Pecyn dogfennau cyhoeddus

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:
Ystafell Bwyllgora 3 - Y Senedd

Dyddiad:
Dydd Iau, 8 Rhagfyr 2011

Amser:
09:30

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

I gael rhagor o wybodaeth, cysylltwch â:

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

Agenda

1. Cyflwyniadau, ymddiheuriadau a dirprwyon

2. Y wybodaeth ddiweddaraf am faterion polisi yr Undeb Ewropeaidd sy'n berthnasol i'r Pwyllgor Iechyd a Gofal Cymdeithasol (09.30 - 09.45) (Tudalennau 1 - 16)
HSC(4)-13-11 papur 1

Gregg Jones, y Gwasanaeth Ymchwil (drwy gyswllt fideo)

3. Ymchwiliad i ofal preswyl i bobl hyn - Cynllun gwaith y Pwyllgor (09.45 - 10.00) (Tudalennau 17 - 22)
HSC(4)-13-11 papur 2

4. Papur Gwyn ar Roi Organau - Sesiwn friffio ar y materion technegol gan swyddogion Llywodraeth Cymru (10.00 - 11.00)
(Tudalennau 23 - 44)
HSC(4)-13-11 papur 3

Chris Jones, Cyfarwyddwr Meddygol GIG Cymru a'r Dirprwy Brif Swyddog Meddygol
Grant Duncan, Dirprwy Gyfarwyddwr y Gyfarwyddiaeth Feddygol, Llywodraeth Cymru

5. Papurau i'w nodi (Tudalennau 45 - 48)

Cofnodion y cyfarfodydd a gynhaliwyd ar 16 a 24 Tachwedd
HSC(4)-11-11 cofnodion
HSC(4)-12-11 cofnodion

5a. Ymchwiliad i'r cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru – Gwybodaeth ychwanegol gan BMA Cymru (Tudalennau 49 – 50)
HSC(4)-13-11 papur 4

5b. Ymchwiliad i'r cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru – Gwybodaeth ychwanegol gan Goleg Brenhinol yr Ymarferwyr Cyffredinol (Tudalennau 51 – 55)
HSC(4)-13-11 papur 5

5c. Ymchwiliad i'r cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru – Gwybodaeth ychwanegol gan Gyngor Iechyd Cymuned Aneurin Bevan (Tudalennau 56 – 77)
HSC(4)-13-11 papur 6

5d. Ymchwiliad i'r cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru – Gwybodaeth ychwanegol gan Fferyllfeydd Cymunedol yr Alban – Newid patrymau ymgynghori â chleifion mewn gofal sylfaenol
(Tudalennau 78 – 85)
HSC(4)-13-11 papur 7

5e. Ymchwiliad i'r cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru – Gwybodaeth ychwanegol gan Fferyllfeydd Cymunedol yr Alban – Adolygu darpariaethau Gwasanaeth Iechyd Cyhoeddus ar gyfer Rhoi'r Gorau i Ysmygu a Chynllun Atal Cenhedlu Hormonaidd Brys y Fferyllfeydd Cymunedol (Tudalennau 86 – 176)
HSC(4)-13-11 papur 8

6. Cynnig o dan Reol Sefydlog 17.42(vi) i benderfynu gwahardd y cyhoedd o'r cyfarfod ar gyfer eitemau 7 ac 8 (11.00)

7. Ymchwiliad i Leihau'r Risg o Strôc – Adroddiad drafft (11.00 – 11.30)

8. Paratoi ar gyfer y sesiwn graffu ar waith y Gweinidog Iechyd a Gwasanaethau Cymdeithasol (11.30 – 11.45)

Research Service
Y Gwasanaeth Ymchwil

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Materion polisi'r UE sy'n berthnasol i'r Pwyllgor Iechyd a Gofal Cymdeithasol

Papur briffio'r pwyllgor

Dyddiad y sesiwn: **08 Rhagfyr 2011**

Cynhyrchwyd y papur briffio hwn gan y Gwasanaeth Ymchwil i aelodau'r Pwyllgor Iechyd a Gofal Cymdeithasol.

I gael rhagor o wybodaeth, cysylltwch â Gregg Jones yn Swyddfa'r UE: Ffôn. 0032 (0)2 226 6692

E-bost: Gregg.Jones@wales.gov.uk

Research Service

Contents

1. Cyflwyniad

Dan strwythurau Pwyllgor newydd y pedwerydd Cynulliad y cytunwyd arnynt gan y Pwyllgor Busnes fis Mehefin 2011, bydd materion yn ymwneud ag Ewrop a'r UE yn cael eu prif ffrydio ar draws y Pwyllgorau perthnasol yn hytrach na chreu Pwyllgor Materion Ewropeaidd ac Allanol newydd.

Golyga hyn fod gan y Pwyllgor Iechyd a Gofal Cymdeithasol gyfrifoldeb dros ymdrin â'r materion Ewropeaidd hynny sy'n dod o fewn ei bortffolio.

Mae hyn yn debygol o ddigwydd mewn dwy ffordd:

- sesiynau penodedig sy'n canolbwyntio ar y blaenoriaethau/materion sydd ar agenda bolisi'r UE ym Mrwsel;
- cyfle i edrych ar Ewrop (a'r dimensiwn rhyngwladol) er mwyn cymharu ag arferion yng Nghymru, gan nodi tystion ac arbenigwyr i ddod â dimensiwn allanol i feysydd gwaith eraill y Pwyllgor.

Mae'r papur hwn yn rhoi gwybodaeth i'r Pwyllgor (yn adran 3) ar ddatblygiadau polisi perthnasol sydd ar y gweill neu ddatblygiadau arfaethedig ar gyfer 2012 ar lefel yr UE.

Cyn manylu ar y datblygiadau hyn, rhoddir gwybodaeth gefndir yn adran 2 am broses llunio polisïau'r UE, i esbonio:

- y cymwyseddau ar lefel yr UE ym maes iechyd a gofal cymdeithasol a'r math o gamau sy'n deillio o'r UE o ganlyniad i weithredu'r cymwyseddau hyn;
- y sefydliadau a'r strwythurau perthnasol sy'n gweithredu ym Mrwsel (yn cynnwys Sefydliadau ffurfiol yr UE a rhai rhwydweithiau'r UE) a chanddynt gyfrifoldebau dros faterion sy'n ymwneud ag iechyd a gofal cymdeithasol

Camau i'r Pwyllgor eu cymryd:

Yn adran 4 amlinellir nifer o gamau posibl i'r Pwyllgor eu hystyried a chytuno arnynt o ran y gwaith atodol ar faterion yn ymwneud â'r UE.

2. Proses llunio polisïau yr UE

2.1. Iechyd a Gofal Cymdeithasol

Mae iechyd a gofal cymdeithasol yn feysydd o **gymhwysedd cenedlaethol unigryw,** sy'n golygu bod y pwerau i'r UE weithredu yn y meysydd hyn yn gyfyngedig, ac wedi'u cyfyngu'n bennaf i gamau sy'n cefnogi, sy'n cydgysylltu neu sy'n ategu gwaith yr Aelod-wladwriaethau (h.y. Llywodraethau cenedlaethol ac, fel y bo'n briodol, Llywodraethau is-wladol/rhanbarthol) yn y maes hwn.

O ganlyniad mae grym yr UE i ddylanwadu ar bolisi iechyd yng Nghymru a'i lywio yn gyfyngedig iawn. Mae hefyd yn golygu y byddai o fudd i Gymru gymryd rhan uniongyrchol mewn trafodaethau'n ymwneud â pholisi ar lefel yr UE lle y gallai'r rhain fod yn ddefnyddiol o ran helpu i gefnogi gwaith a wneir yng Nghymru neu ychwanegu gwerth ato.

Mae rôl yr UE mewn polisi iechyd yn canolbwyntio'n benodol ar y tri maes canlynol:

- amddiffyn pobl rhag bygythiadau i'w hiechyd a chlefydau
- hybu ffyrdd iach o fyw
- helpu awdurdodau cenedlaethol yn yr UE i gydweithio ar faterion iechyd.

Er mwyn rhoi ffocws strategol i hyn mabwysiadodd y Comisiwn **Strategaeth Iechyd yr UE** yn 2008, a oedd yn strategaeth pum mlynedd a fydd yn cael ei hadolygu yn ystod 2012 (ond nid oes unrhyw gyfeiriad o gwbl at yr adolygiad hwn yn Rhaglen Waith 2012 y Comisiwn Ewropeaidd, felly nid oes gennym amcan o amseriad yr adolygiad eto).

Yn ogystal, mae'r Comisiwn Ewropeaidd yn darparu cymorth ariannol er mwyn gweithredu strategaeth Iechyd yr UE, ac mae sefydliadau yng Nghymru (yn cynnwys y Gwasanaeth Iechyd Gwladol) yn gymwys i gymryd rhan yn y cynllun hwn. Mae hyn yn cynnwys cymorth gan raglen ariannu benodedig ar gyfer Iechyd yr UE, ac mae'r un bresennol yn cwmpasu'r cyfnod 2008-2013. Caiff ei holynu gan raglen newydd, sef y rhaglen *Health for Growth 2014-2020* - y cyhoeddwyd cynigion ar ei chyfer ym mis Tachwedd. Mae rhagor o fanylion am hyn yn adran 3.3 isod.

Mae iechyd hefyd yn thema mewn rhaglenni ariannu eraill yr UE: er enghraifft, mae rhywfaint o gyfle i gefnogi mentrau sy'n gysylltiedig ag iechyd o fewn rhaglenni Cronfeydd Strwythurol yr UE, camau gweithredu ar symudedd dan raglenni addysg ac ieuenctid yr UE; ac ymchwil yn gysylltiedig ag iechyd o fewn Rhaglen Ymchwil Fframwaith yr UE (yn arbennig gymorth i ariannu treialon clinigol). Ym mhob un o'r meysydd hyn mae'r Comisiwn Ewropeaidd wedi cyhoeddi cynigion newydd ar gyfer y cyfnod 2014-2020, a fydd yn destun proses drafod ym Mrwsel cyn cytuno arnynt (rhywbryd yn 2013 fwy na thebyg). Mae'r Pwyllgor Menter a Busnes yn cynnal ymchwiliad i Gronfeydd Strwythurol yr UE a bydd hefyd yn edrych ar Raglen Ymchwil yr UE yn y dyfodol (Horizon 2020), a byddai cynigion addysg a symudedd ieuenctid yr UE (Erasmus for All) yn dod yn naturiol o fewn cylch gwaith y Pwyllgor Plant a Phobl Ifanc (ac ystyriwyd hynny ganddo fel rhan o ddiweddariad yr UE yn ei gyfarfod ar 1 Rhagfyr).

Yn olaf, mae gan yr UE gymhwysedd i greu deddfwriaeth mewn nifer o feysydd eraill a gallai'r rhain effeithio ar wasanaethau iechyd a gofal cymdeithasol yng Nghymru. Mae hyn yn cynnwys, yn benodol:

- **Deddfwriaeth cyflogaeth a diogelwch cymdeithasol:** mae hyn yn cwmpasu amrywiaeth o feysydd yn cynnwys hawliau gweithwyr, iechyd a diogelwch, amodau gwaith, cydraddoldeb a chyfle cyfartal. Datblygir deddfwriaeth o'r fath yng nghyd-destun sicrhau bod marchnad sengl yr UE yn gweithredu'n ddidrafferth, er mwyn galluogi gweithwyr i symud yn ddirwystr ar draws ffiniau cenedlaethol.
- **Deddfwriaeth caffael cyhoeddus:** rhaid cynnal proses dendro agored er mwyn darparu nwyddau, gwaith a gwasanaethau uwchlaw'r trothwyon a bennir gan ddeddfwriaeth yr UE. Mae'r cyfarwyddebau'n pennu gofynion o ran y rheolau i'w dilyn i sicrhau proses deg, lle y gallai endidau o bob cwr o'r UE gymryd rhan ynddynt.

2.2. Diogelwch Bwyd

O ran diogelwch bwyd, mae gan yr UE gylch gwaith cryfach i gymryd camau.

Mae hyn yn cynnwys datblygu deddfwriaeth yr UE a chymryd mathau eraill o gamau sy'n canolbwyntio ar sicrhau systemau rheoli effeithiol a gwerthuso cydymffurfiaeth â safonau'r UE ym meysydd: diogelwch ac ansawdd bwyd, iechyd anifeiliaid, lles anifeiliaid, maeth anifeiliaid ac iechyd planhigion o fewn yr UE ac mewn trydydd gwledydd mewn perthynas â'u hallforion i'r UE.

Mae rhai o'r meysydd hyn y tu allan gylch gwaith y Pwyllgor Iechyd a Gofal Cymdeithasol a byddent yn dod o fewn cylch gwaith Pwyllgor yr Amgylchedd a Chynaliadwyedd (e.e. lles anifeiliaid, maeth anifeiliaid ac iechyd planhigion).

I gefnogi'r gwaith o baratoi a gweithredu deddfwriaeth yr UE yn y maes hwn mae nifer o bwyllgor ac asiantaethau ar lefel yr UE. Mae'n werth sôn am y rhain gan fod modd i'r cyrff hyn wneud penderfyniadau pwysig ar bolisïau'r dyfodol yn ogystal ag ar weithredu deddfwriaeth bresennol yr UE.

Y rhai sydd fwyaf perthnasol i waith y Pwyllgor Iechyd a Gofal Cymdeithasol yw:

- **Y Pwyllgor Gwyddonol ar Fwyd:** ei fandad yw ateb cwestiynau gwyddonol a thechnegol yn ymwneud ag iechyd defnyddwyr a diogelwch bwyd yn gysylltiedig â bwyta cynhyrchion bwyd. Yn benodol, mae'n ymdrin â chwestiynau'n ymwneud â thocsicoleg yn y gadwyn cynhyrchu bwyd gyfan, maeth, a cheisiadau am dechnolegau bwyd-amaeth, yn ogystal â'r rhai sy'n ymwneud â deunyddiau sy'n dod i gysylltiad â bwyd, fel deunydd pacio. Fel gyda phob un o'r Pwyllgorau Gwyddonol rheolir ei waith gan y Comisiwn Ewropeaidd ond mae ei aelodaeth yn cynnwys arbenigwyr annibynnol.
- **Awdurdod Diogelwch Bwyd Ewrop (EFSA):** fe'i sefydlwyd yn 2002 ac mae'n darparu cyngor a gohebiaeth wyddonol annibynnol ar y risgiau presennol a risgiau newydd sy'n gysylltiedig â'r gadwn fwyd, sydd wedi'u hanelu at ddiogelu iechyd defnyddwyr Ewropeaidd a sicrhau diogelwch y gadwn fwyd a bwyd anifeiliaid. Mae gwaith EFSA yn cwmpasu pob mater sy'n cael effaith uniongyrchol neu anuniongyrchol ar ddiogelwch bwyd a bwyd anifeiliaid, yn cynnwys iechyd a lles anifeiliaid, diogelu planhigion ac iechyd a maeth planhigion (yn cynnwys cnydau a addaswyd yn enetig).
- **Canolfan Atal a Rheoli Clefydau Ewrop:** fe'i sefydlwyd yn 2005 ac mae'n gweithredu o Stockholm. Ei nod yw nodi, asesu a chyfleu bygythiadau presennol a bygythiadau newydd i iechyd dynol yn sgil clefydau heintus.
- **Y Pwyllgor Sefydlog ar y gadwyn fwyd ac iechyd anifeiliad (SCFCAH):** Pwyllgorau rheoleiddio yw Pwyllgorau Sefydlog sy'n cael eu sefydlu i sicrhau bod deddfwriaeth yr UE yn cael ei gweithredu'n ymarferol ac yn effeithiol. Maent yn bwyllgorau 'technegol' sy'n cynnwys y Comisiwn Ewropeaidd yn ogystal ag arbenigwyr o Aelod-wladwriaeth, ac yn achos SCFCAH mae'n cynnwys swyddogion DEFRA ynghyd â swyddogion perthnasol o Gynrychiolaeth Barhaol y DU ym Mrwsel.

2.3. Proses llunio polisïau a phroses ddeddfwriaethol yr UE

O ran y meysydd y cyfeirir atynt yn adrannau 2.1 a 2.2 lle y mae'r UE yn gallu creu deddfwriaeth, mae proses drafod ffurfiol er mwyn mabwysiadu cyfreithiau o'r fath. Gall Cynulliad Cenedlaethol Cymru ddylanwadu ar y broses hon, yn ystod y cam cyn y broses ddeddfu (h.y. llunio polisi - sy'n cael ei arwain yn bennaf gan y Comisiwn Ewropeaidd) ac yn ystod y broses ddeddfu ei hun.

Lle mae gan yr UE bwerau i ddatblygu cynigion deddfwriaethol (yn cynnwys y meysydd a gwmpesir yn adrannau 2.1 a 2.2 - fel diogelwch bwyd, cyfraith cyflogaeth, hawliau cleifion, a rhaglenni ariannu'r DU), caiff cynigion o'r fath eu paratoi drwy'r weithdrefn ddeddfwriaethol arferol, sy'n ei gwneud yn ofynnol i Senedd Ewrop a Chyngor y Gweinidogion (h.y. Llywodraethau Aelod-wladwriaethau) gytuno ar destun terfynol y gyfraith arfaethedig (ar sail cynnig deddfwriaethol gan y Comisiwn Ewropeaidd) cyn y gellir ei mabwysiadu'n ffurfiol. Gall y broses hon gymryd rhwng blwyddyn a nifer o flynyddoedd, ac mewn rhai achosion efallai na fydd modd dod i gytundeb (e.e. methodd yr ymdrechion diweddar i adolygu'r Gyfarwyddeb Oriau Gwaith yn 2009).

Ar ôl i'r ddeddfwriaeth gael ei mabwysiadu mae'n ofynnol i bob Aelod-wladwriaeth **weithredu deddfwriaeth yr UE ar lawr gwlad,** a bydd y ddeddfwriaeth yn cynnwys darpariaethau ar y terfynau amser ar gyfer trosi'r ddeddfwriaeth (h.y. creu deddfwriaeth ddomestig newydd fel y bo'n berthnasol) ar lefel genedlaethol/rhyngwladol. Yng Nghymru, Llywodraeth Cymru fydd yn gyfrifol am sicrhau bod deddfwriaeth berthnasol yr UE sy'n dod o fewn cymwyseddau datganoledig yn cael ei gweithredu a'i throsi. Os bydd yn methu â gwneud hyn bydd y Comisiwn Ewropeaidd yn codi dirwyon arni.

Ar gyfer y meysydd hynny lle nad oes gan yr UE gymhwysedd deddfwriaethol, mae polisi'n cael ei lunio mewn nifer o ffyrdd. Mae hyn yn cynnwys gohebiaeth gan y Comisiwn Ewropeaidd wedi'i hanelu at annog llywodraethau cenedlaethol i fabwysiadu ymagweddau tebyg mewn meysydd penodol, e.e. hyrwyddo'r defnydd o e-iechyd, a chamau atodol eraill sy'n cynnwys rhanddeiliaid fel *Partneriaeth Arloesedd Ewropeaidd ar Heneiddio'n Iach ac Egnïol* (gweler adran 3.5). Mae hefyd yn cynnwys cydweithredu rhwng llywodraethau drwy'r *Dull Cydgysylltu Agored* (gweler adran 2.5). Ym mhob un o'r meysydd hyn nid oes gofyniad sy'n rhwymo Aelod-wladwriaethau i gymryd camau, a'r unig bŵer ar lefel yr UE yw pwysau gan gymheiriaid drwy enwi a chodi cywilydd ar Aelod-wladwriaethau nad ydynt yn cyflawni camau y cytunwyd arnynt.

2.4. Y Comisiwn Ewropeaidd

Y Comisiwn Ewropeaidd sydd â'r brif rôl o ddatblygu mentrau'n ymwneud â pholisi a deddfwriaeth ym meysydd iechyd, gofal cymdeithasol a diogelwch bwyd.

Y Comisiynydd Ewropeaidd sy'n gyfrifol am Iechyd a Materion Defnyddwyr yw John Dalli.

Y brif gyfarwyddiaeth gyffredinol yn y Comisiwn Ewropeaidd ar gyfer materion yn gysylltiedig ag iechyd, yn cynnwys diogelwch bwyd, yw Cyfarwyddiaeth Gyffredinol Iechyd a Materion Defnyddwyr (sy'n aml yn cael ei gwtogi i DG SANCO, o'r teitl Ffrangeg).

Ar gyfer materion sy'n dod o fewn meysydd polisi ehangach (fel ymchwil, cyflogaeth) byddai'r rhain yn cael eu cwmpasu gan yr adran thematig berthnasol, e.e. Cyfarwyddiaeth Gyffredinol Cyflogaeth a Materion Cymdeithasol.

2.5. Cyngor y Gweinidogion

Mae strwythur aelodaeth yr Undeb Ewropeaidd yn seiliedig ar Lywodraethau cenedlaethol neu Aelod-wladwriaethau sy'n golygu bod Cymru'n cael ei chynrychioli yn strwythurau Llywodraeth ffurfiol yr UE (Cyngor y Gweinidogion a Chyngor Ewrop) drwy Lywodraeth y DU.

Mae materion iechyd a diogelwch bwyd yn gyfrifoldeb i ddau Gyngor o fewn Cyngor y Gweinidogion:

- Y Cyngor Cyflogaeth, Polisi Cymdeithasol, Iechyd a Materion Defnyddwyr
- Y Cyngor Amaethyddiaeth a Physgodfeydd

Bydd y ddau Gyngor hyn yn rhan o drafodaethau ar unrhyw gynigion deddfwriaethol perthnasol sy'n dod o fewn eu cylch gwaith. Byddant hefyd yn cymryd rhan yn y gwaith o lunio polisi, mabwysiadu *Casgliadau'r Cyngor,* yn cynnwys mabwysiadu *Argymhellion* (h.y. cyfraith feddal yr UE - nad yw'n rhwymedig) ar faterion neu bynciau penodol. Ar gyfer materion yn ymwneud â gofal iechyd mae hyn wedi'i strwythuro'n bennaf drwy ddefnyddio'r *Dull Cydgysylltu Agored* (dull rhynglywodraethol), lle mae Aelod-wladwriaethau (gyda chymorth y Comisiwn Ewropeaidd) yn rhannu arferion gorau a phrosesau meincnodi, sy'n canolbwyntio ar wella mynediad, ansawdd a chynaliadwyedd gwasanaethau gofal iechyd cenedlaethol.

Caiff Cymru ei chynrychioli ar Gyngor y Gweinidogion gan Lywodraeth y DU, fodd bynnag daethpwyd i gytundeb gyda'r gweinyddiaethau datganoledig y gall gweinidogion datganoledig fynychu cyfarfodydd y Cyngor (gan weithredu fel cynrychiolwyr y DU) ar faterion sydd o ddiddordeb penodol i'r weinyddiaeth ddatganoledig (e.e. mae Gweinidogion Cymru wedi mynychu cyfarfodydd y Cyngor Addysg a Diwylliant).

Mae Llywodraeth y DU hefyd wedi cytuno ar **Femorandwm Dealltwriaeth** gyda gweinyddiaethau datganoledig – llofnodwyd y fersiwn diweddaraf fis Mehefin 2011 – sy'n cynnwys yr ymagwedd tuag at faterion Ewropeaidd. O ran cyd-destun/materion polisi mae Llywodraeth y DU a Gweinidogion o'r gweinyddiaethau datganoledig yn cyfarfod drwy Gyd-bwyllgor Gweinidogion (Ewrop). Yn ogystal mae Llywodraeth y DU yn ymgynghori â'r gweinyddiaethau datganoledig wrth baratoi memoranda esboniadol ar gynigion a dogfennau polisi yr UE, ym mhob maes cymhwysedd datganoledig a lle ceir diddordeb datganoledig yn y coflenni perthnasol.

2.6. Senedd Ewrop

Mae Cymru'n cael ei chynrychioli yn Senedd Ewrop gan bedwar ASE: John Bufton (Plaid Annibyniaeth y DU); Jill Evans (Plaid Cymru); Dr Kay Swinburne (Ceidwadwyr); a Derek Vaughan (Llafur).

Y prif Bwyllgor ar gyfer materion yn ymwneud â pholisi iechyd a diogelwch bwyd yw:

- **Pwyllgor yr Amgylchedd, Iechyd Cyhoeddus a Bwyd**, dan gadeiryddiaeth yr ASE o'r Almaen Jo Leinen (Grŵp y Sosialwyr a'r Democratiaid - yr un grŵp gwleidyddol ag ASE Cymru Derek Vaughan). Mae'r ASE o Gymru Jill Evans yn aelod o'r Pwyllgor hwn.

Pwyllgorau perthnasol eraill fyddai:

- **Y Pwyllgor Cyflogaeth a Materion Cymdeithasol:** Dan gadeiryddiaeth yr ASE o Ffrainc Pervenche Beres (nid oes unrhyw ASE o Gymru ar y Pwyllgor hwn), mae'n gyfrifol am bob polisi cyflogaeth a phob agwedd ar bolisi cymdeithasol fel amodau gwaith, nawdd cymdeithasol a diogelwch cymdeithasol. Hwn fyddai'r pwyllgor a fyddai'n arwain y diwygiadau i'r Gyfarwyddeb Oriau Gwaith (gweler isod)
- **Pwyllgor y Farchnad Fewnol a Diogelu Defnyddwyr :** Dan gadeiryddiaeth ASE Ceidwadol yr UE Malcolm Harbour (nid oes ASE o Gymru ar y Pwyllgor hwn), hwn fydd y Pwyllgor a fyddai'n arwain ar ddiwygio Cyfarwyddebau Caffael Cyhoeddus (gweler isod) a hwn hefyd yw'r pwyllgor sy'n arwain ar faterion yn ymwneud â chymorth gwladwriaethol.

2.7. Pwyllgor y Rhanbarthau

Mae gan Gymru gynrychiolwyr ar y ddau gorff ymgynghorol (sydd wedi'u lleoli ym Mrwsel), sef *Pwyllgor y Rhanbarthau* (yn cynnwys Christine Chapman AC a Rhodri Glyn Thomas AC) a'r *Pwyllgor Economaidd a Materion Cymdeithasol*. Ymgynghorir â'r ddau gorff hyn ar bob datblygiad polisi'r UE, ond nid oes pŵer ganddynt i orfodi newidiadau i ddeddfwriaeth ddrafft yr UE.

2.8. Rhwydweithiau'r UE

O fewn y meysydd polisi hyn mae nifer o rwydweithiau'r UE sy'n ymwneud yn helaeth â materion iechyd a gofal cymdeithasol.

Ymysg yr enghreifftiau mae'r canlynol (rhestr enghreifftiol yn unig yw hon):

- **Swyddfa Ewropeaidd y Gwasanaeth Iechyd Gwladol:** swyddfa Conffederasiwn y GIG ym Mrwsel.
- **Swyddfa Cymdeithas Feddygol Prydain ym Mrwsel**
- **Cynghrair Iechyd Cyhoeddus Ewrop:** rhwydwaith di-elw o sefydliadau gwirfoddol sy'n gweithio ym maes iechyd cyhoeddus.
- **EuroHealthNet:** rhwydwaith di-elw o 35 o sefydliadau, asiantaethau a chyrff statudol (yn cynnwys Iechyd Cyhoeddus Cymru) o 27 o wledydd Ewrop, sydd oll yn gweithio i hybu iechyd a thegwch drwy fynd i'r afael â'r ffactorau sy'n dylanwadu'n uniongyrchol neu'n anuniongyrchol ar iechyd. Ei lywydd presennol yw David Pattison, Pennaeth Datblygu Rhyngwladol NHS Health Scotland.
- **AGE Platform Europe**: rhwydwaith Ewropeaidd o tua 165 o sefydliadau pobl 50+ ar gyfer pobl 50+ sy'n cynrychioli dros 30 miliwn o bobl hŷn yn Ewrop. Mae Comsiynydd Pobl Hŷn Cymru yn aelod o'r rhwydwaith.

