (11/14) thought that asthma MURs were of benefit to patients	(evaluation by LPC)	
17.	Price A, PCA 2009: Effectiveness of medicines use reviews in asthma *Pharm J* 2009; 283:11	Customers of 100 branches of the Co-operative Pharmacy in South Wales and the south-	Targeted MUR for patients with asthma Patients presenting with prescription for inhalers to complete asthma control test to	• 69% (2,331/3,371) of patients having an asthma control test (ACT) went on to receive a MUR • 219/2331 (9%) were followed up and of these 74% showed an increase in ACT score • 14% had a decrease in score and 12%	Service evaluation	News report Runner-up, RPS pharmaceutical care awards 2009

Ref	Study	Population/ setting	Intervention/ aim	Outcomes/results	Design	Evidence level
	www.pjonline.com/meeting/2009pca_asthma	west of England June-November 2008	assess how well the patient's asthma had been controlled over the previous four weeks Patients with low control were invited to undergo MUR with pharmacist Reassessment with asthma control test at patient's next visit to pharmacy following approval of recommendations by GP	stayed the same • Patient's reported having a better understanding of how to use their inhalers after the MUR		
18.	Bagole LE, Beaumont A, Morgan I. Outcomes of medicines use reviews for people with asthma. *Int J Pharm Pract* 2007; Suppl 2: B66	154 patients with asthma who had a MUR, May to December 2006 (Location not stated, lead author from Lloyds Pharmacy, Coventry)	To assess the impact of MUR on asthma control Patients were asked to answer asthma control test questions in relation to their asthma before and after the MUR	• Patients whose asthma was not controlled decreased from 59% to 45% ($p<0.01$) • 30% patients were referred to their GP or asthma nurse as a result of their MUR • Of those referred, 71% had a treatment or dosage change • The service was rated 'very good' by 73% patients and 'good' by 21%	Telephone interview to assess asthma control as measured using the ACT	2-

Ref	Study	Population/ setting	Intervention/ aim	Outcomes/results	Design	Evidence level
Depression						
19.	Cree N. Depressed patients can gain from directed MURs *Pharm J.* 2010; 285:581 www.pjonline.com/fileproxy/14737	Bristol, England	Directed MUR for people taking antidepressants Aim- to improve concordance and adherence The project was supported by Lundbeck	Pharmacists were provided with additional training to undertake the MUR In the first 10 weeks of offering the service, pharmacists in nine pharmacies conducted 145 MURs. Of these, 54 were for patients who were starting their first course of an antidepressant, and 91 were for those already taking antidepressant medicines Pharmacists identified 11 patients (8%) who needed referral to their GP and a further 26 (18%) were recorded as suffering from side-effects Three (2%) patients were identified as not taking their antidepressant properly Only 37% patients newly started on an antidepressant had received printed information about their medicines from their GP	New service monitoring	News report

Ref	Study	Population/ setting	Intervention/ aim	Outcomes/results	Design	Evidence level
Parkinson's disease						
20.	Colquhoun A. Asking the right questions in Parkinson's. *Pharm J* 2010; 285:626 www.pjonline.com/meeting/2010pca_parkinsons	Salford, England Patients from 8 pharmacies (14 pharmacists) within the local PCT	The project was a collaboration between community pharmacists, GPs and a specialist Parkinson's disease service Pharmacists identified patients using the PMR and offered a MUR. The MUR was conducted in the usual way but an additional five questions relating to Parkinson's disease were asked. These questions were devised by a Parkinson's disease advanced nurse specialist and were designed to assess the level of control of the disease. Depending on the patient's responses, a score was assigned.	74 patients were identified from the PMR, of which 53 received a MUR (16 domiciliary). Eighteen patients (34%) (7 of the domiciliary) were referred to the specialist hospital unit. The report states, ' the project found that patient care was improved due to early referral and consequent resolution of problems leading to better management of the condition. The effect of the service was measured by clinical outcomes, as documented by the advanced nurse specialist, and by an independent patient survey by Parkinson's UK'	Service evaluation	News report Finalist in the Pharmaceutical Care Awards 2009

Ref	Study	Population/ setting	Intervention/ aim	Outcomes/results	Design	Evidence level
			Patients above a threshold were referred to a specialist hospital unit. Domiciliary MURs were available for patients unable to attend the pharmacy The project was supported by Parkinson's UK and GlaxoSmithKline			
Hospital discharge						
21.	Colquhoun A. Home MURs help free hospital beds *Pharm J* 2010; 285:615 www.pjonline.com/meeting/2010pca_homemurs	South Staffordshire PCT, England Elderly patients recently discharged from community beds in secondary care	To reduce re-admissions within 28 days and improve measures of functional independence During discharge planning the patient's regular community pharmacy was identified. A copy of	In the first year of the project April 2009-March 2010, 69 MURs were conducted on patients discharged from a 27-bed ward. The report states, 'the clinical service to the unit as a whole has resulted in fewer admissions to A&E and fewer re-admissions of patients within 28 days as well as an 81% improvement in measures of functional independence following discharge. Further work is required to investigate the impact of the domicillary MURs specifically, for example	Service evaluation	News report Winning project of the Pharmaceutical Care Awards 2009