3. Meysydd blaenoriaeth posibl o ddiddordeb i Gymru

3.1. Strategaeth 'Ewrop 2020'

Mae ***Ewrop 2020***, strategaeth swyddi a thwf yr UE sy'n canolbwyntio ar sicrhau 'twf clyfar, cynaliadwy a chynhwysol' a fabwysiadwyd yn 2010, yn rhoi fframwaith cyffredinol ar gyfer cysoni pob datblygiad polisi arall yr UE (fel y bo'n berthnasol).

Yn strategaeth *Ewrop 2020* mae pum prif darged i'r UE eu cyflawni dros y degawd nesaf (sy'n cwmpasu cyflogaeth, newid yn yr hinsawdd, ymchwil a datblygu, tlodi ac addysg). Nid yw iechyd yn un o'r rhain. Fodd bynnag, caiff ei ystyried gan y Comisiwn Ewropeaidd fel un o'r themâu sy'n gallu cyfrannu at gyflawni'r targedau cyffredinol (e.e. drwy heneiddio'n egnïol, cefnogi arloesedd yn yr economi, gweithlu iach ac ati) fel sy'n gwbl amlwg o deitl y rhaglen ariannu iechyd newydd arfaethedig, *Health for Growth 2014-2020*.

Gweithredir Ewrop 2020 drwy gyfuniad o gamau ar lefel yr UE a chamau ar lefel Aelod-wladwriaethau (cenedlaethol, rhanbarthol a lleol).

Yn ogystal â chymorth ariannol drwy amrywiol raglenni ariannu'r UE, mae camau ar lefel yr UE hefyd yn cynnwys cyfres o fentrau blaenllaw ar themâu penodol i ddarparu fframwaith cydlynus ar gyfer camau ar lawr gwlad gan Aelod-wladwriaethau. Y rhai sydd fwyaf perthnasol i faterion yn gysylltiedig ag iechyd yw:

- Yr Agenda Ddigidol (yn cynnwys camau ar e-Iechyd- gweler adran 3.4).
- Undeb Arloesedd (yn cynnwys camau ar heneiddio'n egnïol - gweler adran 3.5).
- Y Llwyfan Ewropeaidd yn Erbyn Tlodi ac Allgáu Cymdeithas (yn cynnwys camau wedi eu hanelu at fynd i'r afael ag anghydraddoldebau iechyd a thlodi/allgau cymdeithasol).
- Agenda ar gyfer Sgiliau Newydd ar gyfer Swyddi (sy'n nodi prinder o 15 y cant yn y gweithlu gofal iechyd a fydd eu hangen yn yr UE erbyn 2020, h.y. prinder o oddeutu dwy filiwn o swyddi, a byddai hanner y rheini'n weithwyr iechyd proffesiynol).

Ar lefel genedlaethol (lefel y DU) mae'n ofynnol i Aelod-wladwriaethau baratoi Rhaglenni Diwygio Cenedlaethol bob blwyddyn yn amlinellu'r camau arfaethedig a'r gwaith sydd ar y gweill i gyflawni targedau *Ewrop 2020*. Caiff **Rhaglen Ddiwygio Genedlaethol y DU** ei pharatoi gan Lywodraeth y DU drwy ymgynghori â gweinyddiaethau datganoledig (yn cynnwys Llywodraeth Cymru). Sonnir am iechyd mewn un cyd-destun yn y rhannau o'r Rhaglen Ddiwygio Genedlaethol sy'n ymwneud â Chymru, mewn perthynas â thlodi plant a mynd i'r afael ag anghydraddoldebau. Yng nghyd-destun Lloegr ceir cyfeiriad ato mewn perthynas ag ymchwil a mynd i'r afael â heriau gofal iechyd drwy efelychu gweithgaredd busnes ac arloesedd yn y sector iechyd.

3.2. Strategaeth Iechyd yr UE 2008-2013

Fel y nodir yn adran 2.1 mae gan yr UE fandad i ategu camau cenedlaethol ar iechyd a gwneir hyn drwy Strategaeth Iechyd yr UE. Bydd y strategaeth hon yn cael ei hadolygu cyn diwedd 2013, fodd bynnag, nid oes manylion ar gael hyd yma am amseriad yr adolygiad hwn.

3.3. Rhaglen 'Health for Growth 2014-2020' yr UE

Ar 9 Tachwedd 2011 cyhoeddodd y Comisiwn gynigion ar gyfer rhaglen ***'Health for Growth 2014-2020' yr UE*** , gyda chyllideb o €446 miliwn. Byddai hyn yn disodli'r Rhaglen Camau Cymunedol bresennol ym Maes Iechyd, sy'n cwmpasu'r cyfnod 2008-2013.

Caiff y cynigion hyn eu mabwysiadu drwy'r weithdrefn ddeddfwriaethol arferol, sydd (fel y disgrifir yn adran 2.1 uchod) yn golygu bod yn rhaid i Gyngor a Senedd Ewrop gytuno ar y testun terfynol er mwyn i'r rhaglen gael ei mabwysiadu.

Mae'r Comisiwn Ewropeaidd yn bwriadu i'r rhaglen *'Health for Growth 2014-2020'* newydd gefnogi ac ategu gwaith yr Aelod-wladwriaethau i gyflawni pedair amcan:

- **Datblygu systemau iechyd arloesol a chynaliadwy:** camau i hwyluso arloesedd mewn gofal iechyd drwy e-Iechyd, arbenigedd ar ddiwygio gofal iechyd a chymorth i Bartneriaeth Arloesedd Ewrop ar Heneiddio'n Egnïol ac Iach. Bydd camau dan y rhaglen hon hefyd yn cyfrannu at rag-weld y galw am weithwyr iechyd proffesiynol ac yn helpu Aelod-wladwriaethau i sicrhau gweithlu gofal iechyd cadarn.
- **Cynyddu mynediad i ofal iechyd gwell a mwy diogel i ddinasyddion:** bydd y camau yn anelu at gynyddu mynediad i arbenigedd a gwybodaeth feddygol am gyflyrau penodol; yn datblygu atebion a chanllawiau i wella ansawdd gofal iechyd a diogelwch cleifion drwy gamau i gefnogi hawliau cleifion ym maes gofal iechyd trawsffiniol, clefydau prin, defnydd darbodus o wrthfiotigau a safonau uchel o ran ansawdd a diogelwch organau a sylweddau sy'n dod o fodau dynol a ddefnyddir mewn meddygaeth.
- **Hybu iechyd ac atal clefydau:** hybu iechyd da ac atal clefydau drwy fynd i'r afael â'r prif ffactorau risg ar gyfer y rhan fwyaf o glefydau, sef ysmygu, camddefnyddio alcohol a gordewdra. Bydd hyn yn cynnwys meithrin dulliau o nodi a lledaenu arferion gorau ar gyfer mesurau atal cost-effeithiol; yn ogystal â chamau penodol wedi'u hanelu at atal clefydau cronig yn cynnwys canser.
- **Amddiffyn dinasyddion rhag bygythiadau iechyd trawsffiniol:** camau a fydd yn cyfrannu tuag at ddatblygu dulliau cyffredin o gydgysylltu paratoadau'n well mewn argyfyngau iechyd, e.e. gwella'r gallu i asesu risg a phrynu gwrthfesurau meddygol ar y cyd.

Byddai tri math o gamau'n cael eu hariannu drwy'r rhaglen er mwyn cyflawni'r amcanion hyn:

- **Camau ar y cyd:** grantiau ar gyfer camau gweithredu wedi'u cydariannu gan yr awdurdodau cymwys sy'n gyfrifol am iechyd cyhoeddus yn yr Aelod-wladwriaethau a chyda sefydliadau iechyd rhyngwladol.
- **Grantiau i gefnogi Sefydliadau Anllywodraethol sy'n gweithio ym maes iechyd cyhoeddus** sy'n chwarae rhan effeithiol mewn deialog sifil ar lefel yr UE ac sy'n cyfrannu at o leiaf un o amcanion penodol y rhaglen.
- **Contractau caffael**

Yn y rhan fwyaf o achosion, byddai grantiau'r UE yn cyfrannu hyd at **60 y cant** o gostau'r camau neu'r prosiect. Gallai GIG Cymru a chyrff eraill sy'n ymwneud â gofal iechyd yng Nghymru gymryd rhan yn y rhaglen hon.

3.4. Cynllun Gweithredu e-Iechyd

Disgwylir i'r Comisiwn Ewropeaidd gyhoeddi cynllun gweithredu e-Iechyd 2012 - *2020* ar ddechrau 2012.

Mae hwn yn olynu cynllun gweithredu e-Iechyd 2004, sef y fenter gyntaf ar lefel yr UE wedi ei hanelu at annog gwledydd i fabwysiadu technolegau e-Iechyd ar draws yr UE.

Un prosiect a amlygwyd gan y Comisiwn Ewropeaidd yw **RENEWING HEALTH, REgioNs of Europe WorkINg toGether for HEALTH**, sy'n brosiect e-Iechyd a gefnogir dan *Raglen Cymorth Polisi TGCh* yr UE. Daw ag ystod o ddarparwyr gofal ynghyd o naw o wledydd Ewrop a ddisgrifir fel y 'rhanbarthau Ewropeaidd mwyaf datblygedig o ran gweithredu gwasanaethau TGCh sy'n gysylltiedig ag iechyd'. Yn y rhanbarthau hyn darperir gwasanaethau ar lefel leol ar gyfer tele-fonitro a thrin cleifion cronig sy'n dioddef o ddiabetes, clefyd rhwystrol cronig yr ysgyfaint neu glefydau cardiofasgwlaidd. Nod y gwasanaethau hyn yw galluogi cleifion i chwarae rhan ganolog yn y broses o reoli eu clefydau eu hunain, mireinio'r dewis o ddosau a meddyginiaethau, a hyrwyddo cydymffurfiaeth â thriniaeth, a helpu gweithwyr gofal iechyd proffesiynol i ganfod arwyddion cynnar o ddirywiad yn y patholegau a gaiff eu monitro.

3.5. Heneiddio'n Egnïol ac Iach

Mae'r Comisiwn Ewropeaidd wedi nodi bod heneiddio'n egnïol ac iach yn her fawr i gymdeithas sy'n gyffredin i bob un o wledydd Ewrop, ac mae'n edrych arno fel maes lle mae gan Ewrop y potensial i arwain y byd o ran datblygu ymatebion arloesol.

ER mwyn cefnogi'r gwaith o gyrraedd y nod hon mae wedi lansio, fel un o'r camau yn y fenter flaenllaw Undeb Arloesedd (Strategaeth Ewrop 2020), rhaglen beilot, sef ***Partneriaeth Arloesedd Ewropeaidd ar Heneiddio'n Egnïol ac Iach***. Rhoddodd Aelod-wladwriaethau'r UE eu cefnogaeth i'r fenter hon fis Chwefror 2011, ac ym mis Tachwedd 2011 cyhoeddodd y Grŵp Llywio Lefel Uchel (a sefydlwyd i ddatblygu'r peilot) ***Cynllun Gweithredu Strategol***, sy'n amlinellu gweledigaeth gyffredin a chyfres o gamau gweithredol y rhoddir blaenoriaeth iddynt er mwyn mynd i'r afael â'r her heneiddio drwy arloesedd. Fe'i disgrifir fel cynllun wedi'i lywio gan randdeiliaid ac mae'r Comisiwn Ewropeaidd yn gwahodd Llywodraethau cenedlaethol a rhanddeiliaid eraill i ddod yn rhan o ddarparu camau a gaiff eu lansio yn 2012, sy'n cynnwys:

- Ffyrdd arloesol o sicrhau bod cleifion yn dilyn y cyfarwyddiadau ar eu presgripsiynau – ymgyrch benodol mewn o leiaf 30 o ranbarthau Ewrop.
- Atebion arloesol i atal cwympiadau a chefnogi diagnosis cynnar i bobl hŷn.
- Cydweithredu i helpu i atal dirywiad mewn sgiliau gweithredol ac eiddilwch, gan ganolbwyntio'n benodol ar ddiffyg maeth.

- Lledaenu a hyrwyddo modelau gofal integredig arloesol a llwyddiannus ar gyfer clefydau cronig ymysg cleifion hŷn, er enghraifft drwy weithgaredd monitro o bell. Dylid cymryd camau yn nifer o ranbarthau'r UE.
- Cynyddu'r nifer sy'n manteisio ar atebion byw'n annibynnol yn seiliedig ar TGCh rhyngweithredol drwy safonau byd-eang i helpu pobl hŷn i aros yn annibynnol, yn symudol ac yn weithgar am gyfnod hwy.

Yn gysylltiedig â hyn, thema Blwyddyn Ewropeaidd 2012 fydd ***Heneiddio'n Egnïol a Phontio'r Cenedlaethau***, a fydd yn cynnwys nifer o weithgaredd codi ymwybyddiaeth ledled yr UE. Ceir manylion mentrau arfaethedig ar wefan *Blwyddyn Ewropeaidd 2012*, ac ar hyn o bryd nid oes unrhyw weithgaredd wedi'i restru ar gyfer Cymru.

3.6. Moderneiddio'r Cymwysterau Proffesiynol

Mae'r Comisiwn Ewropeaidd yn cynnal adolygiad o *Gyfarwyddeb yr UE ar Gydnabod Cymwysterau Proffesiynol.* Nod y Gyfarwyddeb hon yw hwyluso gallu dinasyddion y DU i symud yn ddirwystr drwy ei gwneud yn haws i weithwyr proffesiynol sydd wedi cymhwyso mewn un Aelod-wladwriaeth ymarfer eu proffesiwn mewn Aelod-wladwriaeth arall, fel rhan o'r ymdrechion i gryfhau marchnad sengl yr UE. Mae'r Gyfarwyddeb yn cwmpasu pob proffesiwn, yn cynnwys proffesiynau gofal iechyd.

Fis Ionawr 2011 lansiodd y Comisiwn Ewropeaidd ymgynghoriad cyhoeddus ac ym mis Mehefin 2011 cyhoeddodd Bapur Gwyrdd, a oedd hefyd yn destun ymgynghoriad gyda rhanddeiliaid. Roedd y prif gynigion yn y Papur Gwyrdd yn cynnwys cerdyn proffesiynol, mynediad rhannol, adolygu cwmpas y proffesiynau sy'n cael eu rheoleiddio a sicrhau bod gwybodaeth a gweithdrefnau gwneud cais ar gael ar lein.

Mynegwyd pryderon ynghylch y Gyfarwyddeb bresennol, yn arbennig mewn perthynas â chymhwysedd rhai gweithwyr iechyd proffesiynol Ewropeaidd - eu cymhwysedd clinigol yn ogystal â'u sgiliau cyfathrebu (Saesneg), a amlygwyd gan Bwyllgor Dethol Tŷ'r Cyffredin fis Ebrill 2010.

Mae adolygu'r Gyfarwyddeb hon ar frig rhestr blaenoriaethau **Swyddfa EU y GIG ym Mrwsel**, a gyflwynodd ymatebion i'r ymgynghoriad a'r Papur Gwyrdd ar ran y GIG. Amlygodd hyn yr angen i ddiweddaru'r safonau goyfnnol ar gyfer cymwysterau er mwyn i weithwyr proffesiynol allu ymarfer ledled Ewrop, a'r angen i gyrff rheoleiddio ledled Ewrop gael mynediad i system electronig gyffredin er mwyn rhannu gwybodaeth am weithwyr proffesiynol a'u cymwysterau. Galwodd am gyflwyno system rybuddio fwy trylwyr sy'n ei gwneud yn ofynnol i gyrff rheoleiddio ledled Ewrop rybuddio eu cyrff cyfatebol os byddant yn dwyn achos yn erbyn meddygon neu weithwyr iechyd proffesiynol twyllodrus neu anghymwys; galwodd ar bob un o wledydd yr UE i sicrhau eu bod yn ei gwneud yn ofynnol i bob gweithiwr iechyd proffesiynol ddiweddaru eu sgiliau, yn hytrach na chael eu rhoi ar gofrestr broffesiynol am oes; a galwodd am osgoi llacio gwiriadau ar gyfer gweithwyr proffesiynol sy'n mudo, er enghraifft drwy ganiatáu'r rhai sy'n gymwys mewn un maes arbenigol i ymarfer mewn meysydd meddygaeth cyffredinol.

3.7. Adolygu'r Gyfarwyddeb Oriau Gwaith

Mae *Cyfarwyddeb Oriau Gwaith* 2003 yn darparu'r fframwaith ar gyfer cyfraith yr UE ar uchafswm yr oriau y gellir disgwyl i gyflogeion eu gweithio mewn wythnos (48 awr). Mae'n cynnwys diffiniadau o oriau gwaith ac mae hefyd yn cynnig y posibilrwydd i gyflogeion 'eithrio' o'r uchafswm o 48 awr.

Ceisiodd y Comisiwn Ewropeaidd adolygu'r Gyfarwyddeb yng ngoleuni cyfraith achos Ewropeaidd, ond methodd yr ymdrechion hyn yn 2009 gan nad oedd modd i Senedd a Chyngor Ewrop ddod i gytundeb ar y diwygiadau arfaethedig. Roedd Llywodraeth y DU yn un o'r lleiafrif o Aelod-wladwriaethau a rwystrodd y gwledydd rhag dod i gytundeb.

Mynegodd ***NHS Employers*** ei bryder ynghylch effaith bosibl unrhyw newid yn y *Gyfarwyddeb Oriau Gwaith* ar weithwyr iechyd, yn arbennig y costau posibl yn sgil cynnwys amser ar alwad nas gweithiwyd fel rhan o'r wythnos waith.

Yn wreiddiol disgwyliwyd i'r Comisiwn gyflwyno cynigion yn ystod 2011 gan ei fod eisoes wedi cynnal dau ymgynghoriad yn ystod 2010 i baratoi ar gyfer yr adolygiad. Fodd bynnag, bu oedi gyda'r rhain ac nid yw'n glir eto pa bryd y cânt eu cyhoeddi, ac nid oedd sôn am amserlen arfaethedig yn Rhaglen Waith y Comisiwn Ewropeaidd ar gyfer 2012.

3.8. Gweithredu'r Gyfarwyddeb ar Hawliau Cleifion i Gael Gofal Iechyd Trawsffiniol

Ym mis Mawrth 2011 mabwysiadwyd Cyfarwyddeb newydd yr UE ar hawliau cleifion mewn gofal iechyd trawsffiniol, ar ôl bron dair blynedd o drafodaethau ym Mrwsel. Cynhaliwyd ymchwiliad byr i'r Gyfarwyddeb ddrafft gan **y Pwyllgor Materion Ewropeaidd ac Allanol** yn ystod y trydydd Cynulliad. Y dyddiad cau ar gyfer trosi'r Gyfarwyddeb yn gyfraith genedlaethol yn y DU (ac ar draws yr UE cyfan) yw 25 Hydref 2013.

Mabwysiadwyd y Gyfarwyddeb hon ar 31 Mawrth 2011 ar ôl bron i dair blynedd o drafodaethau ym Mrwsel. Mae'r Gyfarwyddeb yn gwneud y canlynol:

> …provides rules for facilitating the access to safe and high-quality cross-border healthcare and promotes cooperation on healthcare between Member States, in full respect of national competencies in organising and delivering healthcare… (Erthygl 1.1)

Mae'n:

- amlinellu cyfrifoldebau'r Aelod-wladwriaethau o ran darparu gofal iechyd trawsffiniol (o safbwynt yr Aelod-wladwriaeth lle y darperir y driniaeth a'r Aelod-wladwriaeth y mae'r claf sy'n cael ei drin yn hanu ohoni);
- amlinellu'r egwyddorion ar gyfer ad-dalu costau triniaeth trawsffiniol;
- mynd i'r afael â nifer o faterion ymarferol ynghylch awdurdodi a gweinyddu gwasanaethau gofal iechyd trawsffiniol;
- edrych yn ehangach ar ffyrdd o hwyluso cydweithredu mewn gofal iechyd fel e-iechyd, sefydlu rhwydweithiau cyfeirio Ewropeaidd (e.e. ym maes clefydau prin) a chydweithredu ar asesiadau technoleg.

Mae'r Gyfarwyddeb yn cynnwys dyddiad trosi o 25 Hydref 2013 ar gyfer yr Aelod-wladwriaethau (yn cynnwys y DU) er mwyn

> … bring into force the laws, regulations and administrative provisions necessary to comply with this Directive… (Erthygl 21.1)

Bydd y Comisiwn Ewropeaidd yn paratoi adroddiad cyntaf ar gydymffurfiaeth â'r Gyfarwyddeb erbyn yr un dyddiad (25 Hydref 2013) a phob tair blynedd wedi'r dyddiad hwnnw.

Cynhaliodd y Pwyllgor Materion Ewropeaidd ac Allanol ymchwiliad yn ystod y trydydd Cynulliad, i asesu effeithiau posibl y Gyfarwyddeb (a oedd yn Gyfarwyddeb ddrafft bryd hynny) ar Gymru.

3.9. Anghydraddoldebau iechyd

Cyhoeddodd y Comisiwn Ewropeaidd ohebiaeth yn 2009 yn dwyn y teitl *Solidarity in Health: Reducing Health Inequalities* yn yr UE sy'n amlinellu'r camau y mae'n bwriadu eu cymryd i helpu i fynd i'r afael ag anghydraddoldebau iechyd. Mae hyn yn seiliedig ar gydweithio gydag awdurdodau cenedlaethol a rhanbarthol, cynhyrchu adroddiadau ac ystadegau rheolaidd ar lefel yr UE, asesu effaith polisi yr UE ar anghydraddoldebau iechyd ac ati.

3.10. Plant ac iechyd

Ar 2 Rhagfyr mabwysiadodd Gweinidogion yr UE *Gasgliadau'r Cyngor* ar ddwy broblem iechyd sy'n effeithio ar blant:

- **Clefydau anadlol cronig ymysg plant:** a oedd yn galw am gamau parhaus a chryfach er mwyn atal y clefydau hyn, gwneud diagnosis cynnar ohonynt a'u trin yn gynnar, yn arbennig drwy hyrwyddo arferion gorau, darparu cymorth ar gyfer ymchwil, atal ysmygu, gwella ansawdd yr aer a chydweithrediad cryfach.
- **Anhwylderau cyfathrebu (namau ar y clyw, y golwg a'r lleferydd) ymysg plant:** a oedd yn pwysleisio'r angen i ganfod y namau hyn yn gynnar a'u trin yn gynnar gan bwysleisio pwysigrwydd codi ymwybyddiaeth y cyhoedd, cyfnewid gwybodaeth a phrofiadau, a defnyddio offer e-Iechyd a thechnolegau arloesol er mwyn gwella gofal iechyd yn y maes hwn.

3.11. Cyfarwyddebau Caffael Cyhoeddus

Bydd cynigion i ***foderneiddio Cyfarwyddebau Caffael Cyhoeddus yr UE*** yn cael eu cyhoeddi ar 13 Rhagfyr 2011, yn dilyn adolygiad o weithrediad y rheolau presennol yn cynnwys ymgynghoriad cyhoeddus yn gynharach eleni. Bydd hyn yn uniongyrchol berthnasol i bob awdurdod cyhoeddus yng Nghymru sy'n tendro contractau uwchlaw trothwyon yr UE, ac o ganlyniad bydd unrhyw newid yn y rheolau hefyd o ddiddordeb i fusnesau a fydd yn awyddus i gynnig am dendrau o'r fath.

Bydd y Pwyllgor Menter a Busnes (fel y nodir uchod) yn cynnal ymchwiliad i'r mater hwn yn ystod chwarter cyntaf 2012.

3.12. Gwybodaeth i gleifion

Ar 10 Hydref 2011 cyhoeddodd y Comisiwn Ewropeaidd gynigion diwygiedig ar gyfer cyfarwyddeb newydd, sef ***Cyfarwyddeb ar wybodaeth a chynnyrch meddyginiaethol*** i'w darparu i gleifion ar feddyginiaethau presgripsiwn yn unig.

Yn wreiddiol cyflwynodd y Comisiwn Ewropeaidd gynigion yn 2008, wedi'u hanelu at nodi bwlch yn y wybodaeth i gleifion ar feddyginiaethau presgripsiwn yn unig (yn seiliedig ar ymchwil yn 2007 ac ymgynghoriad cyhoeddus dilynol). Fodd bynnag, cafwyd gwrthwynebiad i'r cynigion gwreiddiol hyn yn 2008 yn Senedd Ewrop ar sail y mathau o wybodaeth a'r ffyrdd y dylid ei chyflwyno i gleifion. Mae'r Comisiwn Ewropeaidd wedi ceisio mynd i'r afael â'r pryderon hyn yn y cynigion diwygiedig, gan ddweud fod y rhain yn cryfhau hawliau'r defnyddwyr, ac yn darparu rhwymedigaethau a gofynion cliriach o ran y ffordd y bwriedir cyflwyno'r wybodaeth.

Bydd y cynigion drafft yn dilyn y weithdrefn ddeddfwriaethol arferol sy'n ei gwneud yn ofynnol i Senedd a Chyngor Ewrop gytuno ar y testun terfynol er mwyn i'r cynigion ddod yn gyfraith yn yr UE.

3.13. Pecyn arloesedd mewn iechyd (dyfeisiau meddygol)

Mae *Rhaglen Waith y Comisiwn Ewropeaidd ar gyfer 2012* yn cynnwys nifer o gynigion a ragwelir ym maes dyfeisiau meddygol, yn ogystal â gohebiaeth ar bolisi arloesi mewn perthynas â dyfeisiau meddygol.

3.14. Gohebiaeth ar ofal hirdymor (i'w gyhoeddi yn 2013)

Mae'r Comisiwn Ewropeaidd yn bwriadu cyhoeddi gohebiaeth ar ofal hirdymor yn yr UE yn 2013.

4. Camau dilynol posibl i'r Pwyllgor eu hystyried

Cam Posibl 1:

Y Pwyllgor i ystyried cynnal sesiwn ddiweddaru benodol ar yr UE gyda rhai o'r sefydliadau sy'n weithgar yn y maes hwn, gan ganolbwyntio ar ystod eang o faterion a amlinellir yn y papur hwn. Byddai'r sesiwn hon yn canolbwyntio ar ystyried sut y gallai'r datblygiadau hyn effeithio ar Gymru a'r flaenoriaeth o ran ymgysylltu â hwy.

Cam Posibl 2:

Y Pwyllgor i gynnal sesiwn gyda Gweinidogion perthnasol yng Nghymru yn edrych ar sut y maent yn cymryd rhan ym mhroses llunio polisïau'r UE ar faterion yn gysylltiedig ag iechyd, yn arbennig o ran defnyddio'r cyfleoedd i feincnodi, rhannu gwybodaeth ar arferion gorau gydag Aelod-wladwriaethau ac is-wladwriaethau/rhanbarthau eraill yn y DU. Egluro sut y caiff buddiannau datganoledig eu hadlewyrchu mewn trafodaethau gyda Chyngor y Gweinidogion ar faterion yn ymwneud ag iechyd.

Cam Posibl 3:

Y Pwyllgor i ystyried cynnal ymchwiliad i edrych ar gyfleoedd dan raglen *'Health for Growth 2014-2020'* i sefydliadau yng Nghymru sy'n gweithio yn y maes hwn gymryd rhan ynddynt. [Ymchwiliad culach ei ffocws ar gyllid yr UE]

NEU

Y Pwyllgor i ystyried cynnal ymchwiliad yn edrych ar sut y mae sefydliadau yng Nghymru yn ymgysylltu'n ehangach â chyfleoedd ariannu'r UE ym maes iechyd, yn cynnwys rhai o'r rhaglenni eraill y soniwyd amdanynt yn y papur briffio. Yn benodol o ran cyfleoedd i sicrhau arian ymchwil, rhoi cynnig ar ffyrdd newydd ac arloesol o ddarparu gofal iechyd, a dysgu o arferion gorau mewn rhannau eraill o Ewrop. [Ymchwiliad ehangach ar gyllid yr UE]

Cam Posibl 4:

Y Pwyllgor i adolygu *eHealth Action Plan 2012-2020* ar ôl iddo gael ei gyhoeddi, ac ymchwilio i'w berthnasedd i ddatblygiadau yng Nghymru, gan gynnwys y posibilrwydd o edrych ar fentrau arfer gorau mewn rhannau eraill o Ewrop.

Cam Posibl 5:

Y Pwyllgor i ystyried cynnal sesiynau ar: (i) *y Gyfarwyddeb Moderneiddio Cymwysterau Proffesiynol* (ii) *y Gyfarwyddeb Oriau Gwaith* – ar ôl i'r cynigion diwygiedig ar gyfer y ddwy gyfarwyddeb gael eu cyhoeddi.

Cam Posibl 6:

Y Pwyllgor i ystyried cynnal sesiwn benodol ar heneiddio'n egnïol yng nghyd-destun *Blwyddyn Ewropeaidd 2012* ac ymchwilio i'r buddiannau posibl i Gymru yn sgil chwarae rhan weithredol yn y *Bartneriaeth Arloesol Ewropeaidd ar Heneiddio'n Egnïol ac Iach*.

Cam Posibl 7:

Y Pwyllgor i edrych ar anghydraddoldebau iechyd o ran yr Ohebiaeth a gyhoeddwyd gan y Comisiwn Ewropeaidd yn 2009 ac edrych ar arferion tebyg o ran mynd i'r afael ag anghydraddoldebau iechyd mewn rhannau eraill o Ewrop.

Y Pwyllgor Iechyd a Gofal Cymdeithasol
HSC(4)-13-11 papur 2

At: Y Pwyllgor Iechyd a Gofal Cymdeithasol

Gan: Y Gwasanaeth Pwyllgorau

Dyddiad: Rhagfyr 2011

YMCHWILIAD I OFAL PRESWYL I BOBL HŶN: CYNLLUN GWAITH Y PWYLLGOR

Diben

1. Ddydd Iau 22 Medi 2011, cytunodd y Pwyllgor Iechyd a Gofal Cymdeithasol i gynnal ymchwiliad i ofal preswyl i bobl hŷn. Diben y papur hwn yw ceisio cytundeb y Pwyllgor o ran sut i fwrw ymlaen â cham nesaf yr ymchwiliad hwn.

Cefndir

2. Cytunodd y Pwyllgor â chylch gorchwyl terfynol yr ymchwiliad ddydd Iau 20 Hydref 2011, yn dilyn ymgynghoriad cyhoeddus ynghylch ei gynnwys. Mae cylch gorchwyl terfynol yr ymchwiliad ynghlwm yn Atodiad A.

3. Cyhoeddodd y Pwyllgor ddydd Llun 24 Hydref 2011 ei fod yn galw am dystiolaeth. Bydd y cyfnod ymgynghori o wyth wythnos yn dod i ben ddydd Gwener 16 Rhagfyr 2011. Neilltuwyd wyth wythnos ar gyfer y cyfnod ymgynghori i roi digon o amser i nifer fawr o randdeiliaid a'r cyhoedd i gyflwyno sylwadau i'r ymchwiliad.

4. O gofio cwmpas eang yr ymchwiliad, cytunodd y Pwyllgor y byddai'n ddefnyddiol ystyried cynllun gwaith i fwrw ymlaen â cham nesaf yr ymchwiliad, a fydd yn cynnwys casglu tystiolaeth lafar. Mae'r dull o weithredu wedi'i amlinellu ym mharagraffau 5 – 12 yn y papur hwn.

Y dull o gasglu tystiolaeth lafar a awgrymir

5. I sicrhau bod y Pwyllgor yn ymdrin â'r holl faterion a restrir yng nghylch gorchwyl yr ymchwiliad, awgrymir bod tystiolaeth lafar yn cael ei chasglu'n unol â dwy egwyddor:

    (i) Sesiynau tystiolaeth lafar i'w trefnu ar sail grwpiau buddiant (gweler paragraffau 6 – 8 isod);

(ii) Dewis themâu penodol, fel y nodir yng nghylch gorchwyl yr ymchwiliad, i'r gwahanol Aelodau ymdrin â nhw yn ystod yr ymchwiliad (gweler paragraffau 9 –12 isod)

(i) Sesiynau tystiolaeth lafar ar sail grwpiau budd

6. I sicrhau bod y Pwyllgor yn ystyried amrywiaeth eang o safbwyntiau wrth gynnal yr ymchwiliad, awgrymir bod tystion yn cael eu gwahodd i ddod i'r Pwyllgor ar sail y grŵp buddiant y maent yn perthyn iddo.

7. Byddai sesiynau unigol yn cael eu trefnu i ganolbwyntio ar safbwyntiau sectorau / lleisiau penodol er enghraifft:

- Defnyddwyr, eu teuluoedd a'u gofalwyr;
- cyrff yn y sector cyhoeddus;
- darparwyr yn y sector preifat;
- cyrff a darparwyr yn y trydydd sector;
- cyrff proffesiynol a chyrff staff;
- rheoleiddiwyr ac arolygwyr
- Llywodraeth Cymru.

8. Os yw'r Pwyllgor yn penderfynu bwrw ymlaen gan ddilyn y drefn hon, cynigir y dylid paratoi:

- rhestr o dystion posibl
- amserlen fras o'r sesiynau tystiolaeth lafar,

wedi i'r dyddiad cau ar gyfer tystiolaeth ysgrifenedig fynd heibio (16 Rhagfyr). Gallai'r Pwyllgor ystyried y papur hwn yn fuan ar ôl toriad y Nadolig gyda'r bwriad o ddechrau'r sesiynau tystiolaeth lafar ddechrau mis Chwefror 2012.[1]

(ii) Rhannu themâu allweddol ymhlith yr Aelodau

9. I sicrhau bod y Pwyllgor yn ymdrin â phob agwedd ar yr ymchwiliad hwn, awgrymir bod aelod(au) penodol o'r Pwyllgor yn gyfrifol am bob un o'r pwyntiau bwled a restrir yn y cylch gorchwyl (hynny yw, pob thema allweddol).

[1] Mae slotiau cyfarfodydd y Pwyllgor ar gyfer Ionawr 2012 eisoes wedi'u neilltuo ar gyfer busnes y Pwyllgor, gan gynnwys: cwblhau'r ymchwiliad i gyfraniad fferylliaeth gymunedol at wasanaethau iechyd yng Nghymru; sesiwn dystiolaeth ynghylch goblygiadau prinder toiledau cyhoeddus ar iechyd y cyhoedd; sesiwn graffu gyffredinol gyda'r Gweinidog Iechyd a Gwasanaethau Cymdeithasol.

10. Yn ymarferol, byddai hyn yn golygu y byddai'r Pwyllgor yn gofyn i Aelod A ac Aelod B ganolbwyntio ar gasglu gwybodaeth yn ymwneud â'r pwynt bwled cyntaf yn y cylch gorchwyl drwy gydol yr ymchwiliad; byddai Aelod C ar y llaw arall yn gyfrifol am faterion yn ymwneud â phwynt bwled dau etc.

11. Byddai pwrpas deublyg i'r dull hwn o weithredu:

    - yn gyntaf, sicrhau bod pob agwedd ar yr ymchwiliad yn cael ei hystyried ym mhob cyfarfod os dilynir y drefn a amlinellir ym mharagraffau 6 a 7 yn seiliedig ar 'grwpiau buddiant;
    - yn ail, rhoi cyfle i'r Aelodau feithrin arbenigedd mewn agwedd benodol ar ymchwiliad y Pwyllgor.

    Ni fyddai hyn yn atal yr Aelodau mewn unrhyw ffordd rhag gofyn cwestiynau am bynciau oddi allan i'w themâu penodol nhw, ond byddai'n sicrhau bod pob thema'n cael ei hystyried, mewn perthynas â'i gilydd.

12. Os bydd yr Aelodau'n penderfynu dilyn y drefn hon, cynigir bod y Pwyllgor yn ystyried (ac yn penderfynu) pwy fydd yn arwain ar bob ymchwiliad ar ôl toriad y Nadolig, wrth drafod tystion posibl ac amserlen yr ymchwiliad.

Ystyriaethau eraill

13. Er mwyn darparu gwybodaeth ar gyfer yr ymchwiliad hwn, gallai'r Aelodau hefyd ystyried y canlynol:

(i) Cyngor arbenigol

14. Mae'r Rheolau Sefydlog yn caniatáu i'r Pwyllgor benodi arbenigwr/wyr i'w gynorthwyo â'i waith, os yw'n penderfynu y byddai hynny'n briodol. Diben cyngor o'r natur hwn yw:

    - ategu, yn hytrach na dyblygu, arbenigedd mewnol y Gwasanaeth Ymchwil
    - ychwanegu gwerth at drafodaethau'r Pwyllgor ar y pwnc dan sylw.

15. O gofio cwmpas yr ymchwiliad hwn, awgrymir bod y Pwyllgor yn cytuno o ran egwyddor i ystyried penodi cynghorwr arbenigol ar gyfer yr ymchwiliad.

16. Os yw'r Aelodau yn cytuno â'r cynnig ym mharagraff 15, gallai'r Pwyllgor nodi cynghorwyr posibl i'w hystyried yn fuan ar ôl toriad y Nadolig, wrth drafod tystion posibl ac amserlen yr ymchwiliad.

(ii) Ennyn diddordeb y cyhoedd

17. I sicrhau bod y Pwyllgor yn clywed barn y cyhoedd am ofal preswyl i bobl hŷn – gan gynnwys barn defnyddwyr presennol a darpar ddefnyddwyr y gwasanaethau hyn – efallai y bydd y Pwyllgor am gynnal rhyw weithgaredd i ennyn diddordeb y cyhoedd y tu hwnt i'r galwadau arferol am dystiolaeth lafar ac ysgrifenedig.

18. Gellid:

- *Sefydlu grŵp cyfeirio o aelodau'r cyhoedd*

  Gellid defnyddio grŵp o'r fath i gyfrannu at drafodaethau'r Pwyllgor ar y themâu allweddol yn ystod yr ymchwiliad ac i gael eu barn am ddarganfyddiadau ac argymhellion y Pwyllgor;

- *Ymweliadau anffurfiol*

  Gellid neilltuo amser yn ystod yr ymchwiliad i ganiatáu i'r Aelodau ymweld yn anffurfiol â'u hetholaethau a'u rhanbarthau eu hunain. Diben yr ymweliadau hyn fyddai caniatáu i'r Aelodau ddeall materion perthnasol yn well a chasglu gwybodaeth i'w helpu i graffu'n ffurfiol ar dystiolaeth y tystion;

- *Casglu tystiolaeth ffurfiol oddi allan i'r Senedd*

  Efallai y bydd y Pwyllgor am gasglu tystiolaeth oddi allan i Gaerdydd e.e. er mwyn ystyried problemau'n ymwneud yn benodol ag amddifadedd neu ardaloedd anghysbell, efallai y bydd yr Aelodau am deithio oddi allan i'r brifddinas. Yn yr un modd, os bydd y Pwyllgor am ystyried effaith poblogaeth hŷn, frodorol wedi'i gyplysu â phoblogaeth hŷn, mudol ar wasanaethau, gallai gasglu tystiolaeth ar hyd arfordir gogledd Cymru.

19. Byddai gweithio yn ôl themâu (fel yr awgrymir ym mharagraffau 9 – 12 o'r papur hwn) yn galluogi'r Pwyllgor i gasglu tystiolaeth tu allan i'r Senedd heb i'r Pwyllgor cyfan gwrdd. Yn amodol ar anghenion cworwm[2], byddai'r Aelodau sy'n arwain ar themâu allweddol yn gallu arwain sesiynau tystiolaeth sy'n cael eu cynnal tu allan i Fae Caerdydd heb i bob Aelod fod yn bresennol.

[2] Yn unol â Rheol Sefydlog 17.31, mae'n rhaid i bedwar aelod fod yn yn bresennol i gynnal cyfarfod Pwyllgor ffurfiol; yn unol â Rheol Sefydlog 17.32, mae'n rhaid i gynrychiolwyr mwy nag un grwp gwleidyddol fod yn bresennol.

20. Os yw'r Pwyllgor am ymgymryd â gweithgareddau tebyg i'r rhai a nodir ym mharagraff 18, gallai Tîm Allgymorth y Cynulliad helpu'r Aelodau yn y cyswllt hwn.

Y cynnig

21. Gwahoddir y Pwyllgor i:

- ystyried a chytuno, o ran egwyddor, ar ddulliau o gasglu tystiolaeth lafar (paragraffau 5 – 12)

- ystyried y dewisiadau a amlinellwyd mewn perthynas â:
  - chyngor arbenigol (paragraffau 14 – 16); ac
  - ennyn diddordeb y cyhoedd (paragraffau 17 – 20),

  a chytuno ar y modd y bydd y Pwyllgor yn defnyddio'r dulliau hyn.

ATODIAD A

Cylch gorchwyl yr ymchwiliad i ofal preswyl i bobl hŷn.

Dyma gylch gorchwyl yr ymchwiliad, fel y'i cytunwyd gan y Pwyllgor ar 20 Hydref 2011:

Ymchwilio i ddarpariaeth gofal preswyl yng Nghymru a'r ffyrdd y gall fodloni anghenion presennol pobl hŷn a'u hanghenion ar gyfer y dyfodol, gan gynnwys:

- y broses a ddilynir gan bobl hŷn wrth iddynt fynd i ofal preswyl ac argaeledd a hygyrchedd gwasanaethau amgen yn y gymuned, gan gynnwys gwasanaethau ailalluogi a gofal yn y cartref.

- gallu'r sector gofal preswyl i fodloni'r galw am wasanaethau gan bobl hŷn o ran adnoddau staffio, gan gynnwys y sgiliau sydd gan staff a'r hyfforddiant sydd ar gael iddynt, nifer y lleoedd a'r cyfleusterau, a lefel yr adnoddau.

- ansawdd gwasanaethau gofal preswyl a phrofiadau defnyddwyr gwasanaethau a'u teuluoedd; effeithiolrwydd gwasanaethau o ran bodloni'r amrywiol anghenion ymhlith pobl hŷn; a rheolaeth ar gau cartrefi gofal.

- effeithiolrwydd trefniadau rheoleiddio ac archwilio gofal preswyl, gan gynnwys y cwmpas ar gyfer craffu mwy ar hyfywdra ariannol darparwyr gwasanaethau.

- y modelau gofal newydd sy'n dod i'r amlwg.

- y cydbwysedd rhwng darpariaeth yn y sector cyhoeddus a'r sector annibynnol, a modelau ariannu, rheoli a pherchnogaeth amgen, fel y rheini a gynigir gan y sector gydweithredol a chydfuddiannol, y trydydd sector, a landlordiaid cymdeithasol cofrestredig.

Penderfynodd y Pwyllgor y dylai'r ymchwiliad ganolbwyntio ar **ofal preswyl,** ond mae'n anochel y bydd trafodion yn cyffwrdd â materion sy'n ymwneud â gofal nyrsio.

Penderfynodd hefyd ganolbwytio ar y gwasanaethau sydd ar gael i **bobl hŷn**, yn hytrach nag i oedolion yn fwy cyffredinol.

Llywodraeth Cymru
Welsh Government

www.cymru.gov.uk

Llywodraeth Cymru

Dogfen Ymgynghori

Cynigion ar gyfer Deddfwriaeth ar Roi Organau a Meinweoedd:

Papur Gwyn gan Lywodraeth Cymru

Dyddiad cyhoeddi: **8 Tachwedd 2011**
Ymatebion erbyn: **31 Ionawr 2012**

Trosolwg

Cynhelir yr ymgynghoriad hwn er mwyn casglu ymatebion ar gynigion Llywodraeth Cymru i ddeddfu ar roi organau a meinweoedd.

Amcan Bil y Cynulliad ar roi organau a meinweoedd yw cyflwyno system yng Nghymru a fydd yn sicrhau bod mwy o bobl yn rhoi organau a meinweoedd yng Nghymru. Byddai hynny'n ein galluogi i arbed mwy o fywydau ac i wella ansawdd bywydau pobl eraill.

Caiff eich ymatebion eu hystyried wrth ddatblygu'r Bil.

Sut i ymateb

Mae'r ffurflen ymateb i'r ymgynghoriad ar gael yn www.cymru.gov.uk/ymgyngoriadau.

Croesewir sylwadau yn Gymraeg neu yn Saesneg.

Dylech anfon eich ymatebion i'r ymgynghoriad drwy'r e-bost neu'r post i'r cyfeiriad isod i'n cyrraedd yn ddim hwyrach na 31 Ionawr 2012.

Rhagor o wybodaeth a dogfennau cysylltiedig

Gellir gwneud cais am fersiynau o'r ddogfen hon mewn print bras, mewn Braille neu mewn ieithoedd eraill.

Mae fersiwn Hawdd ei Darllen o'r ddogfen hon wedi'i datblygu ac mae ar gael drwy gysylltu â'r cyfeiriad isod.

Manylion cysylltu

I gael rhagor o wybodaeth:

Tîm y Bil Rhoi Organau
Y Gyfarwyddiaeth Feddygol
Parc Cathays
Caerdydd
CF10 3NQ

Ffôn: 029 2037 0011

E-bost: organdonation@wales.gsi.gov.uk

Diogelu Data

Sut y byddwn yn defnyddio'r farn a'r wybodaeth a roddwch inni.

Bydd unrhyw ymateb a anfonwch atom yn cael ei weld yn llawn gan staff Llywodraeth Cymru sy'n gweithio ar y materion y mae'r ymgynghoriad hwn yn ymdrin â nhw. Mae'n bosibl y bydd aelodau eraill o staff Llywodraeth Cymru yn gweld yr ymateb hefyd, er mwyn eu helpu i gynllunio ymgyngoriadau ar gyfer y dyfodol.

Mae Llywodraeth Cymru yn bwriadu cyhoeddi crynodeb o'r ymatebion i'r ddogfen hon. Mae'n bosibl hefyd y byddwn yn cyhoeddi'r ymatebion yn llawn. Fel arfer, bydd enw a chyfeiriad (neu ran o gyfeiriad) yr unigolyn neu'r sefydliad a anfonodd yr ymateb yn cael eu cyhoeddi gyda'r ymateb. Mae hynny'n helpu i ddangos bod yr ymgynghoriad wedi'i gynnal yn briodol. Os nad ydych yn dymuno i'ch enw a'ch cyfeiriad gael eu cyhoeddi, rhowch wybod i ni yn ysgrifenedig wrth anfon eich ymateb. Byddwn wedyn yn cuddio'ch manylion.

Mae'n bosibl y bydd yr enwau a'r cyfeiriadau y byddwn wedi'u cuddio yn cael eu cyhoeddi'n ddiweddarach, er nad yw hynny'n debygol o ddigwydd yn aml iawn. Mae Deddf Rhyddid Gwybodaeth 2000 a Rheoliadau Gwybodaeth Amgylcheddol 2004 yn caniatáu i'r cyhoedd gael gweld gwybodaeth a gedwir gan lawer o gyrff cyhoeddus, gan gynnwys Llywodraeth Cymru. Mae hynny'n cynnwys gwybodaeth sydd heb ei chyhoeddi. Fodd bynnag, mae'r gyfraith hefyd yn caniatáu i ni gadw gwybodaeth yn ôl dan rai amgylchiadau. Os bydd unrhyw un yn gofyn am gael gweld gwybodaeth a gadwyd yn ôl gennym, bydd rhaid inni benderfynu a ydym am ei rhyddhau ai peidio. Os bydd rhywun wedi gofyn inni beidio â chyhoeddi ei enw a'i gyfeiriad, bydd hynny'n ffaith bwysig i ni ei chadw mewn cof. Fodd bynnag, fe allai fod rheswm pwysig dros orfod datgelu enw a chyfeiriad unigolyn, er ei fod wedi gofyn i ni beidio â'u cyhoeddi. Byddem yn cysylltu â'r unigolyn ac yn gofyn am ei farn cyn gwneud unrhyw benderfyniad terfynol i ddatgelu'r wybodaeth.

WG13956

Cynnwys

RHAGAIR Y GWEINIDOG IECHYD A GWASANAETHAU CYMDEITHASOL

Mae prinder organau dynol yn dal i achosi marwolaethau a dioddefaint diangen, i gleifion sy'n aros am drawsblaniad ac i'w perthnasau. Ar unrhyw adeg mae tua 300 o bobl ar y rhestr aros am drawsblaniad, ac yn 2010/11 bu farw 51 o bobl yng Nghymru tra'n aros am organau.

Rydym eisoes yn gweithredu'r holl argymhellion a gafodd eu gwneud mewn adolygiad a gynhaliwyd ledled y Deyrnas Unedig, ac mae cynnydd da wedi'i wneud. Y llynedd fe wnaeth 83 o drigolion Cymru roi eu horganau – y nifer fwyaf erioed.

Er hynny, rydym wedi ymrwymo i fynd gam ymhellach, gan nad yw nifer yr organau sydd ar gael i'w trawsblannu yn ddigon i ddiwallu'r angen. Nod Llywodraeth Cymru yw cynyddu nifer yr organau sydd ar gael i'w trawsblannu yn dilyn marwolaeth, a hynny er mwyn gwella iechyd ac ansawdd bywydau'r bobl sydd angen trawsblaniad. Byddwn yn gwneud hyn drwy weithredu ar yr ymrwymiad yn ein maniffesto i gyflwyno Bil a fydd yn cynnig system o optio allan o roi organau.

Trwy drafod ac ymgynghori ar y mater hwn yn ystod y blynyddoedd diwethaf, rydym wedi ein hargyhoeddi bod Cymru'n barod i gymryd y cam hwn, fel cenedl sy'n adnabyddus am ei natur anhunanol, ei haelioni a'i hystyriaeth o bobl eraill. Bu Cymru'n arwain ar roi organau a meinweoedd yn y gorffennol, gan arloesi ar y syniad o gerdyn rhoddwr arennau a Chofrestr Rhoddwyr Organau gyfrifiadurol. Rydym o'r farn y dylem barhau i fod yn flaengar yn y maes hwn, a dilyn esiampl y gwledydd yn Ewrop sydd â record lwyddiannus o roi organau. Rydym am wneud hyn drwy gyflwyno system feddal o optio allan fel un elfen mewn pecyn o fesurau a fydd yn cynyddu nifer y bobl sy'n rhoddwyr organau a meinweoedd. Mae croeso ichi ymateb i'r ymgynghoriad hwn a'n helpu ni i wneud y peth iawn.

Os ydych am gofnodi eich dymuniadau ar y Gofrestr Rhoddwyr Organau bresennol, rydym yn cynnig y byddwch yn dal i allu gwneud hynny. Yn wir, gallwch wneud hynny nawr. Mae manylion ynghylch sut i ymuno â'r Gofrestr Rhoddwyr Organau i'w gweld yn y Papur Gwyn hwn.

I gloi, cofiwch ddweud wrth y rhai sy'n agos atoch eich bod yn credu mewn rhoi organau a meinweoedd. Byddai hynny'n ei gwneud yn llawer haws iddyn nhw ddeall eich dymuniadau petaech yn marw.

Lesley Griffiths AC
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol

CRYNODEB GWEITHREDOL

1. Mae'r Papur Gwyn hwn yn nodi cynigion Llywodraeth Cymru ar gyfer system feddal yng Nghymru o optio allan o roi organau a meinweoedd ar ôl marwolaeth.

2. O dan y system feddal o optio allan a gynigir ar gyfer Cymru, byddai hawl i dynnu a defnyddio organau a meinweoedd onibai fod y sawl a fu farw wedi gwrthwynebu hynny yn ystod ei oes. Bydd mecanwaith ffurfiol ar gael i unigolion allu cofrestru'r gwrthwynebiad hwnnw. Ar ôl i rywun farw, bydd ei berthnasau'n cael eu cynnwys yn broses o benderfynu ynglŷn â rhoi.

3. Mae Llywodraeth Cymru yn gwneud y newid hwn er mwyn sicrhau bod mwy o organau ar gael i'w trawsblannu. Ar gyfartaledd mae un person bob wythnos yn marw yng Nghymru am nad oes modd dod o hyd i roddwr er mwyn sicrhau trawsblaniad. Trawsblannu organau a meinweoedd yw un o'r dulliau mwyaf effeithiol o driniaeth feddygol fodern sy'n arbed bywydau ac yn gwella ansawdd bywyd i gleifion sy'n dioddef o fethiant organau. Trawsblaniad yw'r driniaeth orau bosibl i'r rhan fwyaf o bobl sy'n dioddef o fethiant organau.

4. Ar yr un pryd, mae pobl eraill yn marw o dan amgylchiadau lle byddai rhoi eu horganau a'u meinweoedd yn bosibl, ond nad yw hynny'n digwydd. Nid am fod y sawl a fu farw wedi mynegi ei wrthwynebiad i roi, ond am nad oedd wedi ymuno â'r Gofrestr Rhoddwyr Organau.

5. Yn ôl tystiolaeth o wledydd eraill, gall system fel y system feddal o optio allan a gynigir ar gyfer Cymru gynyddu nifer yr organau sydd ar gael i'w rhoi, a thrwy hynny arbed bywydau. Mae prosesau ymgynghori gan Lywodraeth Cymru yn y gorffennol wedi dangos cefnogaeth gan y cyhoedd i newid yn y ddeddfwriaeth i gyflwyno system feddal o optio allan.

6. Mae'r Papur Gwyn yn manylu ynglŷn â'r system feddal o optio allan a gynigir ar gyfer Cymru, sy'n cynnwys trawsblannu organau a meinweoedd pobl sydd wedi marw. Y prif nodweddion yw –

a) bydd yn berthnasol i bobl 18 oed a throsodd sy'n byw ac yn marw yng Nghymru;

b) bydd cyfle i'r oedolion hynny fynegi eu gwrthwynebiad i roi eu horganau a'u meinweoedd;

c) bydd system effeithiol a diogel i unigolion fynegi eu gwrthwynebiad i fod yn rhoddwyr os ydynt yn dymuno gwneud hynny, a bydd system o'r fath yn caniatáu iddynt wrthwynebu rhoi rhai neu'r cyfan o'u horganau a'u meinweoedd;

d) bydd unrhyw wrthwynebiad gan unigolyn i roi organau a/neu feinweoedd yn cael ei barchu ar ôl iddo farw;

e) bydd y system yn cefnogi'r cyfle i unigolion newid eu meddwl, ac i gynnwys pobl sy'n symud i fyw i Gymru neu sy'n cyrraedd 18 oed;

f) ar ôl i rywun farw, bydd ei deulu yn cael eu cynnwys yn y broses o benderfynu ynglŷn â rhoi organau a meinweoedd.

7. Bydd y cynigion yn berthnasol i roi organau a meinweoedd at ddibenion trawsblaniad yn unig. Ni fyddant yn cynnwys rhoi organau a meinweoedd at ddibenion eraill, megis ymchwil, arddangos neu ddefnydd masnachol.

8. Bydd pryderon yn codi'n aml fod unigolion o dan y system feddal o optio allan yn colli eu hawliau dros eu cyrff, a bod y pŵer i dynnu organau a meinweoedd i'w trawsblannu yn nwylo'r wladwriaeth. Fodd bynnag, yn ôl tystiolaeth, mae unigolion yn fwy tebygol o wneud penderfyniadau am roi organau a meinweoedd yn ystod eu hoes o dan system o'r fath. Bydd penderfyniad unigolyn yn cael ei barchu hefyd ar ôl iddo farw. At hynny, mae'r baich o wneud penderfyniad yn cael ei gymryd oddi ar y perthnasau ar adeg anodd iawn iddynt, pan nad oes ganddynt yn aml unrhyw arwydd clir o ddymuniad y sawl a fu farw.

9. 2015 fydd y cynharaf y caiff y system feddal o optio allan ei gweithredu yng Nghymru. Cyn i'r system newydd ddod i rym, bydd ymgyrch fawr yn cael ei chynnal i godi ymwybyddiaeth y cyhoedd ac i wneud yn siŵr bod yr holl bobl sy'n dymuno optio allan yn gwybod sut i wneud hynny.