Ref	Study	Population/ setting	Intervention/ aim	Outcomes/results	Design	Evidence level
			the discharge form was faxed to the pharmacy, and the community pharmacist did a home MUR within seven days of discharge. Any medicines issues identified were referred to the appropriate professional (e.g. GP, formal care manager)	the community pharmacist's perspective and patient satisfaction.'		
Care homes						
22.	Booth J, White F, Howells H. NHS Dorset medicines use review evaluation report January 2009. www.lpc-online.org.uk/bkpage/files/167/MUR%20audit%20Jan%2009.pdf	51 care homes within NHS Dorset who received MURs on residents	MUR provided to residents at the care home	53% (27/51) homes responded • 93% thought the service benefitted staff and patients • 74% had greater knowledge of residents' medicines and what they had been prescribed for • 82% had greater knowledge of medicines issues and where to seek advice if necessary	Service evaluation Postal questionnaire	

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Older People's Commissioner for Wales
Comisiynydd Pobl Hŷn Cymru

Health and Social Care Committee
HSC(4)-09-11 paper 15
Additional information from the Older People's Commissioner for Wales

This paper provides additional information requested by Health and Social Care Committee Members, following the attendance of the Older People's Commissioner for Wales on 6 October 2011.

Work linked to consultation on service reconfiguration

The Commission noted an increase in enquiries relating to care home closures, particularly about the associated consultation processes and the need for these to be clearly communicated and more inclusive.

Older people and the relatives of those residing in care homes told the Commission that the procedures for closing a home should be fairer and the decision-making process must have the best interests of residents at its core.

As a result of these concerns and ongoing issues relating to the consultation on care home closures in Carmarthenshire, the Commissioner issued the following statement in December 2010:

Statement on Care Home Closure

Introduction

One of the functions of the Older People's Commissioner is to "promote awareness of the interests of older people in Wales and of the need to safeguard those interests". The Commissioner has a particular interest in the needs of older people who are in situations where they are vulnerable.

Through her contact with older people and with voluntary and statutory bodies across Wales the Commissioner has been made aware of people's anxiety and distress surrounding the issue of care home closure. This statement sets out the views formed by the Commissioner so far.

Rights Framework

The United Nations Principles for Older People aim to ensure that priority attention is given to the situation of older people. The Commissioner must have regard to these Principles when considering what constitutes the interests of older people in Wales. The Commissioner considers the following Principles to be particularly relevant to the issue of care home closure:

Principle 5:
"Older persons should be able to live in environments that are safe and adaptable to personal preferences and changing capacities."

Principle 14:
"Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, needs and privacy and for the right to make decisions about their care and the quality of their lives."

The Commissioner's View

- The Commission recognises the challenges faced across Wales when updating care services to meet growing demand both today and in the future.

- The priority in any decisions about care home provisions should be providing a safe home for older people, and offering both quality and continuity of care.

- The Commission is aware of concerns relating to the 'transfer trauma' that older people can suffer when moved from a care home. As a result the Commission is currently working with Swansea University on a research project into the effects of care home closures in Wales.

- All consultation on changes to existing care provision should be fair and unbiased and take full consideration of the rights, needs and wishes of older people.

- Consultation about the potential closure of care homes should be well planned, and provide a genuine opportunity for all stakeholders to participate.

- Decision making should be transparent, address the concerns raised during the consultation process and stand up to external scrutiny.

The Commission has called on the Welsh Local Government Association and Association of Directors of Social Services for assurances regarding consultation about the changes to services used by older people, specifically the closure or change of home setting and changes to domiciliary care providers.

The Commissioner also highlighted these concerns to the Deputy Minister for Social Services, as well as concerns linked to 'Escalating Concerns guidance and social care commissioning guidance twice during 2011.

Most recently, the Commission was made aware of issues relating to the consultation process that was used as the basis for decisions to reconfigure services at Rondel House and Gardenhurst day centres in the Vale of

Glamorgan. Following correspondence with the local authority, which re-iterated the principles in the statement above, the consultation was re-opened meaning that those using the service could contribute to the process in a meaningful way.

The guidance has also been used as a source of advice for those involved in reconfiguration of residential care services in other parts of Wales e.g. Gwynedd.

Care Home Closures Research led by Swansea University

The Commission is working with researchers at Swansea University to look into the effects of care home closures in Wales following a funding award by the National Institute for Social Care and Health Research (NISCHR).

Care home closure is often the subject of media coverage and can be an extremely emotional topic for those that are affected. The closure of care homes is highly relevant because of the impact of relocation on the health and well being of older people.

The 18-month project replicates a study conducted in England, using a variety of methods to investigate care home closure in the last year, including:

- analysis of data collected by the Care and Social Services Inspectorate Wales (CSSIW);
- telephone interviews with CCSIW inspectors and (ex)managers/owners; and
- analysis of local authorities protocols.

The project extends the research conducted in England to look at outcomes for those involved in the closure of care homes and will undertake in-depth interviews (before and after relocation) with providers, older residents, relatives and carers during the closure of four different care homes in Wales.

The project will:

- Identify issues associated with closures of care homes in Wales
- Identify areas where the process of closure departs from Welsh Government guidance
- Provide examples of good practice which could be used in further guidance
- Identify the impact of particular processes of closure on the well-being of older people, their relatives and carers

The research report will be completed in November 2011 and subject to peer-review by NISCHR before it is officially published and distributed as appropriate.