10. Mae Llywodraeth Cymru yn cynnal ymgynghoriad ar y cynigion sydd yn y Papur Gwyn hwn. Dylid cyflwyno ymatebion i Lywodraeth Cymru erbyn **31 Ionawr 2012**, ac mae canllawiau ar sut i wneud hynny yn Atodiad A.

YR ACHOS DROS NEWID

1. Yng Nghymru yn 2010/11, bu farw 51 o bobl tra'r oeddent ar y rhestr aros neu ar ôl iddynt gael eu symud oddi ar y rhestr aros am fod eu hiechyd yn dirywio. Ar draws y Deyrnas Unedig mae mwy na 1,000 o bobl yn marw bob blwyddyn tra byddant yn aros am drawsblaniad organ.

2. Ar yr un pryd, mae pobl eraill yn marw o dan amgylchiadau lle byddai rhoi eu horganau a'u meinweoedd yn bosibl, ond nad yw hynny'n digwydd. Nid am fod y sawl a fu farw wedi mynegi ei wrthwynebiad i roi, ond am nad oedd wedi gwneud dim ynghylch ymuno â'r Gofrestr Rhoddwyr Organau (y Gofrestr) nac wedi rhoi gwybod i'w berthnasau am ei ddymuniad.

3. Trawsblannu organau a meinweoedd yw un o'r dulliau mwyaf effeithiol o driniaeth feddygol fodern sy'n arbed bywydau ac yn gwella ansawdd bywyd i gleifion sy'n dioddef o fethiant eu horganau. Trawsblaniad yw'r driniaeth orau bosibl i'r rhan fwyaf o bobl sy'n dioddef o fethiant organau.

4. Mae'r organau a'r meinweoedd sy'n cael eu rhoi yn cynnwys yr arennau, y galon, yr afu/iau, yr ysgyfaint, y pancreas, y coluddyn bach, y cornbilennau a'r sclera (o'r llygaid), y falfiau a'r pericardiwm (o'r galon), ynghyd â chroen, esgyrn, tendonau a chartilag.

5. Er y byddai bron pawb ohonom yn barod i dderbyn trawsblaniad organ neu feinwe, dim ond 31 y cant o boblogaeth Cymru sydd wedi cofrestru â'r Gofrestr. Mae tystiolaeth yn awgrymu y byddai llawer mwy o bobl yn hoffi ymuno â'r Gofrestr, ond heb wneud hynny eto. Trwy greu amgylchedd lle mae rhoi organau a meinweoedd yn ddewis naturiol, bydd modd sicrhau bod mwy o organau a meinweoedd gael pan fydd fwyaf eu hangen.

6. Mae cymariaethau rhwng gwledydd yn dangos bod amryw o ffactorau yn dylanwadu ar y cyfraddau rhoi organau. Un o'r ffactorau hynny yw cyflwyno system o optio allan. Mae gwaith ymchwil yn awgrymu bod y cyfraddau rhoi organau gan bobl a fu farw yn cynyddu tua 25 i 30 y cant mewn gwledydd lle ceir system feddal o optio allan.

7. Mae Llywodraeth Cymru o'r farn y bydd symud at ddefnyddio system feddal o optio allan yn sicrhau y daw rhoi organau a meinweoedd yn rhywbeth cyffredin, ac y bydd yn annog ac yn hwyluso trafodaeth ar y materion hyn ac yn cynyddu nifer yr organau a'r meinweoedd sydd ar gael i'r rheini sydd eu hangen fwyaf.

Beth sy'n digwydd nawr

Y fframwaith cyfreithiol

8. Deddf Meinweoedd Dynol 2004 yw'r fframwaith deddfwriaethol ar gyfer rhoi organau a meinweoedd yng Nghymru, Lloegr a Gogledd Iwerddon. Mae darpariaethau tebyg yn berthnasol yn yr Alban o dan Ddeddf Meinweoedd Dynol (Yr Alban) 2006.

9. Mae'r ddau fframwaith cyfreithiol yn darparu system o optio i mewn. Mae'r system optio i mewn yn seiliedig ar gydsyniad penodol lle bydd unigolion yn gwirfoddoli i fod yn rhoddwyr organau a meinweoedd. Nid oes raid cael cydsyniad ysgrifenedig, ond yn ymarferol mae'r rhan fwyaf o benderfyniadau ynghylch rhoi yn golygu cario cerdyn rhoddwr wedi'i lofnodi, neu ymuno â'r Gofrestr.

10. Rhaid i unigolion gymryd camau cadarnhaol i gofnodi eu dymuniad i fod yn rhoddwyr.

11. Fodd bynnag, pan nad yw unigolyn wedi rhoi gwybod y naill ffordd neu'r llall am ei benderfyniad i roi ei organau a'i feinweoedd, gall y teulu roi cydsyniad i roi ar ran y sawl a fu farw. Yn ystod 2010/11 roedd ychydig dros 67 y cant o'r rhoddwyr yn y Deyrnas Unedig heb gofrestru â'r Gofrestr.

Cofrestr Rhoddwyr Organau y GIG (y Gofrestr)

12. Cronfa ddata gyfrifiadurol, gyfrinachol yw'r Gofrestr. Mae'n cadw manylion am bobl sydd wedi cofrestru i fod yn rhoddwyr organau a meinweoedd ar ôl iddynt farw. Defnyddir y Gofrestr ar ôl i'r unigolyn farw er mwyn gweld a oeddent am roi eu horganau a'u meinweoedd, ac os felly pa rai.

13. Gall y cyhoedd ymuno â'r Gofrestr mewn amrywiol ffyrdd, gan gynnwys:

- cofrestru ar-lein (www.organdonation.nhs.uk);
- drwy gysylltu â Llinell Rhoddwyr y GIG (0300 123 23 23);
- wrth gofrestru am drwydded yrru gyda'r Asiantaeth Trwyddedu Gyrwyr a Cherbydau (DVLA);
- wrth gofrestru â meddyg teulu;
- wrth wneud cais am Gerdyn Yswiriant Iechyd Ewropeaidd;
- wrth wneud cais am Gerdyn Mantais Boots.

14. Yn y Deyrnas Unedig, caiff organau gan roddwyr eu trawsblannu yn ôl yr angen ac ar sail paru'r math o waed a meinwe. Maent yn cael eu paru yn ôl grŵp gwaed – ac yn achos arennau, yn ôl y math o feinwe. Y trawsblaniadau sydd wedi'u paru orau sy'n arwain at y canlyniadau gorau.

Symud at system feddal o optio allan

15. Yn 2008/09 bu Llywodraeth Cymru yn gofyn am farn pobl ar sut i gynyddu nifer y rhoddwyr organau. Cynhaliwyd cyfres o gyfarfodydd cyhoeddus ar draws Cymru, gan gynnwys cyfarfod rhyng-ffydd. Rhoddwyd ystyriaeth i safbwyntiau ysgrifenedig ac arolwg ffôn.

16. Yn sgil hyn cafwyd dadl gyhoeddus a gadarnhaodd fod cefnogaeth fawr i gynyddu nifer y rhoddwyr organau. Cyflwynwyd ystod eang o awgrymiadau ar sut i gyflawni hyn, gan gynnwys newidiadau posibl i'r system gydsynio ar gyfer rhoi.

17. Cadarnhaodd y ddadl fod pobl yng Nghymru'n awyddus i weld newid i'r system gydsynio, gyda nifer yn ffafrio system feddal o optio allan.

18. Yn sgil y drafodaeth a'r ddadl gyhoeddus, cyhoeddodd Llywodraeth Cymru bapur ymgynghori, *Opsiynau ar gyfer newid y system rhoi organau yng Nghymru.* Roedd canlyniad yr ymgynghoriad yn dangos bod cefnogaeth gref i Lywodraeth Cymru wrth iddi fynd ati i sicrhau newid deddfwriaethol a chyflwyno system feddal o optio allan yng Nghymru.

19. Yn natganiad deddfwriaethol Prif Weinidog Cymru ar 12 Gorffennaf 2011, nododd y byddai Llywodraeth Cymru yn "*...lansio papur ymgynghori gwyn ar Fil Rhoi Organau (Cymru) cyn diwedd y flwyddyn hon. Bydd y Bil yn darparu ar gyfer system o ddewis peidio â rhoi organau, gyda chefnogaeth rhaglen gyfathrebu eang".*

20. Mae'r Papur Gwyn hwn yn nodi cynigion Llywodraeth Cymru ar gyfer system feddal o optio allan, a fydd yn rhoi'r cyfle i bobl Cymru roi organau a meinweoedd ar ôl eu marwolaeth.

Y SYSTEM FEDDAL O OPTIO ALLAN SY'N CAEL EI CHYNNIG AR GYFER CYMRU

21. Mae'r systemau optio allan yn cael eu disgrifio fel rhai caled neu feddal –

a) mewn system galed o optio allan caniateir tynnu a defnyddio organau a meinweoedd y sawl a fu farw os na fydd wedi mynegi gwrthwynebiad i hynny yn ystod ei oes;

b) mewn system feddal o optio allan mae tynnu a defnyddio organau a meinweoedd y sawl a fu farw hefyd yn cael ei ganiatáu os na fydd wedi mynegi gwrthwynebiad i hynny yn ystod ei oes, ond ar ôl iddo farw bydd gan ei berthnasau ran yn y broses benderfynu ynghylch rhoi.

Mae Llywodraeth Cymru yn cynnig system feddal o optio allan ar gyfer Cymru.

22. Dyma brif nodweddion y system feddal o roi organau a meinweoedd ar ôl marwolaeth y mae Llywodraeth Cymru yn bwriadu ei chyflwyno i Gymru –

a) bydd yn berthnasol i bobl 18 oed a throsodd sy'n byw ac yn marw yng Nghymru;

b) bydd cyfle i bobl fynegi eu gwrthwynebiad i roi eu horganau a'u meinweoedd;

c) bydd system effeithiol a diogel i unigolion fynegi eu gwrthwynebiad i fod yn rhodddwyr os ydynt yn dymuno gwneud hynny, a bydd system o'r fath yn caniatáu iddynt wrthwynebu rhoi rhai neu'r cyfan o'u horganau a'u meinweoedd;

d) bydd unrhyw wrthwynebiad gan unigolyn i roi organau a/neu feinweoedd yn cael ei barchu ar ôl iddo farw;

e) bydd y system yn cefnogi'r cyfle i unigolion newid eu meddwl, ac i gynnwys pobl sy'n symud i fyw i Gymru neu sy'n cyrraedd 18 oed;

f) ar ôl i rywun farw, bydd ei deulu yn cael eu cynnwys yn y broses o benderfynu ynglŷn â rhoi organau a meinweoedd.

Pobl a gaiff eu cynnwys yn y system feddal o optio allan

23. Bydd y system feddal o optio allan yn berthnasol i bobl 18 oed a throsodd sy'n byw yng Nghymru, ac sydd wedi cael cyfle i fynegi gwrthwynebiad i'w horganau a'u meinweoedd gael eu rhoi ar ôl eu marwolaeth.

Cyfle i fynegi gwrthwynebiad i fod yn rhoddwr

24. Mae Llywodraeth Cymru o'r farn fod gan bawb yr hawl i fynegi eu gwrthwynebiad i roi eu horganau a'u meinweoedd ar ôl iddynt farw, a bod yr hawl honno'n cael ei pharchu. Er mwyn sicrhau y gellir mynegi gwrthwynebiad, rhaid bod y cyfle i wneud hynny'n bodoli, a rhaid rhoi'r cyfle hwnnw.

25. Er mwyn rhoi cyfle i unigolyn fynegi ei wrthwynebiad, rhaid sicrhau'r canlynol –

a) bod gwybodaeth ar gael yn hawdd am y system feddal o optio allan yng Nghymru;

b) bod yr unigolyn yn gallu deall yr wybodaeth sydd ar gael a dod i benderfyniad;

c) system ar gyfer mynegi gwrthwynebiad.

26. Mae cynigion Llywodraeth Cymru ar gyfer mynegi a chofnodi'r gwrthwynebiad i'w gweld yn nes ymlaen yn y Papur Gwyn hwn.

Byw yng Nghymru

27. Nid yw Llywodraeth Cymru yn bwriadu i'r ddeddfwriaeth newydd gynnwys pawb sy'n marw yng Nghymru, dim ond y rheini sy'n byw ac yn marw yng Nghymru.

28. At hynny, mae Llywodraeth Cymru yn cynnig y bydd y trefniadau newydd yn berthnasol i bobl sydd wedi byw yng Nghymru'n ddigon hir i wybod am y system a'i deall.

29. Y rheswm dros wneud y trefniadau hyn yn berthnasol i bobl sy'n byw yng Nghymru a'r bobl sydd wedi byw yma'n ddigon hir yw ceisio sicrhau y bydd y bobl hyn yn ymwybodol o'r system ac yn gwybod beth yw'r drefn o ran gwrthwynebu. Nid oes disgwyl i bobl sy'n ymweld â Chymru wybod am y trefniadau, ac ni fyddant wedi cael cyfle i wrthwynebu.

30. Cydnabyddir y bydd angen i'r ddeddfwriaeth fod yn eglur ynghylch ystyr byw yng Nghymru.

31. Bydd angen adlewyrchu bywyd bob dydd arferol unigolion wrth ystyried a ydynt yn byw yng Nghymru fel arfer ai peidio, ac ni ddylai absenoldebau dros dro (fel gwyliau, hamdden a busnes) ddylanwadu ar hynny. Rhaid i'r drefn fod yn eglur i'r clinigwyr ac i'r cyhoedd.

32. Fel y nodir uchod, rhaid i unigolyn fod wedi byw yng Nghymru am gyfnod o amser i fod wedi dod i wybod a deall digon am y system feddal optio allan o roi organau a meinweoedd. Yn y Papur Gwyn hwn rydym yn gofyn barn pobl am y cyfnod o amser.

33. Bydd rhaglen helaeth ac eang o godi ymwybyddiaeth yn digwydd yn ystod y cyfnod cyn cyflwyno'r system newydd. Bydd hyn yn ceisio sicrhau y bydd y bobl sy'n byw yng Nghymru yn ymwybodol o'r trefniadau newydd a'r dewisiadau sydd ar gael iddynt.

34. Pan fydd y trefniadau newydd yn eu lle, byddwn yn sicrhau y caiff pobl sy'n symud i fyw i Gymru ddigon o amser i ddod i wybod am y system a'i deall fel y gallant fynegi eu gwrthwynebiad i fod yn rhoddwyr, os ydynt yn dymuno gwneud

hynny. Bydd y camau hyn yn sefydlu'r cyfnod o amser sy'n ofynnol cyn i bobl gael eu cynnwys o fewn y system feddal o optio allan.

Cydsyniad

35. Weithiau gelwir systemau o optio allan, fel y system feddal sy'n cael ei chynnig ar gyfer Cymru, yn system *"cydsyniad tybiedig"* o roi organau a meinweoedd.

36. Mae cydsyniad yn ganolog i'r rhan fwyaf o systemau rhoi organau a meinweoedd. Yn gyffredinol, ystyrir cydsyniad fel y cyfiawnhad moesegol a chyfreithiol dros dynnu a defnyddio organau a meinweoedd.

37. O dan y system bresennol o optio i mewn yng Nghymru, rhoddir cydsyniad i roi pan fydd unigolion yn gwirfoddoli i fod yn rhoddwyr organau a meinweoedd drwy ymuno â Chofrestr Rhoddwyr Organau y GIG. Yn ogystal â hynny, yn absenoldeb cydsyniad yr unigolyn, gall y teulu roi cydsyniad ar ran y sawl a fu farw pan nad yw'r unigolyn hwnnw wedi gwneud penderfyniad sy'n hysbys o blaid neu yn erbyn rhoi.

38. O dan y system feddal o optio allan a gynigir ar gyfer Cymru, os na fydd unigolyn yn mynegi gwrthwynebiad fe fydd ei organau a'i feinweoedd ar gael i'w rhoi ar ôl iddo farw. Felly, yn absenoldeb gwrthwynebiad, cymerir bod cydsyniad. Ond, fel cam diogelwch, bydd teulu'r sawl a fu farw yn cael eu cynnwys yn y broses o benderfynu ynglŷn â rhoi.

Y gallu i ddeall

39. Mae Deddf Galluedd Meddyliol 2005 yn cadarnhau bod yn rhaid rhagdybio bod gan unigolyn y gallu i wneud penderfyniadau os na phrofir yn wahanol. Ni chaiff yr egwyddor hon ei newid gan y system feddal arfaethedig o optio allan o roi organau a meinweoedd yng Nghymru.

40. Rydym yn cydnabod, o dan y trefniadau cyfredol o roi, na phrofir galluedd meddyliol unigolion i ddeall natur y penderfyniad i ymuno â'r Gofrestr Rhoddwyr Organau (y Gofrestr).

41. Gall fod gan bobl y galluedd meddyliol i wneud penderfyniadau am rai agweddau ar eu bywydau, ond nid am rai eraill. Sylweddolir na fydd gan rai pobl byth y galluedd meddyliol i wneud penderfyniad penodol. Bydd rhai pobl yn colli'r galluedd meddyliol i wneud y penderfyniad hwnnw, a bydd galluedd meddyliol pobl eraill yn amrywio.

42. Canlyniad hyn yw na all unrhyw system o roi organau a meinweoedd sy'n dibynnu ar gyfle a gallu unigolyn i optio allan wneud rhaniad gor-syml rhwng y rhai sy'n meddu a'r rhai nad ydynt yn meddu ar y galluedd meddyliol digonol i wneud penderfyniad.

43. Mae Llywodraeth Cymru yn cynnig y bydd clinigwyr, yn dilyn marwolaeth oedolion ac ar ôl cael trafodaeth â'u teuluoedd, yn dynodi'r rhai hynny sydd â diffyg galluedd i wneud penderfyniad am roi organau a meinweoedd.

Oedolion 18 oed a throsodd

44. Mae Llywodraeth Cymru yn cydnabod bod anawsterau'n bodoli wrth ragdybio y bydd plant yn deall natur a phwrpas rhoi organau a meinweoedd, er mwyn gallu mynegi gwrthwynebiad i hynny.

45. Mae adran 2 o Ddeddf Meinweoedd Dynol 2004 yn nodi ystyr cyfredol 'cydsyniad priodol' mewn perthynas â gweithgareddau'n ymwneud â chorff plentyn sydd wedi marw. At ddibenion yr adran honno, mae plant yn bobl o dan 18 oed.

46. Felly rydym yn cynnig na fydd plant a phobl ifanc sydd heb gyrraedd 18 oed yn cael eu cynnwys o dan y symudiad at y system feddal o optio allan; bydd y system yn cynnwys pobl ifanc pan fyddant yn cyrraedd eu pen-blwydd yn 18 oed.

Pobl na fydd yn cael eu cynnwys yn y trefniadau newydd

47. Ni chaiff y canlynol eu cynnwys yn y system feddal o optio allan o roi organau a meinweoedd yng Nghymru –

a) pobl sy'n marw yng Nghymru ond nad ydynt fel rheol yn byw yng Nghymru (er enghraifft ymwelwyr);
b) pobl sy'n marw yng Nghymru ac yn byw fel rheol yng Nghymru, ond heb fyw yno am y cyfnod o amser sy'n ofynnol;
c) pobl sydd fel arfer yn byw yng Nghymru, ond sy'n marw y tu allan i Gymru;
d) pobl nad oes modd eu hadnabod ar ôl iddynt farw;
e) oedolion (18 oed a throsodd) nad oes ganddynt y galluedd i ddeall a gwneud penderfyniad ynghylch gwrthwynebu rhoi;
f) plant a phobl ifanc o dan 18 oed.

Gweithredu'r system feddal o optio allan yng Nghymru

48. Bydd Llywodraeth Cymru yn sicrhau y bydd yna system gadarn a diogel i unigolion allu gwrthwynebu rhoi rhai neu'r cyfan o organau neu feinweoedd unigolyn. Bydd y system hefyd yn sicrhau bod unrhyw wrthwynebiad gan unigolyn i roi ei organau a/neu ei feinweoedd yn cael ei barchu ar ôl ei farwolaeth.

49. Bydd y system feddal o optio allan yn galluogi unigolion i newid eu meddwl, gan dynnu eu gwrthwynebiad yn ôl er enghraifft, yn ogystal â chynnwys pobl sy'n symud i Gymru neu sy'n cyrraedd 18 oed.

Parhau â'r Gofrestr Rhoddwyr Organau gyfredol ar gyfer pobl Cymru

50. Cronfa ddata gyfrinachol, gyfrifiadurol yw'r Gofrestr Rhoddwyr Organau (y Gofrestr), sy'n cadw manylion y bobl hynny sydd wedi ymrwymo i roi eu horganau a'u meinweoedd ar ôl iddynt farw. Defnyddir y Gofrestr wedi i berson farw i ganfod a oedd yn dymuno rhoi ei organau a'i feinweoedd ac, os oedd, pa rai.

51. Mae Llywodraeth Cymru wedi ystyried yn ofalus a fydd y Gofrestr gyfredol yn parhau i fod yn berthnasol yng Nghymru wedi i'r ddeddfwriaeth newydd ddod i rym. Cydnabyddir gwerth a phwysigrwydd y Gofrestr gyfredol, a'r ymrwymiad gan unigolion wrth ymuno â'r Gofrestr. Am y rhesymau hynny, bydd Llywodraeth Cymru yn sicrhau y bydd unigolion sy'n byw yng Nghymru yn gallu parhau i ddefnyddio'r Gofrestr.

52. Bydd cadw'r Gofrestr ar gyfer yr unigolion hynny sy'n byw yng Nghymru sy'n dymuno ei defnyddio, ynghyd â'r system feddal newydd o optio allan, yn cynnig manteision i unigolion –

a) y gallu i gofnodi dymuniadau rhag ofn i'r unigolyn farw y tu allan i Gymru, lle na fydd y system feddal o optio allan yn berthnasol;

b) y gallu i gofnodi dymuniadau unigolyn os nad yw'n rhan o'r system feddal o optio allan yng Nghymru hyd yma, er enghraifft am ei fod wedi symud i Gymru yn ddiweddar neu am ei fod o dan 18 oed;

c) gan y bydd organau a meinweoedd yn cael eu derbyn gan bobl ledled y Deyrnas Unedig, waeth ble y cânt eu rhoi, bydd cadw'r Gofrestr ar y cyd â'r system feddal o optio allan yn golygu y bydd mwy o organau a meinweoedd ar gael i'r bobl hynny sydd eu hangen. Bydd hyn yn gwella iechyd ac ansawdd bywyd pobl sydd angen trawsblaniad.

Cadw cofnodion

53. Gwaed a Thrawsblaniadau'r GIG (Awdurdod Iechyd Arbennig ar gyfer Cymru a Lloegr) sy'n cynnal a chadw'r Gofrestr gyfredol. Er bod Llywodraeth Cymru yn ymrwymedig i gadw'r Gofrestr (fel y nodir uchod), rydym yn cydnabod nad yw hi ar hyn o bryd yn gofnod o'r holl bobl a fyddai'n fodlon rhoi eu horganau. Yn y flwyddyn ddiwethaf yn unig, nid oedd ychydig dros 67 y cant o'r rhoddwyr yn y Deyrnas Unedig ar y Gofrestr.

54. Nid yw chwaith yn gofnod o'r bobl hynny nad ydynt yn dymuno rhoi eu horganau – yn wir, ar hyn o bryd nid oes unrhyw drefn ffurfiol i bobl sy'n teimlo'n gryf yn erbyn rhoi eu horganau allu cofrestru eu gwrthwynebiad. Heb drefn o'r fath, mae'n amhosibl bod yn siŵr bod barn yr unigolyn yn cael ei pharchu ar ôl ei farwolaeth.

55. Am y rhesymau hyn, ni all Llywodraeth Cymru ddefnyddio'r Gofrestr gyfredol, ar ei ffurf bresennol, i ddarparu system feddal o optio allan sy'n ddiogel ac yn effeithiol.

56. Mae Llywodraeth Cymru felly wedi ystyried nifer o opsiynau cadw cofnodion, i gydredeg â'r Gofrestr bresennol, a fydd yn sicrhau y caiff barn unigolyn ei pharchu ar ôl ei farwolaeth. Mae'r rhain yn cynnwys –

a) Opsiwn A – cofrestr i Gymru o'r bobl sydd heb wrthwynebu, a chofrestr o'r bobl sydd wedi gwrthwynebu;

b) Opsiwn B – cofrestr i Gymru yn cynnwys dim ond y bobl sydd heb wrthwynebu;

c) Opsiwn C – cofrestr i Gymru yn cynnwys dim ond ond y bobl sydd wedi gwrthwynebu;

d) Opsiwn D – dim cofrestr(au), ond cofnod o wrthwynebiad yn cael ei roi i feddyg teulu'r person, a'i gadw yno.

57. Ar wahân i opsiwn D, sy'n dibynnu ar gofnod meddyg teulu, mae'n rhaid cadw cofrestr. Mae hyn yn dangos y byddai angen cadw cofrestr ganolog ddiogel a chyfrinachol, y gallai clinigwyr gael gafael arni ar ôl marwolaeth y person.

58. Mae Llywodraeth Cymru yn cydnabod bod yn rhaid i'r system gofnodion a ddefnyddir i weithredu system feddal o optio allan yng Nghymru integreiddio â threfniadau rhoi organau a meinweoedd y DU, a chydweddu â hwy. Gallai trefniadau o'r fath gynnwys addasu'r Gofrestr gyfredol er mwyn ymdrin â'r system feddal o optio allan yng Nghymru.

59. Caiff yr ystyriaethau ymarferol sy'n gysylltiedig â dal a chynnal unrhyw gofrestr ganolog eu hystyried yng ngoleuni'r ymatebion i'r Papur Gwyn hwn.

Sut i wrthwynebu rhoi organau a meinweoedd

60. O ran yr union ddull(iau) gwrthwynebu, bydd yn dibynnu a gaiff cofrestr ei chadw, ac os felly pa fath o gofrestr (neu gofrestrau). Beth bynnag fydd yn digwydd, bydd Llywodraeth Cymru yn sicrhau bod unrhyw ddulliau a gyflwynir yn galluogi unigolyn i wrthwynebu rhoi organau a meinweoedd mewn dull cyfrinachol, hwylus a hygyrch.

61. O dan y trefniadau cyfredol gall unigolyn gofrestru ei fwriadau i roi ei holl organau a'i feinweoedd neu ddethol organau neu feinweoedd penodol. Mae Llywodraeth Cymru yn deall y gallai unigolion fod yn hapus i roi rhai o'u horganau a'u meinweoedd, ond nid y cyfan.

62. Bydd y trefniadau ar gyfer y system feddal o optio allan yng Nghymru yn galluogi unigolyn i optio allan o roi unrhyw organau neu feinweoedd, neu i optio allan o roi rhai organau neu feinweoedd.

Cadw'r system feddal o optio allan yn gyfredol

63. Bydd gofyn i'r system feddal o optio allan fod yn ddigon hyblyg i allu ymdopi â newidiadau wedi i'r prif drefniadau newydd gael eu cyflwyno. Bydd newidiadau o'r fath yn cynnwys –

a) unigolyn sy'n newid ei feddwl, er enghraifft rhywun oedd yn gwrthwynebu o'r blaen ond sydd erbyn hyn yn dymuno bod yn rhoddwr;

b) pobl sy'n symud i Gymru neu oddi yno;

c) pobl ifanc sy'n cyrraedd 18 oed.

64. Mae Llywodraeth Cymru yn deall y bydd yn rhaid i'r system feddal o optio allan y bydd yn ei chyflwyno gydnabod a galluogi'r newidiadau hyn, er mwyn sicrhau y bydd dewisiadau unigolion yn cael eu parchu a'u dilyn ar ôl iddynt farw.

65. Bydd y penderfyniad ynghylch cadw cofrestr ai peidio, ac os felly pa fath o gofrestr (neu gofrestrau) a gedwir, yn dylanwadu ar yr ystyriaethau gweithredol pwysig hyn.

Y diogelwch a ddarperir gan rôl y teulu

66. Ar hyn o bryd, pan fydd rhoi organau yn cael ei ystyried, bydd clinigwyr yn edrych i ddechrau ar y Gofrestr i weld a oedd unigolyn wedi nodi ei fod yn dymuno rhoi ei organau. P'un a yw unigolyn ar y Gofrestr neu beidio, bydd y clinigwyr yn siarad ag aelodau'r teulu er mwyn gweld beth oedd dymuniadau a barn y sawl a fu farw ynghylch rhoi organau a meinweoedd. Mae hyn yn sicrhau eu bod yn deall unrhyw dystiolaeth gan deulu'r unigolyn ynghylch ei ddymuniadau diweddar.

67. O dan Ddeddf Meinweoedd Dynol 2004 (y Ddeddf), a'r Codau Ymarfer cysylltiedig, mae'r clinigwyr yn trafod â'r perthnasau yn y drefn ganlynol:

- priod neu bartner;
- rhiant neu blentyn;
- brawd neu chwaer;
- nain/taid neu ŵyr/wyres;
- nith neu nai;
- llystad neu lysfam;
- hanner brawd neu hanner chwaer;
- cyfaill ers amser maith.

68. O dan y Ddeddf, rhoddir y lle blaenaf i ddymuniadau'r sawl a fu farw, ac ni fydd Llywodraeth Cymru yn gwyro oddi wrth yr egwyddor bwysig hon o dan y ddeddfwriaeth newydd. Yn wir, bydd y system feddal o optio allan yn cynnig mwy o eglurder ar safbwyntiau'r unigolyn, gan na ellir cofnodi gwrthwynebiad o fewn y system bresennol.

69. Mae'r Codau Ymarfer ar hyn o bryd yn cynghori gweithwyr iechyd proffesiynol i annog y perthnasau, mewn ffordd sensitif, i dderbyn dymuniadau'r sawl a fu farw, gan egluro hefyd nad oes gan y perthnasau yr hawl i wrthdroi'r dymuniadau hynny.

70. Mae Llywodraeth Cymru wedi ymrwymo i system feddal o optio allan o roi organau a meinweoedd lle bydd safbwyntiau perthnasau yn cael eu hystyried. Bydd parhau i gynnwys perthnasau yn y ffordd hon yn cyflawni nifer o amcanion –

a) mae'n ddull diogelu pwysig: mae'n bosibl bod teuluoedd yn ymwybodol o wrthwynebiad sydd heb ei gofrestru;
b) mae'n cydnabod dyletswydd gofal y meddyg at y perthnasau i leddfu yn hytrach na gwaethygu eu gofid a'u profedigaeth;
c) gall manylion gan y teulu ynghylch hanes meddygol ac ymddygiadol y claf chwarae rhan bwysig yn llwyddiant y trawsblaniad.

71. O dan system feddal o optio allan o roi organau a meinweoedd, ar y cyd â rhaglen ymwybyddiaeth gyhoeddus helaeth, mae unigolion yn llawer mwy tebygol o fod wedi trafod eu safbwyntiau â'u teuluoedd ac wedi mynegi eu barn yn glir cyn eu marwolaeth.

72. Mae Llywodraeth Cymru yn cydnabod pwysigrwydd rôl y teulu mewn system feddal o optio allan. Bydd dymuniadau'r teulu yn cael eu parchu, ac er mwyn diogelu'r dymuniadau hynny mae'n hanfodol fod y teulu'n rhan o'r broses. Hoffem gael eich barn ynglŷn â rôl y teulu wrth ichi ymateb i'r Papur Gwyn hwn.

73. Fe fydd yna ymgynghori â pherthnasau o hyd, ond bydd yn lleddfu'r baich o wneud penderfyniad ar adeg mor anodd, os nad oes yna unrhyw arwydd o ddymuniadau'r sawl a fu farw.

Beth na fydd yn newid yn sgil y system feddal o optio allan

74. Dim ond deddfwriaeth yn ymwneud â Chymru y gall Llywodraeth Cymru ei chynnig, felly dim ond i Gymru y bydd y system feddal o optio allan yn berthnasol.

75. Amcan polisi Llywodraeth Cymru o ran y cynigion hyn yw –

a) na fyddant yn newid y ffordd o ofalu am gleifion (gan gynnwys y driniaeth feddygol a roddir iddynt) hyd at, a chan gynnwys, adeg eu marwolaeth;

b) na fyddant yn newid y ffordd y caiff y farwolaeth ei chadarnhau – mae yna safonau a gweithdrefnau clir a chaeth iawn ynghylch cadarnhau marwolaeth;

c) na fyddant yn cynnwys organau a meinweoedd gan roddwyr byw (sef trawsblannu organ neu feinwe o roddwr byw – sy'n aml yn gyfaill neu'n aelod o'r teulu – i dderbynnydd);

d) na fyddant yn newid y ffordd y bydd Gwaed a Thrawsblaniadau'r GIG yn dyrannu organau a meinweoedd;

e) na fyddant yn newid y penderfyniadau clinigol ynghylch trawsblaniadau, a'r prosesau sy'n gysylltiedig â hynny;

f) na fyddant yn caniatáu i organau a meinweoedd a roddir fod ar gael at unrhyw ddibenion heblaw trawsblannu. Ni fydd y system newydd yn golygu y caiff organau a meinweoedd a roddir eu defnyddio at ddibenion megis ymchwil ac arddangos neu i'w defnyddio'n fasnachol;

g) na fyddant yn atal unigolion rhag ymuno â'r Gofrestr Rhoddwyr Organau gyfredol.

76. O dan y system feddal o optio allan a gynigir ar gyfer Cymru, byddai hawl i dynnu a defnyddio organau a meinweoedd onibai fod y sawl a fu farw wedi gwrthwynebu hynny yn ystod ei oes. Bydd mecanwaith ffurfiol ar gael i unigolion allu cofrestru'r gwrthwynebiad hwnnw. Ar ôl i rywun farw, bydd ei berthnasau'n cael eu cynnwys yn broses o benderfynu ynglŷn â rhoi.

77. Bydd system o'r fath yn gwella'r modd y gall unigolion yng Nghymru fynegi eu dymuniadau o ran rhoi, ac yn cryfhau sefyllfa'r rhai hynny nad ydynt yn dymuno rhoi, ond gan sicrhau hefyd y bydd mwy o organau a meinweoedd ar gael i'r rheini fydd eu hangen.

GWEITHREDU'R DDEDDFWRIAETH ARFAETHEDIG

Asesu'r effaith

Asesu'r effaith ar gydraddoldeb

78. Mae Llywodraeth Cymru wedi ymrwymo i sicrhau bod pob ymdrech yn cael ei gwneud, wrth i bolisïau, strategaethau, cynlluniau gweithredu a deddfwriaeth gael eu datblygu, i gyfrannu at greu amgylchedd nad yw'n gwahaniaethu. Mae rhan o hyn yn ymwneud ag asesu'r effaith y gallai polisïau a chamau gweithredu ei chael ar bobl Cymru, er mwyn sicrhau nad yw Llywodraeth Cymru yn gwahaniaethu ond yn hytrach yn achub ar bob cyfle i hyrwyddo cydraddoldeb a chydberthnasau da.

79. Mae'r polisi yn y Papur Gwyn hwn wedi derbyn asesiad sgrinio cychwynnol am gydraddoldeb yn unol ag arferion Llunio Polisi Cynhwysol Llywodraeth Cymru. Casgliadau'r asesiad cychwynnol hwn oedd –

a) bod y polisi'n berthnasol iawn mewn perthynas â hil, ffydd a hawliau dynol;

b) perthnasedd canolig o ran anabledd ag oedran;

c) dim tystiolaeth o effaith benodol y polisi o ran cyfeiriadedd rhywiol, priodas a phartneriaeth sifil, na rhywedd neu ailbennu rhywedd.

80. Yn ystod y broses asesu gychwynnol, nodwyd bod cleifion o'r un grŵp ethnig yn fwy tebygol o gydweddu'n agos yng nghyd-destun rhoi organau.

81. Mae pobl o darddiad Asiaidd neu Affricanaidd-Caribïaidd dair i bedair gwaith yn fwy tebygol na phobl wyn o ddatblygu camau terfynol methiant yr arennau sy'n golygu bod angen trawsblaniad arennau arnynt. Yn ôl data Gwaed a Thrawsblaniadau'r GIG mae 23 y cant o'r rhai sydd ar y rhestr aros i dderbyn arennau yn perthyn i'r grwpiau ethnig Asiaidd neu Affricanaidd-Caribïaidd, er mai dim ond 8 y cant o'r boblogaeth sy'n perthyn i'r grwpiau hyn (ar sail ffigurau Cyfrifiad 2001). Dim ond 3 y cant o roddwyr a fu farw sydd o darddiad Asiaidd neu Affricanaidd-Caribïaidd.

82. Bydd Llywodraeth Cymru yn ceisio, drwy'r broses ymgynghori ar y Papur Gwyn hwn, cael trafodaethau penodol â chymunedau pobl dduon a lleiafrifoedd ethnig a grwpiau ffydd.

83. Bydd Llywodraeth Cymru yn datblygu ac yn cyhoeddi Asesiad manwl o'r Effaith ar Gydraddoldeb fel rhan o'r broses o gyflwyno deddfwriaeth yn y dyfodol. Gwahoddir y rhai yr ymgynghorir â hwy i roi eu sylwadau ar effaith y polisi ar feysydd cydraddoldeb:

a) anabledd;

b) hil;

c) rhywedd ac ailbennu rhywedd;

d) oedran;

e) crefydd a chred ac anffyddiaeth;

f) cyfeiriadedd rhywiol; ac

g) hawliau dynol.

Asesu'r effaith ar breifatrwydd

84. Bydd asesiad o'r effaith ar breifatrwydd yn asesu goblygiadau, o ran preifatrwydd, unrhyw weithgareddau sy'n defnyddio (neu'n newid y modd y defnyddir) data personol fel y'u diffinnir gan Ddeddf Diogelu Data 1998.

85. Yn dilyn yr ymgynghoriad ar y Papur Gwyn hwn, cynhelir proses sgrinio gychwynnol o dan yr asesiad o'r effaith ar breifatrwydd, i ystyried y goblygiadau o ran preifatrwydd sy'n gysylltiedig â gwneud a chofnodi unrhyw wrthwynebiad o dan y system feddal o optio allan.

Asesiad Effaith Rheoleiddiol

86. Pan gaiff y ddeddfwriaeth arfaethedig ei gosod gerbron Cynulliad Cenedlaethol Cymru, bydd Llywodraeth Cymru yn darparu Memorandwm Esboniadol a fydd yn cynnwys Asesiad Effaith Rheoleiddiol.

87. Bydd yr Asesiad hwn yn amlinellu'r costau a'r manteision sy'n gysylltiedig â chwrdd ag amcanion strategol y Bil arfaethedig, sef sicrhau bod cymaint â phosibl o gleifion yng Nghymru yn rhoi eu horganau a'u meinweoedd.

88. Wrth gyfrifo'r costau, bydd yr Asesiad Effaith Rheoleiddiol yn ceisio pennu:

a) pwy fydd yn ysgwyddo unrhyw gostau;

b) unrhyw gostau untro (er enghraifft, creu cofrestr neu ymgyrchoedd ymwybyddiaeth cychwynnol ar gyfer y cyhoedd);

c) unrhyw gostau rheolaidd (er enghraifft y costau sy'n gysylltiedig â rhedeg cofrestr, neu raglenni cyfathrebu parhaus); a

d) unrhyw gostau eraill.

89. Datblygwyd amcangyfrif cychwynnol o'r costau fel rhan o'r broses o baratoi'r Papur Gwyn hwn. Yn ôl yr amcangyfrif cychwynnol hwn, bydd gofyn gwario £2.85m ar hyfforddi a chyfathrebu cyn gweithredu'r system.

90. Bydd gofyn gwneud mwy o waith i fireinio'r costau gweithredol rheolaidd fydd yn gysylltiedig â'r system, gan gynnwys unrhyw gofrestrau a systemau cadw cofnodion.

Amserlen

91. Dogfen ymgynghori yw'r Papur Gwyn hwn ac mae Llywodraeth Cymru yn gwahodd sylwadau ar y cynigion erbyn **31 Ionawr 2012.**

92. Ar ôl ystyried yr ymatebion i'r ymgynghoriad, bydd Llywodraeth Cymru yn llunio Bil ac yn ei gyflwyno yng Nghynulliad Cenedlaethol Cymru yn ystod 2012/13.

93. Ar hyn o bryd, disgwylir y byddai yna gyfnod paratoi rhwng creu'r ddeddfwriaeth a gweithredu'r system feddal o optio allan. Byddai cyfnod o'r fath yn caniatáu amser i sefydlu'r mecanweithiau a'r systemau gweithredu priodol, ac i gynnal ymgyrch ymwybyddiaeth gyhoeddus sylweddol.

94. Mae'n debygol mai dwy flynedd fyddai'r cyfnod hwn, felly ni fydd y system feddal o optio allan ar waith yng Nghymru tan o leiaf 2015. Rhoddir rhagor o fanylion am y rhaglen weithredu ym Memorandwm Esboniadol ac Asesiad Effaith Rheoleiddiol y Bil pan gaiff ei gyflwyno.

Darpariaeth ynghylch y Gymraeg

95. Bydd y system feddal o optio allan yn cydymffurfio â gofynion Deddf yr Iaith Gymraeg 1993, ac unrhyw ddarpariaethau perthnasol ym Mesur y Gymraeg (Cymru) 2011 a fydd mewn grym ar y pryd.

Ymgyrch ymwybyddiaeth gyhoeddus

96. Mae'r Papur Gwyn hwn wedi nodi pa mor angenrheidiol a phwysig yw cynnal ymgyrch fawr i godi ymwybyddiaeth y cyhoedd cyn i'r system feddal newydd o optio allan gael ei chyflwyno. Rhoddir manylion llawnach am ymgyrch o'r fath yn y Memorandwm Esboniadol a'r Asesiad Effaith Rheoleiddiol ond mae'r cynigion cynnar yn cynnwys –

- gweithgarwch oddi allan i'r cartref (ee hysbysfyrddau);
- gweithgarwch helaeth ar y teledu, y radio, y wasg ac ar-lein;
- gweithgarwch cymunedol;
- trafod â rhanddeiliaid; ac
- argraffu a dosbarthu taflen ddwyieithog i bob aelwyd yng Nghymru (gyda chopïau atodol ar gyfer lleoliadau megis meddygfeydd).

97. Bydd yr ymgyrch gyhoeddusrwydd yn un helaeth o ran defnyddio gwahanol gyfryngau, a hefyd o ran ei hyd (cyn ac ar ôl i'r ddeddfwriaeth ddod i rym) er mwyn sicrhau bod pawb sy'n dymuno optio allan yn gwybod sut i wneud hynny.

CWESTIYNAU'R YMGYNGHORIAD

Fel rhan o'r broses ymgynghori mae Llywodraeth Cymru yn gofyn am ymatebion ar agweddau penodol ar y cynigion polisi, ond mae croeso i ymatebwyr roi tystiolaeth a sylwadau ychwanegol ar y cynnig yn ei gyfanrwydd.

Pobl a gaiff eu cynnwys yn y system feddal o optio allan

1. Mae'r Papur Gwyn yn nodi y dylai unigolion fod wedi byw yng Nghymru am gyfnod digonol o amser cyn cael eu cynnwys yn y system feddal o optio allan.

    a) Pa ffactorau ddylid eu hystyried wrth benderfynu a yw unigolyn yn 'byw yng Nghymru'?

    b) Beth ddylai'r cyfnod o amser fod?

2. Ydych chi'n cytuno y bydd trafodaethau rhwng clinigwyr a'r teulu, ar ôl marwolaeth unigolyn, yn nodi ac yn diogelu'r rhai heb alluedd?

3. Ydych chi'n cytuno y dylai'r system feddal o optio allan ar gyfer Cymru fod yn berthnasol i bobl sy'n 18 oed ac yn hŷn yn unig? Os nad ydych chi, pam hynny?

Gweithredu'r system feddal o optio allan yng Nghymru

4. Ydych chi'n cytuno y dylai'r Gofrestr Rhoddwyr Organau gyfredol barhau ar y cyd â'r system feddal o optio allan?

5. O ran yr opsiynau cadw cofnodion ar gyfer y system feddal o optio allan –

    a) Pa un o'r opsiynau ydych chi'n ei ffafrio? (Gweler paragraff 56 o'r Papur Gwyn.)

    b) Yn eich barn chi, oes yna unrhyw opsiynau eraill fyddai'n sicrhau system effeithiol a diogel?

6. Pa rôl ddylai'r teulu ei chael o ran diogelu dymuniadau'r sawl a fu farw?

Gweithredu

7. Sut gall Llywodraeth Cymru sicrhau bod yr ymgyrch gyhoeddusrwydd yn effeithiol?

8. Byddai Llywodraeth Cymru yn croesawu eich sylwadau ar effeithiau posibl y system feddal arfaethedig o optio allan ar y Gymraeg, hil, ffydd, anabledd, oedran, cyfeiriadedd rhywiol, rhywedd, ailbennu rhywedd, priodas neu bartneriaeth sifil.

9. Mae Llywodraeth Cymru wedi gofyn nifer o gwestiynau penodol. Os oes gennych chi sylwadau ar unrhyw faterion eraill sydd heb eu trafod yn benodol, mae croeso ichi eu cofnodi yma.

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:	**Ystafell Bwyllgora 1 – Y Senedd**
Dyddiad:	**Dydd Mercher, 16 Tachwedd 2011**
Amser:	**09:30 – 11:45**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Gellir gwylio'r cyfarfod ar Senedd TV yn:
http://www.senedd.tv/archiveplayer.jsf?v=cy_200000_16_11_2011&t=0&l=cy

Cofnodion Cryno:

Aelodau'r Cynulliad:	**Mark Drakeford (Cadeirydd)** **Mick Antoniw** **Rebecca Evans** **Vaughan Gething** **William Graham** **Elin Jones** **Lindsay Whittle** **Kirsty Williams**
Tystion:	**Lisa Turnbull, Coleg Nyrsio Brenhinol Cymru** **Sue Thomas, Coleg Nyrsio Brenhinol Cymru** **Melanie Gadd, Y Gymdeithas Cynllunio Teulu** **Jason Harding, Diabetes UK Cymru**
Staff y Pwyllgor:	**Llinos Dafydd (Clerc)** **Naomi Stocks (Clerc)** **Mike Lewis (Dirprwy Glerc)** **Stephen Boyce (Ymchwilydd)** **Victoria Paris (Ymchwilydd)**

1. Cyflwyniad, ymddiheuriadau a dirprwyon

1.1 Cafwyd ymddiheuriadau gan Darren Millar a Lynne Neagle. Nid oedd neb yn dirprwyo.

2. Ymchwiliad i'r cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru – tystiolaeth gan Goleg Nyrsio Brenhinol Cymru

2.1 Bu'r tystion yn ateb cwestiynau gan aelodau'r Pwyllgor ynghylch y cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru.

2.2 Cytunodd y tystion i ddarparu gwybodaeth ychwanegol am y modelau a ddefnyddir i ddarparu gofal iechyd sylfaenol yn Lloegr.

3. Ymchwiliad i'r cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru – tystiolaeth gan Diabetes UK Cymru a'r Gymdeithas Cynllunio Teulu

3.1 Bu'r tystion yn ateb cwestiynau gan aelodau'r Pwyllgor ynghylch y cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru.

3.2 Cytunodd y Gymdeithas Cynllunio Teulu i ddarparu'r canlynol:

- Ffigurau ar nifer y fferyllfeydd yng Nghymru sy'n cymryd rhan yn y cynllun atal cenhedlu hormonaidd brys (EHC); a
- Rhagor o fanylion ynghylch a oes amrywiaeth ledled Cymru yng ngallu'r rhwydwaith fferyllfeydd cymunedol i ddarparu gwasanaethau EHC.

3.3 Gofynnodd y Pwyllgor am nodyn gan ei ysgrifenyddiaeth sy'n archwilio i ba raddau mae trefniadau ar waith i fferyllwyr drosglwyddo'u hyfforddiant a'u cymwysterau ar draws ffiniau byrddau iechyd lleol gwahanol a rhwng Cymru a Lloegr.

4. Papurau i'w nodi

4.1 Nododd y Pwyllgor y llythyr gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol a'r Dirprwy Weinidog Plant a Gwasanaethu Cymdeithasol yn cynnwys y wybodaeth ychwanegol am gyllideb ddrafft 2012-13. Cytunodd y Pwyllgor i ysgrifennu at y Gweinidog i ofyn am gadarnhad o'r union ffigur a ddefnyddiwyd gan y Llywodraeth, wrth gyfrifo'r gyllideb, i adlewyrchu'r chwyddiant ym maes iechyd.

5. Cynnig o dan Reol Sefydlog 17.24(vi) i benderfynu gwahardd y cyhoedd o'r cyfarfod ar gyfer eitem 6

5.1 Cytunodd y Pwyllgor ar y cynnig i wahardd y cyhoedd o'r cyfarfod ar gyfer eitem 6 yn unol â Rheol Sefydlog 17.42(vi).

6. Ymchwiliad i leihau'r risg o strôc – trafodaeth breifat am y prif faterion

6.1 Trafododd y Pwyllgor brif negeseuon ac argymhellion yr ymchwiliad i leihau'r risg o strôc.

TRAWSGRIFIAD

Trawsgrifiad o'r cyfarfod.

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:	**Ystafell Bwyllgora 3 – Y Senedd**
Dyddiad:	**Dydd Iau, 24 Tachwedd 2011**
Amser:	**09:30 – 11:15**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Gellir gwylio'r cyfarfod ar Senedd TV yn:
http://www.senedd.tv/archiveplayer.jsf?v=cy_400000_24_11_2011&t=0&l=cy

Cofnodion Cryno:

Aelodau'r Cynulliad:	**Mark Drakeford (Cadeirydd)** **Mick Antoniw** **Rebecca Evans** **Vaughan Gething** **William Graham** **Elin Jones** **Lynne Neagle** **Lindsay Whittle** **Kirsty Williams**
Tystion:	**Elspeth Weir, Fferyllfeydd Cymunedol yr Alban** **Malcolm Clubb, Fferyllfeydd Cymunedol yr Alban** **Alex MacKinnon, Y Gymdeithas Fferyllol Frenhinol**
Staff y Pwyllgor:	**Llinos Dafydd (Clerc)** **Catherine Hunt (Dirprwy Glerc)** **Stephen Boyce (Ymchwilydd)**

1. Cyflwyniad, ymddiheuriadau a dirprwyon

1.1 Cafwyd ymddiheuriadau gan Darren Millar. Nid oedd dim dirprwyon.

2. Ymchwiliad i'r cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru – Tystiolaeth gan Fferyllfeydd Cymunedol yr Alban a Chymdeithas Fferyllol Frenhinol yr Alban

2.1 Ymatebodd y tystion i gwestiynau gan Aelodau'r Pwyllgor ar y cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd.

2.2 Cytunodd tystion o Fferyllfeydd Cymunedol yr Alban ddarparu:

- copi o adroddiad gan Lywodraeth yr Alban ar ei adolygiad o wasanaeth iechyd cyhoeddus y fferyllfeydd cymunedol ar gyfer rhoi'r gorau i ysmygu a dulliau brys o atal cenhedlu hormonaidd;
- linc i adroddiad gan Brifysgol Manceinion ar y newid mewn dulliau ymgynghori â chleifion mewn gofal sylfaenol a oedd yn archwilio i nifer y bobl yn yr Alban a ddefnyddiodd y Gwasanaeth Mân Anafiadau yn yr Alban.

3. Deiseb ar y Ddarpariaeth o Doiledau Cyhoeddus yng Nghymru – Ystyried dull y Pwyllgor Iechyd a Gofal Cyndeithasol o weithredu

3.1 Ystyriodd y Pwyllgor y papur ar ei ddull o weithredu mewn cysylltiad â'r ddarpariaeth o doiledau cyhoeddus yng Nghymru. Cytunodd y Pwyllgor y dylai ei waith ganolbwyntio ar y diffyg darpariaeth toiledau cyhoeddus ac effaith hyn ar iechyd y cyhoedd, ac y dylai'r ymgynghoriad cyhoeddus ddod i ben ar 23 Rhagfyr 2011.

3.2 Cytunodd y Pwyllgor i ychwanegu sefydliadau ychwanegol at y rhestr ymgynghori arfaethedig.

4. Papurau i'w nodi

4.1 Nododd y Pwyllgor gofnodion y cyfarfod a gynhaliwyd ar 10 Tachwedd.

4.1 Ymchwiliad i'r cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru – Tystiolaeth ychwanegol gan Fferylliaeth Gymunedol Cymru

4.2 Nododd y Pwyllgor y dystiolaeth ychwanegol gan Fferylliaeth Gymunedol Cymru.

5. Cynnig o dan Reol Sefydlog 17.24(vi) i benderfynu gwahardd y cyhoedd o'r cyfarfod ar gyfer eitem 6

5.1 Cymeradwyodd y Pwyllgor y cynnig o dan Reol Sefydlog 17.42(vi) i benderfynu gwahardd y cyhoedd o'r cyfarfod ar gyfer eitem 6.

6. Ymchwiliad i'r cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru – Trafodaeth breifat am y materion sy'n codi

6.1 Ystyriodd y Pwyllgor y materion sy'n codi o'i ymchwyliad i'r cyfraniad a wneir gan fferyllfeydd cymuneol i wasanaethau iechyd yng Nghymru.

TRAWSGRIFIAD

Gweld trawsgrifiad o'r cyfarfod.

Health and Social Care Committee

HSC(4)-13-11 paper 4

Inquiry into the contribution of community pharmacy to health services in Wales – Additional information from BMA Cymru Wales

In response to your email regarding the additional information arising from the Committee meeting which took place on 2nd November please find below responses to the points you highlighted.

1. **Dispensing practices:**

The BMA's written evidence states that dispensing can provide a sizeable proportion of a practice's resources. Please could the panel provide further detail about:

- **How much resource it provides for dispensing practices and what is meant by "sizeable proportion"?**

Without having the information from each dispensing practice we are not in a position to provide exact figures, we can only interpret the experience of our dispensing members which is that removal of dispensing income would compromise other services. However for a national perspective, the NHS Wales Business Service Centre and individual Health Boards are responsible for paying practices and no doubt they will keep a record of how much they spend. This applies to both dispensing payments and GMS funding.

As an illustrative example, from Dr Philip Whites Practice in North Wales:

There are 3.8 (WTE) GP partners working over two sites straddling the Menai Straits, the practice list stands at 5,500 patients. That's a ratio of 1447 patients per GP (WTE). The Practice provides full GMS and enhanced services - including minor surgery and IUCD's – they also teach students and have previously been a training practice.

The Practice dispensary is located in Felinheli (the previous pharmacist died suddenly 30 years ago and nobody came forward to take over because the potential for non-NHS turnover is too low to make it attractive) from where they dispense to about 2,000 patients.

Last year their gross dispensing profit was £136,217. Of this they paid dispensary staff wages of £63,659 and £72,558 funded a GP. Loss of dispensing would lead to 3.5 (WTE) staff redundancies and the reduction of GP numbers to 2.8 (WTE) and a subsequent reduction in GMS and enhanced services. It would also change the ratio of patients to 1964 per GP (WTE).

The average GP (WTE) salary in this practice is £90,700 (UK average £100,400, £109,400 in England, £93,500 in Wales NHS Information Centre GP Earnings and Expenses 2009/10 (Nov 2011)). Rather than look to make redundancies, if the loss of dispensing was offset by the current GPs agreeing to a salary cut it would equate

to a reduction in their income of over one third, taking them to a salary at half that of the UK average.

It is clear how much dispensing contributes to the delivery of wider GMS services in this practice and how its removal would make the continuation of this practice unviable without impacting on GMS.

In addition, though not directly related to pharmacy services, the practice is heavily dependant on the Correction Factor (over 30%) as are a very large number of Welsh rural practices. The deficit arises from such diverse causes as multiple sites and heavy investment in staff in the past. As the Correction Factor may be abolished in the future this would further destabilise rural Welsh practices leading to serious problems for HB's who would need to cover general medicine in these areas.

For a full picture of what a proportion of practice income dispensing provides the BSC and HBs are best placed to provide this, although colleagues from the DDA may equally have access to such information.

- **How many practices in Wales are dispensing?**

David Baker will be able to provide the most recent and accurate figure on the number of dispensing practices in Wales. We are informed that this stands at close to 90.

- **The Committee would also welcome a map outlining where dispensing practices are located in order to understand the current pattern of provision, particularly the relationship between dispensing practices and rural areas of Wales.**

As to locations – again, Health Boards as holders of the GMS contract will have the addresses of all the dispensing practices within their areas.

Enclosure 3: National Medicines Management Programme Board

Driver: Reduce Volume Intervention: Targeted MUR's

Situation

The MUR process attempts to establish a picture of the patient's use of their medicines - both prescribed and non-prescribed. The review will help patients understand their therapy and it will identify any problems they are experiencing along with possible solutions. A report of the review will be provided to the patient and to their GP where there is an issue for them to consider. It is hoped that this service will aid concordance with medicines and reduce wastage, it has also been suggested that MUR's may be used to reconcile medicines at discharge from hospital so that patient safety is improved. Health boards have been unable to direct MUR's at target group but have actively encouraged pharmacists to do so. Throughout ABHB "targeted" MUR's in the areas of discharge from hospital, NSAID prescribing and inhaler usage have been actively encouraged by the health board, the latter utilising the Local Pharmacy Practice Forum. A Chronic Conditions Bid around targeted MUR's was also successful and evaluated and this is described below.

Background

The Directed Medicines Use Reviews (MUR's) initiative actively targeted "high risk" patients for MUR utilising a pharmacist resource funded by the initiative. Key areas of **adherence, waste and clinical intervention** were recorded and outcomes if available. Pharmacists were given time to target patients which would not normally be singled out due to their complexity, this was appreciated greatly by the pharmacists involved. By targeting MUR's to discrete patient groups, more effective use was made of pharmacists' expertise in medicines management and more time was spent with patients who need support. A key area for improvement is for pharmacists to develop effective interaction with GP's in relation to MUR effects and outcomes.

The scheme was set up as a result of a Chronic Conditions Management Initiative. It aimed to allow effective integration of Community Pharmacist input into the pharmaceutical care of CCM patients by carrying out directed MUR's in patients at risk, for example:

- Patients with polypharmacy >6 items
- Patients > 75 years on > 4 items
- "Frequent Fliers" or patients recently discharged from hospital
- Housebound Patients
- Patients where wastage of medicines is identified
- Respiratory patients on inhalers

Some of these services are enhanced MUR's around Inhaler technique assessment, brown bag reviews (where patient brings all their medicines into the pharmacy for review) and domiciliary visits.

Community pharmacists were already providing this service, the key difference here was that the target groups were specified, fitting in with the CCM agenda (MUR's cannot be directed within the Community Pharmacy Contract – suitable patient types can only be "suggested" as targets). It was proposed, and accepted, to backfill

community pharmacist time to effe ctively direct and target MUR's to patients wit h complex medicines management needs. The re was an expected commit ment t o discuss MUR's with GP, record interventions and follow up outcomes in terms of medicines management issues.

Performance Monitoring

- Estimates of waste reduction – live intervention data with quantifiable data on actual cost savings due to reduction/cessation of excessive supply
- Impact of In terventions by pharmacist – co st and quality – live data collated by pharmacists
- Effect on readmission rates
- Improvement in Prescribing Performance Indicators/AOF targets

The above performance monitoring criteria were somewhat ambitious in terms of t he overall take up of the scheme, especially concerning readmissio n rates an d improvement in prescribing indicat or/AOF targ ets, however there were effective interventions which, if actioned, could effectively contribute to better patient care.

Assessment

Overall, the results are illustrated below. Ob viously some patients had multiple issues around concordance, waste and clinical problems with their medicines.

Total Number of patients	Average time of consultation in minutes	% of Domicillary Visits	% of patients with adherence issues	% of patients with medication waste	% of patients where a clinical intervention was made	% where no action made	% to follow up
270	25	19%	51%	22%	42%	48%	34%

The main themes arising from this small scheme were:

Adherence

In this high risk group of patients just over half of them had a dherence issues, this is in line with the estimated level of concordant behaviour demonstrated in the literature and emphasises the importance of medicines management interventions in patient s with chronic conditions. The following commen ts were an notated by pharmacists carrying out the reviews

"Patient prescribed Dosulepin 25mg last year but being used by patient on a "when required basis" for no apparent reason." – Dosulepin is an anti-depressant deemed less suitable for prescribing (AWMSG Indicator)

"Patient had stock of Lorsartan 50mg and 100mg and did not notice the difference in strength, therefore was taking either tablet instead of just the 100mg tablet" – This could lead to poor blood pressure control.

"Patient was told to stop taking a certain tablet by the hospital but is unsure which one. Has stopped taking Furosemide as a result" – This could lead to admission due to fluid retention.

"Patient not taking isosorbide mononitrate twice daily only taking in the morning" – This is an ineffective dose which could result in angina attack and possible admission

"Pain relief from maximum dosage of tablets not enough. Occasionally taking more than recommended dose of medication"

"Poor inhaler technique " No-one has ever shown me how to use one"- Could result in increased chance of hospital admission, this was a **recurring** theme

"Patients blood glucose monitor not functioning"- Could result in unsatisfactory Control of blood glucose and wastage of strips

"Patient unsure what a lot of her medication for"

"Patients medication out of sync and has to visit the surgery regularly to order medication"

"Patient unsure which inhalers to use when. Patient has been quite short of breath recently" -" Could result in increased chance of hospital admission

"Patient complained that she did not like taking simvastatin due to the fact that it makes her ache" - Could be changed to another statin with less side effects?

" The best intervention I had was a customer who had not taken their ramipril (for high blood pressure) for 6 months, ….. contacted GP who reviewed medication and called patient in for BP check"

"Patient expressed the wish that she would like to come off Priadel (Lithium)…. Advice given re. contact clinic, Lithium card given to patient"

Waste

Wasted medicines was also highlighted in 22% of patients, the MUR tool can be used to produce significant cost savings to the NHS – one intervention was to stop Singulair (a medicine for asthma) in a patient who was not taking it – this one intervention amounts to approximately £300 annualised savings). There was also an intervention where the combination inhaler Symbicort dose was reduced by two thirds after consultation with the GP which could amount to £700 savings in addition to any advantages in terms of safety.

One of the pharmacists carried out "Brown bag reviews", where patients were encouraged to bring all their medicines with them so that they could be reviewed. A significant proportion of these patients (33%) had excessive quantities of medicines in relation to their dosage, this excessive supply was estimated to be in the region of £1300. Patients were instructed not to order excessively at their next repeat prescription order and the practices were informed in some cases.

MUR's were often used to synchronise medicines so that excessive prescription requests, from patients to practices, were reduced.

Clinical Intervention

There were a number of clinical interventions which were accepted by Gp's and changes made to patients therapy, examples include

- Adcal D3 – dose changed from one tablet daily to the evidence based dose one tablet twice daily
- New HRT prescribed – Dixarit still on WP10 – referred to GP – Dixarit stopped (savings potential £100 per year)

- Seretide and Serevent on same script – referred – Serevent stopped (Savings potential £360 per year)
- Asthma patient at Step 1 with Ventolin only – poor control – referral to GP ? add steroid
- Patient referred to GP ? start statin – statin started
- Patient with inadequate supply of analgesics – GP review
- Gliclazide stopped in 75 year old patient on referral to GP via MUR
- Ipratropium and Tiotropium on regular repeat prescription – MUR referral to GP- Ipratropium stopped

Health Promotion
One pharmacist in particular used the MUR to get over important lifestyle information to the patients. This consisted of BP monitoring, Dietary advice, exercise referral and smoking cessation advice.

Summary

This small pilot shows that half of all patients who are offered MUR's, have no resultant actions arising from the intervention but are still provided with support from this service. 50% of patients in this study showed multiple problems ranging from adherence issues, to the necessity for clinical intervention by GP. Wastage of medicines is also highlighted by this intervention and this can be used to reduce the supply of unwanted medicines to patients.

There were subtle differences in the way each pharmacist carried out this intervention, with varying degrees of emphasis on adherence, wastage and health promotion intervention. However all pharmacists teased out significant interventions which could lead to poor control of chronic conditions. Many of these directed patients would not be obvious targets to the current MUR service provision, due to their complexity This CCM intervention allowed pharmacists the time to interact better with their complex patients and develop a professional client-centred service. Pharmacists taking part in the scheme felt that their relationships with patients improved as a direct result of having the opportunity to spend more time with customers, talking to them, and providing advice about the importance of medicine taking as just one facet of managing their illnesses.

Recommendations

- Developing closer links with GP's and working with them to improve patient care, by improving quality and usefulness of the MUR. This can be achieved with active targeting into disease areas that matter, integrated with medicines management strategies for the health board.

- Notifying pharmacies of patients who have recently been discharged from hospital could also be improved, although this is improving. IT development and sharing information with community pharmacists is again pivotal to this.
- Documentation of outcome of MUR needs to be improved and show-cased, to raise healthcare professionals' awareness of how effective this tool can be.

- "Brown bag" reviews and domiciliary visits to hard to reach patients can highlight significant medicine usage interventions that can improve patient

care and improve efficiency in resource utilisation. A fee structure around this and effective advertising and referral pathways will aid development.

This project does show that there is room to cement the MUR in the care of patients with chronic conditions. There is much work to do with both the public and GP's to improve the outcomes from MUR's and raise their profile as an important intervention. However, there were significant interventions demonstrated within this small study which gave pharmacists a real chance to target the patients that matter.

ALL AREA COMMITTEES

REPORT

SUBJECT:	REPORT ON THE PHARMACY SERVICES REVIEW 2009
REPORT OF:	STRATEGY AND COMMISSIONING OFFICER AND PUBLIC INVOLVEMENT OFFICER
STATUS:	FOR DECISION
CONTACT:	LINDA TAYLOR / DAVID KENNY
DATE	Friday, 27th AUGUST 2009

PURPOSE:

The purpose of this report is to enable Area Committees to examine the information and evidence gathered on the provision of Community Pharmacy Services that are funded by the NHS, throughout Gwent.

BACKGROUND:
Gwent CHC decided in January 2009, to move towards more formal reviews of NHS services to inform the development of a structured scrutiny approach to our monitoring duties. It was agreed that the first review would be undertaken between March and September 2009 and would focus on the provision of Community Pharmacy Services.

AIM OF THE SERVICE REVIEW:

In representing the interests of patients and the public in the NHS, Gwent Community Health Council aim to keep under review the local provision of pharmacy services by assessing; current local provision, the medium and long term plans for developing and sustaining reasonable access to pharmacy services, assess any inequalities in provision and make recommendation for service improvements.

OBJECTIVES OF THE SERVICE REVIEW:

1. **Identify the number and location of pharmacies in each Local Health Board (LHB) area**

2. **Identify the provision and access to 'out of hours' pharmacy services**
3. **Identify the range of services available from each pharmacy including;**

- Stop Smoking Services
- Minor Ailment Service
- Supplementary Prescribing by Pharmacists
- Emergency Hormonal Contraception Service
- Supervised consumption of methadone
- Prescription collection and delivery service
- Drugs return and disposal service
- Needle exchange
- Health screening
- Individual patient medicines reviews

4. **Examine the level of access to premises and the quality of the patient environment**
5. **Examine what contract and performance monitoring is undertaken by LHBs**
6. **Examine the local joint working initiatives and arrangements between GPs and Pharmacies**
7. **Examine the LHB strategy/plans for pharmacy services or level of inclusion in primary care needs assessments and strategies and how these services are promoted and patients informed of their benefits.**
8. **Examine the LHB strategy/plans for dealing with minor ailments long term conditions.**
9. **Examine the level of investment by LHBs into pharmacy services to provide support to vulnerable patients, their families or carers.**
10. **Examine how repeat dispensing is made available to patients in the LHB area, how patients are made aware of the services.**
11. **Examine how the LHBs are planning to deliver on the 'National Service Framework for Older People' through joint GP and pharmacy initiatives.**
12. **Examine information on Patient and Public experiences of services**

EXAMINATION OF THE SERVICE INFORMATION AND EVIDENCE

1. WHAT IS A COMMUNITY PHARMACY?

1.1 Community pharmacies are stores or shops which dispense prescriptions and provide over the counter medication. These stores are found on the High Street in many towns and sometimes in large supermarkets. They mainly provide the dispensing service of drugs/therapeutic aids/medication that help patients either with their treatment or with maintaining a quality of life.

"*Community Pharmacy Services are seen by patients and the public as essential local primary care facilities and a major part of community and social networks, pivotal to generations and sustaining local retail activity*"

1.2 A new contractual framework was introduced for community pharmacy in April 2005, drawing on the skills, expertise and the experience of pharmacists and their staff. Given its presence in the community with a tradition of ready access to all, community pharmacy aims should:

I. be – and be seen to be – an integral part of the NHS family in providing primary care and community services
II. support patients who wish to care for themselves
III. respond to the diverse needs of patients and communities
IV. be a source of innovation in the delivery of services
V. help deliver the aspirations within Designed for Life, and
VI. help to tackle health inequalities.

1.3 There is increasing emphasis on community pharmacies providing a greater range of services to improve access for patients and reducing the workload of GPs. However, there is an emerging variation of services provided from pharmacies in different locations, which may in time exacerbate inequalities in access to health services for some population groups.

1.4 Pharmacy is a profession which does not have a 'performers list'. A performers list is a list of medical personnel who can provide services to the general public. Pharmacists are not required to be on a performers list, unlike GPs and Dentists who provide treatment for patients, the pharmacists dispense the patient's drugs or medication, they do not provide a 'treatment' service.

1.5 Pharmacy is a 'notifiable' profession, whereby the police have a responsibility to inform the professional registration body of all misdemeanours. Pharmacists are not routinely checked against police computers; however, there is ongoing debate around the need for Criminal Records Bureau (CRB) checks considering some of the more sensitive services that Pharmacists provide for the public. Within the Gwent area, Monmouthshire is the only area where pharmacists are checked against the Criminal Records Bureau.

2. THE PHARMACY CONTRACT

2.1 The NHS Community Pharmacy Contract was agreed between Pharmaceutical Services Negotiating Committee (PSNC), the Department of Health (DOH) and the NHS Confederation (NHS Employers) and was accepted by pharmacy contractors in two ballots. The new arrangements began in April 2005. The contract applies to both England and Wales and is made up of three different service levels:

- Essential services - **provided by all contractors and includes;** Dispensing of Medicines**,** Repeat Dispensing**,** Waste Management, Public Health, Signposting, Support for Self-Care and Clinical Governance
- Advanced services - can be provided by all contractors once accreditation requirements have been met. An example of this is

Medicine Use Review. The review will help patients understand their therapy and it will identify any problems they are experiencing along with possible solutions. A report of the review is provided to the patient and to their GP.

- Enhanced services – are commissioned locally by Local Health Boards (LHBs) in response to the needs of the local population. This includes services such as condoms dispensing, methadone dispensing and the morning after pill etc. A needs analysis should enable Local Health Boards to ascertain what services will need to be purchased at a local level.

2.2 There is increasing emphasis on community pharmacies providing a greater range of services to improve access for patients and reducing the workload of GPs. However, there is an emerging variation of services provided from pharmacies in different locations, which may in time exacerbate inequalities in access to health services for some population groups.

3. CONTRACT AND PERFORMANCE MONITORING

3.1 All Local Health Boards undertake Contract and Performance Monitoring of pharmacy services. The Local Health Board send a contract monitoring self assessment document to all pharmacies within their area and four of the five Local Health Boards then select pharmacies they wish to visit. Caerphilly Local Health Board visits all their pharmacies on an annual basis. Once the New Local Health Board has been established, all pharmacies across Gwent will be evaluated on an annual rolling programme.

3.2 The selection process for performance monitoring visits is based on:

- the quality of the returned self assessment
- whether the self assessment has been returned
- if there are significant action plans from previous year's visit
- change of premises, relocation, or change of ownership

4. PHARMACY LOCATIONS IN GWENT

4.1 There are 126 pharmacies in the Gwent Area. The service locations are coterminous with Local Authority and Local Health Board boundaries and the breakdown of these services by borough are as follows:

Local Health Board area	Number Of Pharmacies In Each Local Health Board
Blaenau Gwent	**16**
Caerphilly	**43**
Monmouthshire	**17**
Newport	**30**
Torfaen	**20**
Total Pharmacies in Gwent	**126**

5. OUT OF HOURS PHARMACY OPENING TIMES BY BOROUGH

5.1 Out of Hours pharmacy service operates throughout Gwent and provides urgent access to medication outside the normal working hours. This service is provided on weekday evenings, Saturdays and Sundays and Bank Holidays.

5.2 Patients requiring medication out of normal working hours may first access the General Practitioner Out of Hours Service which carries a limited amount of prescription/over the counter drugs that can be given to a patient for a short period of time until patients are able to visit their own GP or access a pharmacy. However where there is a clinical need, a full course of antibiotics will be administered by the Out of Hours General Practitioner service. In some cases this service may offer "a delayed antibiotic service", which entails the clinician providing the patient with a prescription for antibiotics to be dispensed should the patient's symptoms persist.

5.3 Out of Hours Pharmacy Rotas are also provided across Gwent for special bank holidays – New Year's Day, Easter Sunday, Christmas Day and Boxing Day. Lists for all pharmacy services across Gwent are published and displayed in prominent and appropriate venues.

5.4 Opening times for Sundays and Bank holidays by each Local Health Board area are as follows:-

Blaenau Gwent

Ebbw Vale	5:30-6:30
Abertillery	12-1
Tredegar	5:30-6:30
Brynmawr	12-1

Caerphilly

Bargoed	5:30-6:30
Caerphilly	12-1, 1-2, 4-5
Crumlin	5-6
Newbridge	5-6
Blackwood	9-5:30, 12:30-1:30
Ystrad Mynach	2-3
Nelson	2-3
New Tredegar	11:30 12-30

Monmouthshire

Abergavenny	10-6, 10-4
Caldicot	11:30 -12:30

Newport

Newport	11-1
Newport	2-4
Pill, Newport	4-6
Rogerstone, Gaer, Always, Bettws and Malpas	5-6

Torfaen

Blaenavon	12-1
Cwmbran, Pontnewydd, Old Cwmbran and Llanyrafon	9-5, 4-6
Pontnewynydd and Pontypool	9 -5:30, 9-5, 11:45-2:45

5.5 The pharmacy rota excludes some pharmacies which open outside normal working hours for commercial reasons and although they have a pharmacist on site and are able to dispense medicines, this service is not part of the pharmacy out of hours funded service.

6. COMMERCIAL SERVICES

The range of services available from each pharmacy will vary, where some of the free services available to patients will be provided purely on a commercial basis i.e. health screening and the prescription collection and delivery service. These services are not part of the NHS and as such are not funded by the Local Health Board or the NHS.

6.1 PRESCRIPTION COLLECTION AND DELIVERY SERVICES

Although the prescription collection and delivery service is valued by patients, the clinical benefits are questionable and concerns have been raised that it leaves little interaction between the clinical professional and the patient. However, it could be argued that the lack of contact between the patient and clinician is not a consequence of the collection and delivery service but as a result of the prescribing practices and the mechanisms in place to ensure appropriate medicine reviews by GP practices. From a patient/public perspective, the collection and delivery services can be invaluable for those with limited mobility and those with long term conditions that have limited family or community support to access their prescriptions.

7. **PHARMACY SERVICES**

7.1 The main or essential role of the community pharmacy is to dispense medication. The essential services are provided by all contractors and include dispensing of medicines, repeat dispensing, waste management, public health, signposting and support for self-care. All essential services are subject to clinical governance policies and procedures.

8. FREE PRESCRIPTIONS

8.1 When patients need to see their GP, the GP will make a clinical decision on whether the patient will benefit from prescription medication to alleviate symptoms and/or to improve health. Prescription medicine is now being provided free, as part of the treatment.

8.2 The purchase of non-prescription medication, ‘over-the-counter’ without the need to see your GP, continues in the normal way and the pharmacist is

available to advise the patients and the public on the appropriate use of these medications. Those that prescribe medication, decide on **clinical grounds** what a patient needs on prescription to help improve their health.

9. WHO IS ENTITLED TO FREE PRESCRIPTIONS?

9.1 All patients registered with a Welsh GP, who get their prescriptions from a Welsh pharmacist, are entitled to free prescriptions.

9.2 Welsh patients who have an English GP and who get their prescriptions from a Welsh pharmacist will be entitled to free prescriptions. They will need to present their prescription with an accompanying entitlement card.

9.3 Along with free prescriptions, charges for wigs and appliances were also abolished. Patients who receive these services from an English NHS Trust should have their costs met by their Local Health Board.

10. WHAT ARE THE ADVANTAGES OF FREE PRESCRIPTIONS?

10.1 Free prescriptions should specifically benefit those people on modest incomes or who have chronic illnesses, such as heart disease, high blood pressure and cancer. Research shows that many people on moderate or low incomes were deterred from taking regular medication that would help them live healthier lives, because of the cost of paying for regular prescriptions.

11. WHAT ARE THE DISADVANTAGES OF FREE PRESCRIPTIONS?

11.1 The cost for providing free prescriptions in Wales is £30m per annum.

11.2 Where patients no longer pay for prescriptions, there is a risk that they do not consider the actual amount they need and that repeat prescriptions are ordered with less thought than if the items are chargeable, therefore increasing waste and the cost to the NHS.

12. SCHEMES TO REDUCE MEDICINES WASTE AND THE COST OF DRUGS.

12.1 Medicines waste is a significant problem for the NHS and the Gwent area is no exception. Large quantities of medication are dispensed by repeat prescription with many instances of patients requesting medication that they do not need or are unwilling to use. There are numerous schemes to reduce the costs of prescribing some of which are described below;

13. 'GENERIC PRESCRIBING' AND 'SPECIALS'

13.1 Generic prescribing is a means of looking at the most medically and cost effective drug to be prescribed for the patients symptoms. Pharmacy leads in Local Health Boards undertake the work to promote generic prescribing and advise General Practitioners on which generic drugs to prescribe. . However,

General Practitioners do not have to adhere to this advice and hence some surgeries may prescribe more expensive drugs.

13.2 'Specials' are drugs that come in a different shape or form to normal drugs, and are prescribed to cater for the specific needs of the patient where tablet, capsule, soluble form or suspensions can be prescribed. The cost for these different preparations varies and a prescription for the same drug in a different form can substantively increase the costs of prescribing. The variation in the costs of these different preparations is an area of major concern for the NHS and subject of ongoing debate as to the reasons for patient choice and GP preference in prescribing.

14. 'NON DISPENSING SCHEME' OR 'NOT REQUIRED SCHEME'

14.1 The purpose of these schemes is to reduce the number of medicines and appliances supplied unnecessarily. The 'non dispensing scheme' or 'not required scheme' enables the pharmacist to discuss with patients, who receive repeat prescriptions for medicines or appliances, their actual needs and the effective use of their medications. The process can identify items that are either not needed or those that can be reduced from monthly request to accommodate the patient's needs and avoid dispensing unwanted or underused medications. In full agreement with the patient, the pharmacist will mark the prescription 'Not Required (NR)' and record the prescription information on a record form. This enhanced service is currently being piloted in Gwent and offers the following benefits;

- Unused and unwanted medicines account for a substantial amount of resources that are wasted. Some waste is inevitable and it will be unrealistic to expect complete reduction.
- It is essential that this is addressed to improve patient safety, clinical effectiveness and cost efficiency, maximising NHS resources.
- The public will be asked to only order what they require, advised not to stockpile medicines, and reminded that any medication that has left the community pharmacy cannot be reused on returned even if it has not been opened.
- Encouraging patients to have a Medicines Use Review (MUR)

14.2 A Non Dispensing Scheme in England has been successful in Primary Care Trusts and has been proven to lessen waste, improve safety and decrease prescribing costs. However the benefits of these schemes in Wales may not be realised in the short to medium term but may have an impact on waste reduction in the long term.

15. ADVANCED SERVICE MEDICINE USE REVIEW

15.1 A Medicines Use Review (MUR) or medicines check up is a meeting between the patient and the pharmacist to talk about:

- The medicines being taken
- What they do

- How well they work
- How to get the most out of them

15.2 This NHS funded service usually takes place in the local pharmacy and the purpose of the review is to:

- Help to find out more about the medicines being taken.
- Pick up any problems with the medicines.
- Improve the effectiveness of medicines. There may be easier ways to take them, or the pharmacist may find the patient needs fewer medicines than before.
- Get better value for the NHS – making sure that medicines are right prevents unnecessary waste.
- Enable the pharmacist to provide advice and information on changes to medicines.
- Enable the patient to ask questions about their medication or discuss any concerns

15.3 If changes to medications are required, the pharmacist will write to the patient's GP with a proposal to change drugs or modify the patient's prescriptions.

15.4 The majority of pharmacists in Gwent are accredited in this area of work, where 110 out of 126 pharmacies provide the service. The Business Services Centre validates this information based on the pharmacist's letters to General Practitioners. A Pharmacist will only be accredited to provide this service if they are able to provide a separate consultation room, where two people can sit and talk without being overheard using normal speech. All pharmacies that have been accredited in the Gwent area have been visited by staff from Local Health Boards to ensure that rooms are fit for purpose.

15.5 This service can be provided to 'housefast' patients and these patients would probably benefit the most from this service; however in reality very few house visits are undertaken. Where a pharmacy has only one pharmacist, if they were to leave the pharmacy to conduct a home visit, the pharmacy may be left without a dispensing pharmacist.

15.6 This service is validated by the Business Services Centre and pharmacists must be accredited to operate it. Pharmacies are allowed to claim for up to 400 Medicine Use reviews per annum and this is supervised by Local Health Boards. No patient details are given to Local Health Boards, but pharmacists may use a patient identifier to monitor the system. A full list of the pharmacies which have accredited pharmacists that operate this service is below.

Local Health Board	Number Of Pharmacies In Each Local Health Board	No Of Pharmacies Undertaking Medicine Uptake Review In Each Local Health Board
Blaenau Gwent Local Health Board	**16**	**13**
Caerphilly Local Health Board	**43**	**39**
Monmouthshire Local Health Board	**17**	**16**
Newport Local Health Board	**30**	**24**
Torfaen Local Health Board	**20**	**18**
Total Pharmacies	**126**	**110**

16. COMMUNITY PHARMACY ENHANCED SERVICES

16.1 All pharmacies in Gwent deliver one or more enhanced services, which are extra to the pharmacy contract and contracted (based on population need) and monitored by the relevant Local Health Board. They include the following services:

Emergency Hormonal Contraception
Condom Card
Methadone Dispensing
No smoking Level 2
Needle Exchange
Non dispensing /not required Service
Out of Hours palliative care
Pharmacy Care Homes Review
Minor ailments

16.2 There are varying reasons why some pharmacies offer different services not least local population needs for services such as Emergency Hormonal Contraception or the Methadone Enhanced Services, or because they are unable to comply with the environmental requirements for the service. To deliver the Medicine Use Review service they are required to provide a separate consulting room or area, whereas the delivery of other services such as the Methadone or contraception services, pharmacies do not require the provision of 'a quiet corner'.

17. MINOR AILMENTS SERVICE

17.1 A minor ailments service offers the patient the opportunity to attend the pharmacy and be provided with advice and treatment from the pharmacist instead of attending the GP practice. The intent of this service provision is to alleviate the strains on GP services and to provide accessible and appropriate advice and treatment for patients.

17. 2 Pharmacists that offer this service are required to inform the Local Health Board of the numbers of treatments offered in order to receive payment for the service.

17.3 Within Gwent there is only one scheme in place which covers the Torfaen area. The scheme, although widely used in England, has not been generally picked up in Wales because of a range of factors, not least the lack of evidence that it actually reduces the burden on GP services. Feedback about the service from professionals and the public has been positive, but this may not be sufficient to determine the ongoing viability of the scheme. It is not yet decided if this scheme will be rolled out across Gwent once the Aneurin Bevan Local Health Board has been established.

18. CONTRACTED PHARMACY HOURS

18.1 Pharmacies are required to open for a minimum of 40 hours a week unless they get permission from their LHB to open for a shorter period. Contractors were required to notify the LHB of their actual opening hours by 30 June 2005 so that the LHB could carry out a local assessment of the available pharmaceutical services. It was important that pharmacies disclosed their full hours so that the LHB obtained a reliable picture of the services available. Future changes of hours will require an application to amend the 40 core contractual hours, or notification with at least 90 days notice to amend hours other than the 40 core contractual hours.

18.2 Provided the pharmacy is opening for the minimum of 40 hours, the LHB is able to issue a direction to the pharmacy to open for longer hours, but only if it is satisfied that the pharmacy will receive reasonable payment. There is a right of appeal where a LHB directs a pharmacy to open for additional hours.

19. PHARMACY PRACTICE LEAFLETS

19.1 The clinical governance requirements for pharmacies require the pharmacy to "… produce in an approved manner, a practice leaflet containing approved particulars in respect of his pharmacy".

The Department of Health published on 15 October 2008, a clinical governance system acceptable to the Secretary of State for the pharmacy practice leaflet. From 15 October 2008, all pharmacies must produce a practice leaflet that complies with the specification.

19.2 The practice leaflet must include the following:

1. Name, address and telephone number of the pharmacy;
2. If owned by a company based elsewhere, the contact details for their head office;
3. Opening hours;
4. List or description of NHS services available at the pharmacy (including Advanced, but not necessarily Enhanced services);
5. Access arrangements for disabled customers;
6. NHS Direct details as follows:
   "When the pharmacy is closed, health advice and information, including details of other local health services, is available round the clock from NHS Direct. You can use:
   - NHS Direct online at www.nhsdirect.nhs.uk
   - NHS Direct Interactive on digital TV
   - The NHS Direct telephone service. Call 0845 4647";
7. Notice that the pharmacy is not obliged to serve violent or abusive customers;
8. Notice that the pharmacy complies with the Data Protection Act and the NHS code on confidentiality;
9. Detail of how to find out more about services offered, comment on those services, or make a complaint;
10. Contact details of the local PCT; and
11. The leaflet may, under a separate heading "Other services we provide", refer to healthcare-related non-NHS services provided by the pharmacy.

19.3 The leaflet must be printed using a plain font in minimum size 12 pt. The leaflet must be branded with the NHS logo and the pharmacy descriptor line "Providing NHS Services" in the bottom right hand corner on the first page. The NHS logo must, as a registered trademark, be used in accordance with the NHS identity guidelines for pharmacies. A review of the leaflets available from pharmacies in Gwent is currently underway and the results will be made available to Committee by the end of August 2009

20. HANDLING COMPLAINTS

20.1 Under the provisions of the *National Health Service (Pharmaceutical Services) Regulations 2005* pharmacy contractors are required to make arrangements for the handling and consideration of complaints. These arrangements must ensure:

- complaints are dealt with efficiently;
- complaints are properly investigated;
- complainants are treated with respect and courtesy;
- complainants receive, so far as is reasonably practical—
  - assistance to enable them to understand the procedure in relation to complaints; or
  - advice on where they may obtain such assistance;
- complainants receive a timely and appropriate response;

- complainants are told the outcome of the investigation of their complaint; and
- action is taken if necessary in the light of the outcome of a complaint.

20.2 Major changes

The new regulations introduce several major changes which are described in detail below. These are:

- Each pharmacy must appoint a 'responsible person';
- Oral complaints dealt with to the satisfaction of the complainant no later than the following day do not need to be handled under the new procedures;
- The time limit for making complaints increases from 6 to 12 months;
- The pharmacy must offer to discuss handling of the complaint and setting the time for a response, with the complainant;
- The maximum time for responding to a complaint increases to six months;
- An 'annual report' about complaints must be published, made available to anyone who requests it, and be sent to the LHB.

21. CHC VISITING MONITORING ANALYSIS

21.1 Gwent Community Health Council members have visited 35 of the 126 pharmacies in Gwent during 2008/9 as part of our local monitoring programme (28% of the total). In terms of Boroughs, 2 pharmacies were visited in Blaenau Gwent, 14 in Caerphilly, 4 in Monmouthshire, 9 in Newport and 6 in Torfaen.

21.2 Prescription collection and delivery service.
Of those visited the overwhelming number (33) operated a prescription collection and delivery service. Only 2 did not.

Conclusion: The overwhelming number of pharmacies offered this service, though there are many permutations and criteria for availability – ie the service could be generally offered or just on the basis of individual patient need. When considering the competing perspectives of those providing the service, those recieving the service and the concerns raised through a clinical governance perspective, issues of convenience for the patients, good clinical governance, and the potential for wastage, are all factors that should be considered. This is an area for more detailed scrutiny.

21.3 Drug return and disposal service

All pharmacies visited offered this service.

21.4 Staff identification:

In more than half (20 pharmacies) staff wore name badges, the highest proportion being in Torfaen where in 5 out of the 6 pharmacies visited staff were identified. 2 pharmacists reported that they did not want their staff to be named for personal safety reasons.

Conclusion: CHCs in Wales have taken the view that all health professionals should be identified by name and position, a requirement which is also widely enforced for assistants in retail outlets. This principle should therefore be applied to pharmacy staff and clearly there is a level of resistance to this principle.

21.5 Lunchtime cover :

More than half the pharmacies (20) claimed to offer lunchtime cover, with clear majorities in Newport and Torfaen. In Caerphilly a small majority (8 out of 14) did not have lunchtime cover, and neither did the 2 pharmacies visited in Blaenau Gwent. Closures ranged between an hour and one and a half hour.

Conclusion: This could be a problem where there is limited choice in a small community. Ideally pharmacies might close at differing times to ensure continuity of service though this may be difficult to achieve as Pharmacists have a retail aspect to their services where there seems to be a reluctance to work collaboratively with competitors.

21.6 Average time for dispensing:

The great majority of pharmacies (28) said that they dispensed prescriptions within 5 to 10 minutes.

Conclusion: The wait for dispensing does not appear to be a problem, however enquiries and complaints received by Gwent CHC would indicate that further work is required to establish patient satisfaction with dispensing times.

21.7 Extra services such as health checks, blood tests, health promotion and the minor ailments scheme.

A clear majority (26 out of 35) pharmacies visited offered extra services, with a particularly high proportion in Caerphilly. All the 6 pharmacies visited in Torfaen offered extra services.

Conclusion: A high proportion of pharmacies appear to offer extra services

21.8 Policy on handing complaints:

Of the 32 responders to this question only 2 pharmacies did not have a policy. 1 pharmacy reported that they “didn’t get complaints” so this was not required.

Conclusion: All pharmacies are required to have a policy for handling complaints and the Local Health Boards should ensure compliance.

21.9 Complaints leaflet:

9 of the 32 responders to this question did not have a complaints leaflet. Half the pharmacies visited in Torfaen (3 out of 6) did not have a complaints leaflet.

Conclusion: All pharmacies should be able to produce a complaints leaflet and approaching a third of our sample could not offer a copy on request. This is an area that requires improvement.

21.10 Communication with those with sensory impairment

Of the 32 responders to this question, 23 did make special arrangements – loop system, magniyfying glass, dispensing aids etc. 9 pharmacies did not, including half those visited in Torfaen (ie 3 out of 6 pharmacies).

Conclusion: Generally positive though some progress needs to be made to ensure equitable service delivery for patients with a sensory impairment.

21.11 Bilingual service (Welsh)

Only 4 of the pharmacies visited; 1 in Newport and 3 in Caerphilly had special arrangements to offer a bilingual service. 11 pharmacies considered that this service was “not applicable” to them.

Conclusion: There is no obligation for pharmacies to offer a service in Welsh and this facility is likely to be demand led. It is recognised that this provision may be difficult for smaller pharmacies to offer this service.

21.12 Communicating with people who do not have English/Welsh as a first language

Only 6 of the pharmacies visited had special arrangements for people in this category. 3 of these pharmacies were in Caerphilly with 1 positive response from Newport, Blaenau Gwent and Torfaen. The need might be expected to be particularly high in Newport, though this is not obviously reflected in the sample. Language Line seems to be the arrangement of choice for most pharmacies. No pharmacies indicated this issue was “not applicable” to them though one reported that “they had no customers who did not have English as a first language”

Conclusion: This is an area for improvement. With a more mobile population, asylum seekers and economic migrants this is likely to be a growing need, particularly in major centres such as Newport.

21.13 Needle exchange programme

A relatively small number of the 35 pharmacies sampled (4) operated a needle exhange programme for intravenous drug misusers. None of the Monmouthshire or Blaenau Gwent pharmacies sampled operated this service. 11 pharmacies considered the service "not applicable".

Conclusion: This is understood not always to be a "popular" service with pharmacists, and the number operating the service seems to be small. To ensure safe practice and compliance there does need to be reasonable cover.

21.14 Policy for the disposal of "sharps"

Only 8 of the sample of 35 have a procedure for the disposal of "sharps" 12 pharmacies described such a service as "not applicable" probably reflecting the fact that local authorities in Gwent provide a household collection service for patients who take medication intravenously (eg diabetic patients).

Conclusion: This is a client group which now seems well served.

21.15 Methadone programme

A small majority of the sample (19) operate a methadone programme. 5 pharmacies did not participate with 11 pharmacies describing the service as "not applicable."

Conclusion: Reasonable cover needs to be provided but there are parallel centres in each locality, operated by the drug misuse service which also provide this service.

21.16 People with learning disabilities

All the pharmacies visited agreed they had special arrangments to support patients with learning disabilities – charts, medicine calendars, bubble packs etc.

Conclusion: A very positive response.

21.17 Access

- Blaenau Gwent: The two pharmacies visited were rated Good and Excellent respectively

- Caerphilly: The majority were described as Good or Fair. 3 pharmacies were reported as Poor for the disabled and 4 as Poor for wheelchair and pushchair access.

- Monmouthshire 2 (out of the 4 visited) were rated as Poor for disabled access. 3 offered Poor access for people with wheelchairs and pushchairs.

- Newport: The great majority scored Good or Excellent against access criteria. A pharmacy was recorded as Poor against the suitability of the doors, access for the disabled and wheelchair and pushchair access (the summary information does not identify whether one pharmacy is poor on these three counts or whether more than one pharmacy is being identified)

- Torfaen: Most of the 6 pharmacies recorded scores of Good or Excellent for access. One was thought to be Poor in terms of disabled access.

Conclusion: Generally positive response but more progress needed on disabled access.

21.18 Decoration /Appearance (Entrances, Reception, Common areas)
Generally phamacies scored well. 12 pharmacies were placed in the Excellent category including all the 6 visited in Torfaen. 19 were rated as Good, 3 Fair. 1 was rated Poor, a pharmacy in Blaenau Gwent.
Conclusion: Generally positive feedback.

21.19 Patient information

- Blaenau Gwent pharmacies (2) were generally Good for patient information

- Caerphilly pharmacies (14) were generally rated as Good, 1 was, however, rated Poor in terms of information related to making a complaint, over half (8) had no information related to Community Health Councils.

- Monmouthshire pharmacies (4) There was a wide variation in response. All pharmacies were rated as Excellent or Good for general patient information leaflets and health promotion information. Half the pharmacies (2) were rated Poor for notice boards and information about health and social care services. 3 out of the 4 pharmacies had no information about Community Health Councils.

- Newport pharmacies (9) again rated generally Good or Excellent in terms of patient information. A pharmacy (not necessarily the same one) was rated poor against all the indices – patient information leaflet, how to make a complaint etc (the summary information does not identify whether one or more than one pharmacy is being identified).

- Torfaen pharmacies (6) generally rated Good or Excellent in terms of patient information. 2 pharmacies however, were rated Poor on information about making a complaint. Only 1 pharmacy appeared to offer information about the Community Health Council.

Conclusion: Pharmacies are required to have a practice leaflet and most appear to do so. Lack of information on making a complaint is the major area of concern.

21.20 Private consultation

Private consultation rooms are a requirement for Medicine Use Reviews (MUR), undertaken by the large majority of pharmacies. Of the 35 pharmacies only 4 identified a private consultation facility as "not applicable". Of the others 20 were described as Good, 7 as Excellent, and 2 as Fair. 2 pharmacies rated Poor for private consultation, both in Newport.

Conclusion: Generally good facilities though still room for improvement. The 4 pharmacies who identified a private consultation room as "not applicable" were not on the MUR list and hence this facility was not a requirement. In at least one case lack of space was cited as an issue. The two Newport pharmacies which were judged to have a poor facility were on the MUR list.

22. COMPARISION OF SERVICES ACROSS GWENT

23.1 The number and location of pharmacies tend to mirror the resident population. Most pharmacies undertake Medicine Use Review -110 out of 126. All pharmacies undertake some or all enhanced services – albeit some different services for different pharmacies. However the following issues identified from the service review require further consideration;

A. Patterns of service

Given the different patterns of pharmacy services between rural, valley and urban areas, it is essential that Council take a view on what constitutes fair access to services throughout Gwent.

Recommendation:
That Council further discuss the distribution of pharmacy services across Gwent and form a view on the following;

- **appropriate access for urban and rural areas.**
- **positive investment in rural areas or areas of deprivation.**

B. Variations of Service

There are variations in the services provided such as Emergency Hormonal Contraception for under age patients, Needle Exchange Scheme, health promotion, health screening and disease prevention. Although it is reasonable for each locality to provide services tailored to local needs, should there be more central direction from the new LHB for pharmacies to develop a more comprehensive and an equitable range of services for each locality?

Recommendation;
That Council review the different pattern of services between localities and form a view on the following;

I. Should the pharmacy minor ailments scheme be extended beyond Torfaen to other parts of Gwent. It is free to the patient though the pharmacist charges the Local Health Board. What is the balance of advantage for the patient in terms of convenience and the costs of offering free over the counter medications?

II. Should the Council consider the minor ailments scheme evaluation to assess if there have been significant improvements in the reduction of strain on GP in and Out of Hours services?

III. Should we consider how primary care services can be offered from other professionals besides GPs and specifically, could the role of pharmacists change to enable them to prescribe (within limits and as part of GP treatment plan) thus offering an alternative out of hours service that could reduce the burden on GPs and Out of Hours GP services?

IV. Should we consider the issues of the variation of services between pharmacies in each of the localities and the impact on health equality?

V. Should the Council request that the Health Board undertake a patient/service user satisfaction survey to assess if the service is meeting patient needs.

C. Generic Prescribing

We have been informed that prescribing costs in Monmouthshire are substantially more than any other Borough in the Gwent area because of the level of GP dispensing to rural communities. We have also been informed by the Local Health Board that 'Dispensing GPs' are resistant to introducing cheaper generic prescribing because of loss of income to local practices. The effect on patients is probably neutral in regards to the efficacy of the medication, but this inflexibility does have substantial resource implications.

Where local pharmacies have applied to provide a service to local communities, we have experience of complaints from GPs about the viability of their practice and the potential or real loss of primary care services.

Recommendation;
For the Council to request evidence from the NHS in regard to actual cost of the reported resistance from GPs to generic prescribing, the level of disadvantage to GP surgeries from reducing the prescribing budget and the consequent effects on patient services. Should the CHC recommend that this issue be actively addressed.

D. Medicines Use Reviews
Currently the review of medications is undertaken by both GPs and Pharmacists and although it is recognised that the pharmacist delivery of Medicines Use Reviews and the Non dispensing/Not required schemes is

intended to reduce unnecessary dispensing and hence wastage of medicines, there would seem to be a duplication of effort. It could be argued that pharmacists are more expert in the efficacy of medications and in a better position to judge when actually dispensing, though they have to refer suggested changes back to the GP.

Recommendation:
Council is requested to come with a view as to whether pharmacy reviews represent "added value" in terms of professional scrutiny, value for money, and patient convenience or is it an unnecessary duplication of the regular reviews of repeat prescription medication which GPs are, or should be, undertaking?

E. Privacy and dignity
Pharmacies are only required to have available a private area/consulting room if they provide Medicine Use Reviews. Most pharmacies undertake MURs and therefore have this facility, though a number of smaller pharmacies do not. Should this be extended to other areas of consultations/ advice giving eg hormonal contraception.

Recommendation:
Council should consider whether to recommend that all pharmacies should be required to offer private area/consulting rooms together with an implementation time-table, recognising that ensuring compliance may be difficult.

F. Dealing with Complaints
Pharmacies are required to have a practice leaflet. From our pharmacy visits few pharmacies appeared to have a complaints leaflet. Most practice leaflets received by the CHC, however, appear to have details on how to make a complaint.

Recommendation:
That LHBs should seek to require that all pharmacies either have a complaints leaflet or include details on how to make a complaint within their practice leaflet.

G. Staff name badges
A substantial minority of pharmacies visited by the CHC did not identify staff by name badge. A range of responses were received on the grounds that local people knew the staff anyway or that wearing badges had implications for personal security. CHCs have always maintained that health professionals should be readily identified to patients and that identity badges should be worn.

Recommendation:
Council is requested to consider their views on the 'wearing of name badges' to inform a recommendation to the Local health Board on the patient expectation of good practice in identifying clinical staff and their relevant positions.

H. Criminal Records Bureau (CRB) checks
GPs and dentists who clearly have a close professional relationship with patients, often on a one-to-one basis are required to have a CRB check. Pharmacists currently are not required to have a CRB check. Given their extended role and wider professional contacts with patients there is a case for pharmacists to be included.

Recommendation:
Council is requested to consider the issues of patient and public safety in regard to clinical staff being subject to Criminal Record Bureau Checks and agree a recommendation to the Local Health Board on this issue.

I. Prescription collection and delivery services

The great majority of pharmacies offer a prescription collection and some a delivery service. Though there are many permutations and criteria for availability, most are on demand to everyone. The service is free and provided on a commercial basis.

Recommendation:
Council is requested to consider undertaking a patient survey to identify the patient experience of the service and further consider the wider implications of a collection and delivery service.

J. Communication with those having sensory impairment and special needs

The majority of pharmacies visited by the CHC did make special arrangements for those with sensory impairment – a loop system, magnification aids, dispensing aids etc. A significant number of pharmacies, however, did not have such arrangements and very few pharmacists were able to offer specifics on the way in which they made reasonable adjustment for disabled patients, the older confused patients or those with learning difficulties.

Recommendation:
Council are requested to consider the value of undertaking a full audit of Gwent pharmacies re their arrangements for people with special needs with a view to making recommendation on expected best practice in service delivery.

K. The rurality of Monmouthshire

This suggests that the resident population could have an inferior Out of Hours Pharmacy service, because of the local geography.

Recommendation:
That Council request further information from the NHS on how the decision on the provision of the Out of Hours Pharmacy in Monmouthshire was made.

G Model
HEAP-2549; No. of Pages 8
ARTICLE IN PRESS
Health and Social Care Committee
HSC(4)-13-11 paper 7
Health Policy xxx (2010) xxx–xxx

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

Changing patient consultation patterns in primary care: an investigation of uptake of the Minor Ailments Service in Scotland

Andrew Wagner*, Peter R. Noyce, Darren M. Ashcroft

Centre for Innovation in Practice, School of Pharmacy and Pharmaceutical Sciences, University of Manchester, Oxford Road, Manchester M13 9PT, UK

ARTICLE INFO

Keywords:
Community pharmacy
Minor ailment
Consultation
General practice
Equity

ABSTRACT

Objectives: To study the impact and potential predictors of uptake of patient registrations and supplied medicines under the Minor Ailments Scheme (MAS) in Scotland. The MAS was introduced in 2006, intending to improve health care access by re-directing patients from primary care to community pharmacies.
Methods: Numbers of dispensed MAS items and patient registrations were obtained for all community pharmacies in Scotland for the period 2006–2009. Local demographic and socioeconomic characteristics were attributed to community pharmacies as potential predictors of MAS service uptake.
Results: There were significantly more MAS registrations in community pharmacies located in the most deprived areas. MAS registrations in rural areas were significantly lower than in urban areas. Rates of MAS items supplied ranged from 219.9 to 3604.6 items per 10,000 Health Board population in 2008/09. Urban pharmacies supplied 72.6 MAS items per month compared to 43.3 items per month by rural pharmacies. 96.7 items per month were supplied by pharmacies in the most deprived areas compared to 53.2 items per month in the least deprived areas.
Conclusion: There has been geographical variation in uptake of the MAS service. Community pharmacies under multiple ownership engaged in MAS activity to a greater extent than independent pharmacies, with higher uptake in community pharmacies located in deprived and urban areas.

1. Background

Investigation into patients' consultation behaviour has postulated that the decision to consult a general practitioner (GP) is not solely based on the presence or absence of an individual's poor health, but may be influenced by a multiplicity of socioeconomic, demographic and psychosocial factors [1]. Cost of medicines and ease of access have been found to be key determinants in selecting either GP-provided prescriptions or over the counter (OTC) medicines from community pharmacies for acute, self-limiting illnesses (or "minor ailments") [2]. Exemption from prescription payments was strongly associated with the decision to visit the GP for conditions that could be self-treated, rather than to pay for OTC medicines at the pharmacy.

A decade ago, patient demand for minor ailments treatment by GPs was the focus for a feasibility study, investigating management of self-limiting illnesses in North West England [3,4]. The "Care at the Chemist" study sought to re-direct patients to community pharmacists for a group of 12 minor ailments including head lice, vaginal thrush, sore throat, cough and diarrhoea. Patients who were exempt from prescription payments obtained medicines from a specified formulary through the community pharmacy. Overall the trial resulted in a transfer of 38% of the workload associated with the 12 conditions studied, and demonstrated that reconsultation rates did not differ

* Corresponding author.
E-mail address: andrew.wagner@manchester.ac.uk (A. Wagner).

0168-8510/$ – see front matter © 2010 Elsevier Ireland Ltd. All rights reserved.
doi:10.1016/j.healthpol.2010.07.002

Please cite this article in press as: Wagner A, et al. Changing patient consultation patterns in primary care: an investigation of uptake of the Minor Ailments Service in Scotland. Health Policy (2010), doi:10.1016/j.healthpol.2010.07.002

significantly between those patients who consulted a GP and those who were treated by a pharmacist. Although the study found no change in overall GP workload, workload was reduced for the minor ailments group.

Primary Care Organisations (PCOs) in England were keen to establish pharmacy-based MAS [5], and their adoption was promoted nationally [6]. The model used in the feasibility study formed the basis for the Department of Health service specification template for MAS, introduced as a locally commissioned NHS enhanced pharmaceutical service. By 2007/8, 26% of English community pharmacies were contracted by 57% of the 152 PCOs to provide MAS services [7]. More recently, the Department of Health has undertaken an impact assessment of MAS, noting:

- the longer opening hours of community pharmacies and their ready accessibility in more deprived areas
- a reduction in the burden of minor illness on GPs, and
- the potential cost savings from improved efficiency [8].

Paradoxically, in a recent analysis of the development of community pharmacy-based clinical services in England, it has been suggested that there is limited evidence for the commissioning of MAS [9].

Also using a similar model to "Care at the Chemist", the Direct Supply of Medicines Scheme (DSoM) piloted community pharmacy-based Minor Ailments Services in two areas of Scotland from 2001 [10,11]. The service was mainly used by patients aged under 16, while elderly patients were low users of the scheme, preferring GP consultations for minor ailments. Community pharmacists welcomed the transfer of general practice workload as an enhancement of their contribution to patient care. The DSoM prefigured the introduction of a national MAS in Scotland in July 2006. The national scheme was limited to patients exempt from prescription charges, including children, people aged 60 or over, those in receipt of state benefits or pensions and people with certain chronic illnesses or continuing physical disability [12]. Eligible patients were registered at a Scottish NHS general practice and not resident in a care home. Patients could register with a single NHS community pharmacy having the ability to transfer registration to a different pharmacy should they wish. The scheme was favourably received by patients, who were satisfied with the easier access provided by community pharmacies and by the quality of advice and service provided.

The MAS was implemented as one of four core components within the new Scottish Pharmacy Contract including public health, acute medication and chronic medication services with a phased introduction managed on three administrative levels: nationally by the Scottish Executive Health Department, by the 14 NHS Health Boards and by local implementation groups [13,14]. The MAS was introduced with key health enhancement aims: (i) to improve patient access; (ii) promote care through community pharmacy; (iii) transfer care from GPs and nurses to pharmacists where appropriate and (iv) address health inequalities. Achievement of these aims is challenged by particular difficulties for the Scottish health system, which is presented with traditionally high levels of chronic urban morbidity and barriers to health care access for dispersed rural communities [15,16]. Scotland's diverse socioeconomic and geographical characteristics present potential local obstacles for consistent introduction, implementation and integration of the MAS which were highlighted as possible reasons for uneven uptake during the DsoM pilot. This paper aims to study the impact and potential predictors of uptake of MAS patient registrations and supplied medicines in Scotland.

2. Method

2.1. Data sources

Data were obtained from the NHS National Services Scotland Information Services Division including monthly aggregates of MAS items supplied with drug name and formulation, total MAS patient registrations, and medication items (i.e. MAS and non-MAS) supplied for each community pharmacy. The dataset included monthly reimbursement amounts, registration bandings, identifying independent or multiple pharmacy ownership (multiple pharmacies are chains of six or more branches). Community pharmacies received reimbursement through banded capitation fees based on the number of people on the pharmacy MAS register. The four bands and fees as at September 2008 were: £325.83 per month for between 1 and 250 registered patients; £488.58 for 251 to 500 patients; £651.47 for 501 to 750 patients and £651.42 for over 750 patients plus an extra £0.67 per head over 750 patients [17]. Should a MAS registered patient not receive treatment or advice under the scheme over a 12-month period, the registration would lapse for remuneration purposes, though might be re-activated should they subsequently present at the pharmacy for treatment. Monthly data were provided between July 2006 and March 2009 allowing analysis from the scheme's inception.

Potential locality-based determinants were identified to test the extent that MAS activity could be explained by these factors. Data were aggregated to NHS Health Board level and local data zones, statistical areas typically populated by between 500 and 1000 household residents designed, where possible, to contain households with similar social attributes [18]. Pharmacy postcodes were linked to data zones using the May 2009 National Statistics Postcode Directory. The potential determinants used in the analysis included the 2006 Scottish Index of Multiple Deprivation (SIMD), a deprivation measure commonly used to investigate relationships between population characteristics and local service provision [19]. Percentage of people with limiting long-term illness was included, a self-reported indicator allowing between area comparisons of health need [20]. We used population aggregates as proxy measures of intensity of pharmacy workload, including total resident population, residents aged under 16 and residents aged 65 or over. A dichotomous urban or rural locality indicator was included to account for variations that may affect the 18.7% of the 5.1 million Scottish population living in rural areas [21]. Locations of dispensing general practices were included in the dataset identified by postcode. Health Boards usually introduce dispensing general practices into sparsely populated areas where access to community phar-

Please cite this article in press as: Wagner A, et al. Changing patient consultation patterns in primary care: an investigation of uptake of the Minor Ailments Service in Scotland. Health Policy (2010), doi:10.1016/j.healthpol.2010.07.002

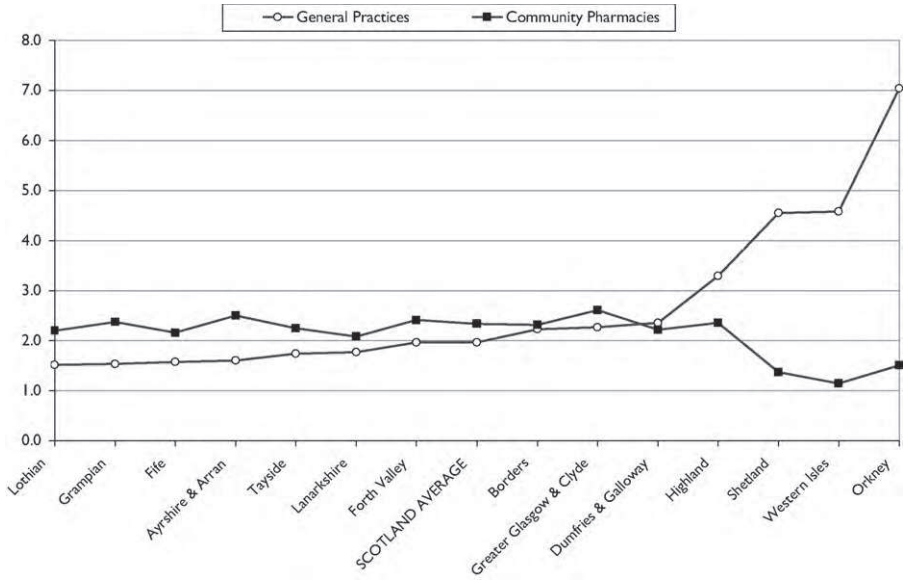


Fig. 1. Numbers of community pharmacies and general practices per 10,000 Health Board population (2009).

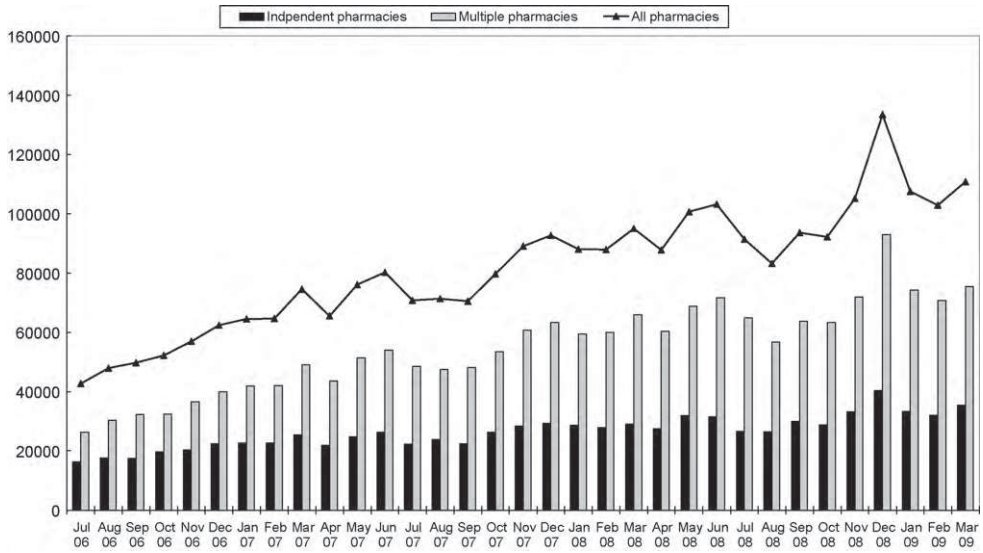


Fig. 2. Minor Ailments Service items supplied per month in Scotland between July 2006 and March 2009.

macy services is limited and can supply medicines directly to patients. Dispensing general practices provided 3.7% of all dispensed prescriptions in 2008/09 [22].

2.2. Statistical method

Data analysis was performed using SPSS (version 16.1). The SIMD data zone rankings were grouped into quintiles ranging from the most deprived to least deprived data zones. The urban or rural indicator was conflated into two categories using the Scottish Executive's 8-fold version of settlement size classifications, with the rural category consisting of "very remote small towns", "accessible rural", "remote rural" and "very remote rural" [23]. Independent-samples *t*-tests were performed to compare MAS dispensing and registration rates between rural and urban pharmacies. One-way analysis of variance was performed to explore the impact of deprivation on MAS activity. Multiple linear regression was used to determine associations between supplied MAS items and the potential explanatory variables.

3. Results

3.1. Community pharmacy distribution

There were 1206 community pharmacies in Scotland as at March 2009, of which two-thirds (66.3%) were multiple pharmacies. Over a quarter of independent pharmacies (27.6%) and multiple pharmacies (27.5%) were located

Please cite this article in press as: Wagner A, et al. Changing patient consultation patterns in primary care: an investigation of uptake of the Minor Ailments Service in Scotland. Health Policy (2010), doi:10.1016/j.healthpol.2010.07.002

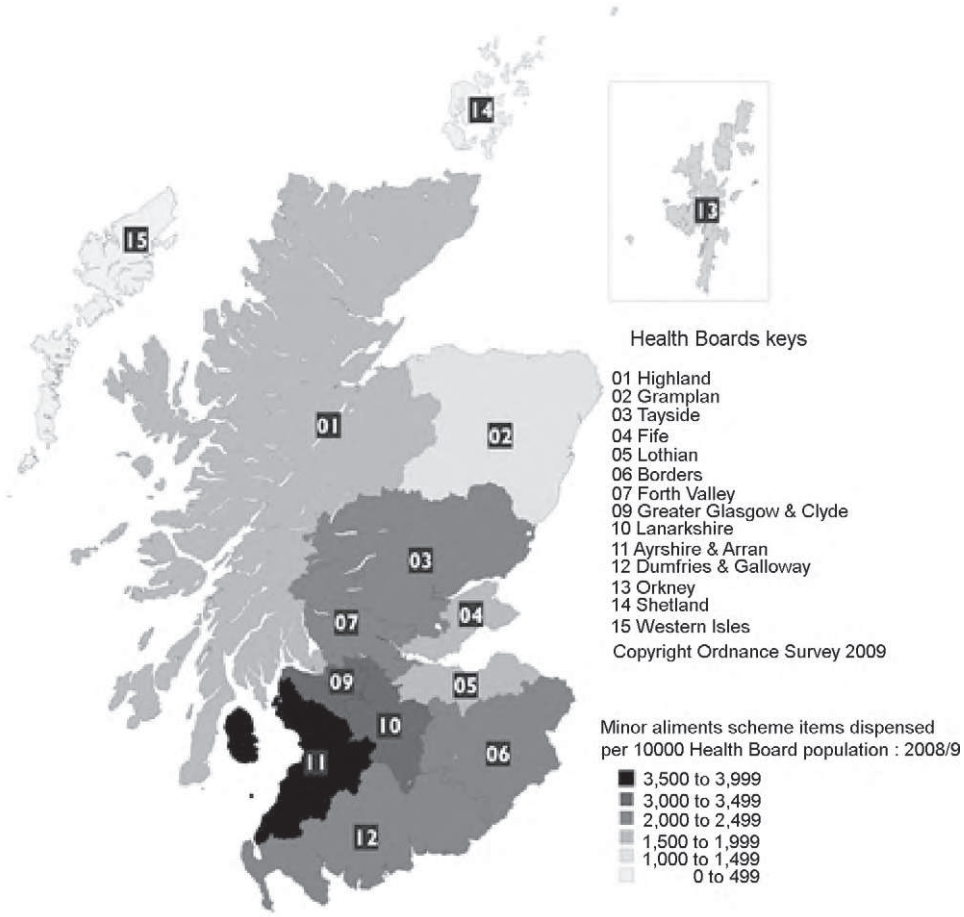


Fig. 3. Minor Ailments Service items supplied per 10,000 Scottish Health Board population 2008/09.

in the most deprived SIMD quintile (Pearson's $X^2 = 5.2$, $p = 0.27$). A larger proportion of independent pharmacies (21.6%) were sited in rural areas compared to multiple pharmacies (10.8%) (Pearsons's $X^2 = 27.1$, $p < 0.05$).

Distributions of community pharmacies and general practices were broadly similar, other than within the more sparsely populated Health Boards. There were 2.3 community pharmacies per 10,000 Health Board population (SD = 0.4) compared to a rate of 2.0 for general practices ($n = 1017$; SD = 1.6). Five Health Boards showed lower rates for community pharmacies than for general practices, most notably in four least densely populated Health Boards of Highland, Shetland, Western Isles and Orkney (Fig. 1). These four Health Boards contained 78 (60%) of Scotland's 129 dispensing general practices.

3.2. Registrations

The first 12 months of the scheme showed monthly increases in numbers of people registered with a sharp decrease in July 2007 as people who had not received treatment over the year were removed from the register. Mean monthly registrations were significantly greater in community pharmacies in the most deprived SIMD quintiles over the period July 2006 to March 2009 ($F = 43.9$, $p < 0.001$). Urban community pharmacies had registered significantly more ($t = 12.7$, $p < 0.001$) patients per month (mean = 542.3; SD = 72.6) than those in rural areas (mean = 347.5; SD = 49.6).

3.3. MAS items volumes

1,211,900 MAS items were supplied during 2008/09. The share of all MAS items supplied by multiple pharmacies increased from 64.2% during the first 9 months of the scheme from July 2006 to March 2007, to 68.9% during 2008/09. Numbers of MAS items supplied continued to increase over the whole study period with winter and summer seasonal fluctuations (see Fig. 2). The mean rate of MAS items supplied per 10,000 population in Scotland was 2344.8 (median = 1940.5; SD = 926.7) for 2008/09, with a wide variation in rates of MAS items supplied per 10,000 Health Board populations, ranging from 219.9 items per 10,000 population (Western Isles) to 3604.6 (Ayrshire and Arran) (see Fig. 3). Mean monthly MAS items dispensed were significantly higher for community pharmacies located in the most deprived SIMD quintiles (mean = 96.7 items per month, SD = 73.3) compared

Please cite this article in press as: Wagner A, et al. Changing patient consultation patterns in primary care: an investigation of uptake of the Minor Ailments Service in Scotland. Health Policy (2010), doi:10.1016/j.healthpol.2010.07.002

Table 1
Multivariate analysis of Minor Ailments Service items dispensed and potential predictors of uptake in Scotland 2008/09.

Predictor	Multivariate model		
	Beta coefficient (CI)	*t*	*P* value
SIMD deprivation score[a]	7.2 (3.9,10.5)	4.3	<0.001*
Urban pharmacy location[b]	278.4 (140.3,416.5)	3.9	<0.001*
Independent pharmacy[c]	−113.1 (−212.0, −14.2)	−2.2	0.03**
Percentage of population aged under 16[d]	15.8 (1.4,30.1)	2.2	0.03**
Percentage of population with limiting long-term illness[e]	7.2 (−0.6, 14.9)	1.8	0.07
Percentage of population aged 65 or over[d]	1.6 (−6.7, 9.8)	0.4	0.7
Constant	188.6 (−84.7, 461.9)	1.4	0.2

$F(6, 1270)$, 14.8 F, <0.001; adjusted $R_2 = 0.06$.
[a] Scottish Executive: Scottish Index of Multiple Deprivation 2006.
[b] May 2009 National Statistics Postcode Directory (reference category = rural pharmacy location).
[c] NHS National Services Scotland Information Services Division (reference category = multiple pharmacy).
[d] Mid-2008 population estimates—General Register Office for Scotland.
[e] Scottish Population Census 2001—General Register Office for Scotland.
* $P < 0.001$.
** $P < 0.05$.

to those in the least deprived areas (mean = 53.2 items per month, SD = 47.4), (one-way Anova: $F = 34.1$, $p < 0.001$). Mean items per month were also significantly higher ($t = -7.93$; $p < 0.001$) in urban pharmacies (mean = 72.6; SD = 17.6) compared to those in rural areas (mean = 43.3; SD = 11.8).

Overall, there were 0.2 MAS items supplied per registration per month in 2008/09 (median = 0.16; SD = 0.2). The annualised rate for 2008/09 was 1.9 MAS items per registration. The lowest annualised rate was 1.3 items per registration (Western Isles) ranging to the highest rate of 2.2 (Ayrshire and Arran). Mean MAS items supplied per pharmacy in Scotland was 1015.8 (median = 877.3; SD = 339.9).

Table 1 shows results from the multivariate regression analysis for the six potential predictors. Four significant variables were found, with higher provision of MAS items more likely in pharmacies located in data zones experiencing higher SIMD deprivation (B coefficient 7.21; 95% CI 3.91,10.5; $p < 0.001$). Similarly, pharmacies in urban settings were more likely to have higher levels than rural pharmacies (B coefficient 278.39; 95% CI 140.28, 416.49; $p < 0.001$). Independent pharmacies were less likely to have higher MAS dispensing rates than multiple pharmacies (B coefficient −113.13; 95% CI −212.04, −14.21; $p < 0.05$). Pharmacies in areas with higher proportions of people aged under 16 were significantly associated with higher MAS levels (B coefficient 15.77; 95% CI 1.43, 30.11; $p < 0.05$).

3.4. MAS medicines supplied

The MAS share of all dispensed items was 1.4% in 2008/9 (see Table 2). The top 10 medicines with the highest MAS dispensing volumes took an aggregated 12.0% share of all dispensed items in that group, with markedly high shares for head lice treatments and simple linctus. Paracetamol was the most commonly supplied MAS medicine (19.4% of all MAS items), followed by ibuprofen (6.8%), simple linctus (6.0%), chloramphenicol eye drops (3.6%) and emollients (3.5%). There were some differences in proportions of items supplied between community pharmacies located in the most deprived and least deprived areas. Citric acid (simple linctus) was the second highest supplied medicine in the most deprived areas (7.3%) and fifth most supplied

Table 2
Top 10 Minor Ailments Service medicines dispensed in Scotland 2008/09.

Approved drug name (minor ailment)	All items dispensed[a]	MAS items dispensed	MAS items dispensed as % all items	% of MAS total (rank)	% Most deprived quintile (rank)	% Least deprived quintile (rank)
Paracetamol (pain, fever)	1,862,874	234,791	12.6	19.4 (1)	20.2 (1)	19.2 (1)
Ibuprofen (pain, fever, inflammation)	703,200	82,507	11.7	6.8 (2)	6.4 (3)	7.9 (2)
Citric acid i.e. simple linctus (cough)	115,858	73,034	63.0	6.0 (3)	7.3 (2)	3.8 (5)
Chloramphenicol (eye infection)	23,0677	43,640	18.9	3.6 (4)	2.9 (6)	5.0 (3)
Emollients (skin)	1,353,640	42,594	3.1	3.5 (5)	2.7 (7)	4.6 (4)
Clotrimazole (vaginal thrush)	279,686	39,456	14.1	3.3 (5)	3.4 (4)	2.9 (7)
Dimeticone (head lice)	65,731	36,119	54.9	3.0 (7)	3.4 (5)	2.3 (10)
Chlorphenamine maleate (Hay fever)	187,654	34,679	18.5	2.9 (8)	2.6 (9)	3.3 (6)
Malathion (head lice)	41,243	31,449	76.3	2.6 (9)	2.7 (8)	2.0 (12)
Compound alginic acid preparations (indigestion)	564,506	29,305	5.2	2.4 (10)	2.4 (11)	2.3 (9)
Total top ten MAS medicines	5,405,069	647,574	12.0	54.4		
Remaining MAS medicines	80,915,868	564,326	0.7	46.6		
Total	86,320,937	1,211,900	1.4			

[a] Prescriptions dispensed by community pharmacists, appliance suppliers and dispensing doctors. Source: ISD prescription cost analysis (2008/09).

Please cite this article in press as: Wagner A, et al. Changing patient consultation patterns in primary care: an investigation of uptake of the Minor Ailments Service in Scotland. Health Policy (2010), doi:10.1016/j.healthpol.2010.07.002

(3.8%) in the least deprived areas. Overall, the combined percentage for the head lice treatments dimeticone and malathion was 5.6%, with a combined total percentage of 6.1% in highly deprived areas compared to 4.3% in the least deprived areas. The percentage of chloramphenical eye drops supplied under MAS dispensing was higher in the least deprived areas (5.0%) than highly deprived areas (2.9%).

3.5. Remuneration

The first 12 months of the MAS scheme showed a steady increase in numbers of community pharmacies in the top remuneration band of over 750 registered patients (see Fig. 4). There were 135 (11.7%) pharmacies in the top band in July 2006, increasing to 433 (36.6%) over the 12 months. Following the large-scale reduction of inactive registered patients in July 2007, the top band fell to 180 (15.2%) pharmacies. Over the following period, the number and proportion continued to increase, though at a slower rate with almost a quarter in the top remuneration band in March 2009 (284 pharmacies, 23.5%). There mean monthly number of MAS registrations in participating pharmacies 523 during 2008/09 and there was no evidence of clustering around payment band boundaries.

Multiple pharmacies were more likely to be in the highest remuneration band and the proportion increased at a greater rate than independent pharmacies. There were 81 (11.1%) multiple pharmacies in the highest remuneration band at July 2006, increasing to 205 (25.8%) at March 2009. This was greater than the rate of increase and proportion of independent pharmacies in the highest remuneration band which was 54 (12.6%) at July 2006, rising to 79 (19.2%) at March 2009. Almost a third (29.9%; $n = 123$) of independent pharmacies were in the lowest remuneration band of 250 registered patients or less, compared to 17.7% ($n = 141$) of multiples.

4. Discussion

The MAS is a significant nationally funded innovation devoted to managing patient access to clinical services. Numbers of MAS registrations and dispensed items have grown steadily since the introduction of the scheme, improving patient access to treatments for the management of self-limiting conditions via community pharmacies for those patients that do not pay prescription charges. There is no evidence that the remuneration structure encouraged gaming behaviour at the payment band boundaries or distorted provision. This study has found variations in MAS uptake, based on location characteristics and type of pharmacy ownership. Community pharmacies under multiple ownership, have engaged in MAS activity to a greater extent than independent pharmacies, with higher overall uptake in community pharmacies located in deprived and urban areas. MAS activity in relatively remote and less densely populated Health Boards is likely to be affected by higher numbers of dispensing practices and fewer pharmacies.

A potential disadvantage of the study design is the possible presence of ecological fallacy, attributing homogenised population characteristics to community pharmacies, based on aggregated data for the pharmacy's geographical location. Though research into general practice population characteristics commonly uses this method to create proxy indicators, general practices usually enjoy geographically bounded registered patient lists. Intuitively, commercial settings of community pharmacies will provide greater variation in patients' home starting point and, therefore, attaching aggregated local characteristics may have weaker validity. However, the strong associations between levels of uptake and higher proportions of children, deprivation and urban settings within our results, suggest patient utilization is related to local health need. Patterns of pharmacy use have previously been linked to the nature of particular illnesses and specific demographic groups [24]. Females, particularly those with young children, are more likely to consult a pharmacist while older people, though high users of dispensed medicines, are less likely to visit for advice.

The MAS service has been promoted by policy makers as an additional patient-focused service intending to improve efficiency and ease of patient access. Increasing MAS medication volumes and registrations suggest growing perception of and commitment to the scheme, though it is not clear how consistent patient commitment to MAS is. Recent studies indicate that the extent of shifting the management of minor ailments to community pharmacists is affected by influences on patient preferences. A 2006 discrete choice experiment survey in Scotland found that patients preferred to self-manage self-limiting conditions, with community pharmacists as the preferred source of advice compared to practice nurses or the NHS 24 telephone service [25]. Patients were, however, prepared to take a less-preferred avenue of health care advice should they incur reduced costs and waiting times.

Other studies have investigated barriers to patient utilization of community pharmacies for minor ailments treatment and advice. Evidence from an evaluation of patient awareness and comfort with community pharmacist prescribing indicated demographic factors such as older age, better self-rated health status and higher educational attainment predicted greater awareness of the service [26]. However, the study described patient concerns about the extent of pharmacists' diagnostic knowledge compared to GPs and unease with privacy and confidentiality in pharmacy settings. The original Care at the Chemist study showed clear demographic divergence in service utilization and treatment choice for several of the 12 conditions included in the study [4]. Approximately three quarters of the pharmacy-provided service users were female while older people were more likely to visit the GP. Patients favoured community pharmacies for head lice and vaginal thrush treatments, while the GP was the predominant destination for earache, cough and upper respiratory tract infections.

Abolition of all patient prescription charges in Scotland will be introduced April 2011, with an intervening phased reduction in payments (i.e. 2007 prescription charge per item: £6.85; 2008: £5.00; 2009: £4.00; 2010: £3.00). How the reduction and abolition in charges in Scotland might impact on the distribution of health care seeking behaviour is unclear. However, a study of non-sedative antihistamine

Please cite this article in press as: Wagner A, et al. Changing patient consultation patterns in primary care: an investigation of uptake of the Minor Ailments Service in Scotland. Health Policy (2010), doi:10.1016/j.healthpol.2010.07.002

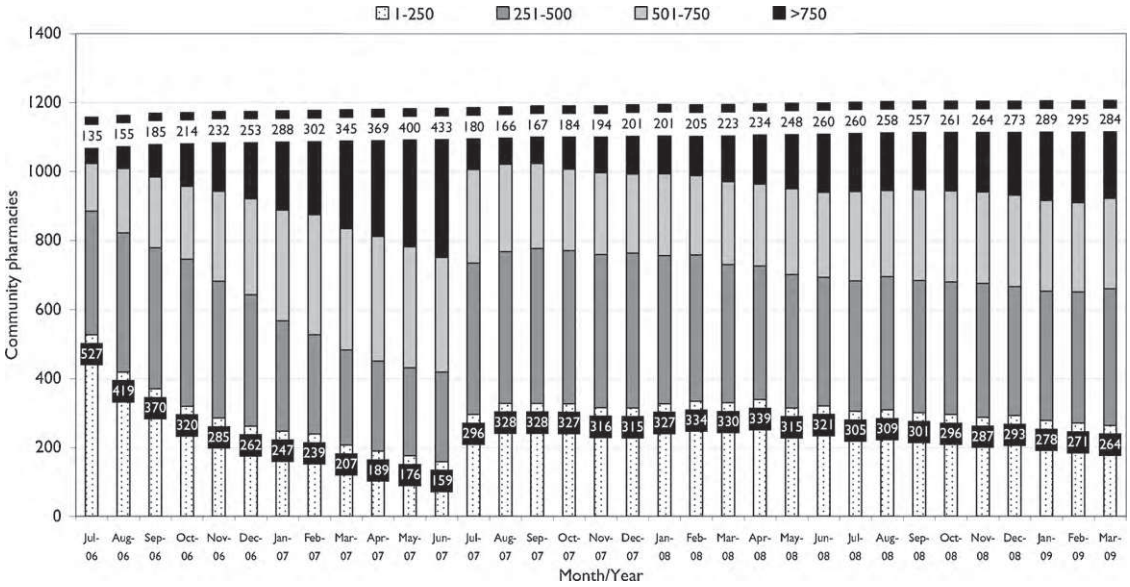


Fig. 4. Number of community pharmacies by Minor Ailments Service remuneration bands in Scotland, between July 2006 and March 2009.

prescribing in Wales during a similarly phased abolition of the prescription charge showed increased prescribing in the least deprived areas. It was suggested patients not exempt from payments were visiting the GP to avoid more expensive OTC medicine payments and sacrificing speedier access [27].

A key aim of the service was to reduce health inequalities through better access [28]. Our findings show that community pharmacies in urban and the most deprived areas have been most active in providing MAS services. Lower uptake rates in rural areas suggest that rural patients have not benefited to the same extent, placing a possible additional inequity on remote communities' existing reduced healthcare options, often constrained by extended travel times and appointment-based services. In designing and establishing a wider range of community pharmacy services, attention needs to be given to these revealed inequalities and how they can be reduced.

This analysis of the uptake and impact of the national MAS in Scotland is the culmination of a series of evaluation studies [3–5,10] through feasibility to national implementation stages of pharmacy-based services that aim to improve access and efficiency of the treatment of minor ailments in primary care, They demonstrate the effectiveness and efficiency of MAS and this study in particular shows the association between levels of uptake and local deprivation and urban setting.

A final observation is that the remuneration structure for MAS in Scotland may provide clues to avoiding the perverse incentives of volume-driven payment arrangements for other pharmacy services, notably medicines use reviews [26]. Instead of simply concentrating on the impact of pharmacy ownership on service provision and quality, and characterising general medical practice as "NHS primary care" and pharmacy as the "for profit community pharmacy sector" as recent commentators have [9], more effort should be directed at commissioning services on the basis of appropriateness and quality. Renewed thought needs to be given to effective remuneration frameworks for community pharmacy [29,30] that appropriately incentivise both community pharmacy owners and practitioners.

References

[1] Campbell SM, Roland MO. Why do people consult the doctor? Family Practice 1996;13:75–83.
[2] Thomas DH, Noyce PR. The interface between self medication and the NHS. British Medical Journal 1996;312(March (7032)):688–91.
[3] Hassell K, Whittington Z, Cantrill J, Bates F, Rogers A, Noyce P. Managing demand: transfer of management of self limiting conditions from general practice to community pharmacies. British Medical Journal 2001;323(July (7305)):146–7.
[4] Whittington Z, Hassell K, Cantrill J, Noyce P. Care at the chemist: a question of access. A feasibility study comparing community pharmacist and general practice management of minor ailments. Royal Pharmaceutical Society of Great Britain 2001.
[5] Blenkinsopp A, Noyce PR. Minor illness management in primary care: a review of community pharmacy NHS schemes. Keele University: Department of Medicines Management; 2002.
[6] National Prescribing Centre. Community pharmacy minor ailment schemes. Liverpool, October: MeReC Briefing No. 27; 2004.
[7] The Health and Social Care Information Centre. General pharmaceutical services in England and Wales 1998–99 to 2007–08; 2008.
[8] Department of Health. Partial impact assessment of proposals to expand the provision of minor ailment schemes (March); 2008. London.
[9] Richardson E, Pollock AM. Community pharmacy: moving from dispensing to diagnosis and treatment. British Medical Journal 2010;340:c2298.
[10] Schafheutle E, Noyce P, Sheehy C, Jones L. Direct supply of medicines in Scotland: evaluation of a pilot scheme. Scottish Executive Social Research; 2003. Report No.: 29.
[11] Sheehy C, Jones L. Direct supply of medicines in Scotland: extended monitoring of a pilot scheme. Scottish Executive Social Research; 2003. Report No.: 30.
[12] NHS National Services Scotland. Prescription exemption categories. NHS National Services Scotland, Practitioner Services; 2009 [cited 2009 July 17], Available from: URL: http://www.psd.scot.nhs.uk/doctors/exemptions.html#entitlement.
[13] Scottish Executive. Delivering for health; 2005. Edinburgh.

Please cite this article in press as: Wagner A, et al. Changing patient consultation patterns in primary care: an investigation of uptake of the Minor Ailments Service in Scotland. Health Policy (2010), doi:10.1016/j.healthpol.2010.07.002

[14] Bellingham C. Introducing the new Scottish contract. The Pharmaceutical Journal 2005;275:637.
[15] Leon D, Morton S, Cannegieter S, McKee M. Understanding the health of Scotland's population in an international context. London School of Hygiene & Tropical Medicine: Public Health Institute of Scotland; 2003.
[16] Remote and Rural Steering Group. Delivering for remote and rural healthcare. The final report of the remote and rural workstream. Edinburgh, NHS Scotland: The Scottish Government; 2007.
[17] NHS National Services Scotland. Community pharmacy services: Remuneration arrangements and drug tariff PT 7 reimbursment arrangements for 2008–09. Edinburgh: Primary and Community Care Directorate, 2008. Report No.: NHS circular, PCA (P) (2008) 13.
[18] Flowerdew R, Graham E, Feng Z. The production of an updated set of data zones to incorporate 2001 Census geography and data. Report to the Scottish Executive. University of St Andrews; 2004.
[19] Woodward M, Brindle P, Tunstall-Pedoe H. Adding social deprivation and family history to cardiovascular risk assessment: the ASSIGN score from the Scottish Heart Health Extended Cohort (SHHEC). Heart 2007;93(February (2)):172–6.
[20] Brown D, Leyland AH. Population mobility, deprivation and self-reported limiting long-term illness in small areas across Scotland. Health Place 2009;15(March (1)):37–44.
[21] General Register Office for Scotland. Social Focus on Urban Rural Scotland 2003. http://www scotland gov uk/Publications/2003/05/17207/22176 2009 [cited 2009 October 13].
[22] NHS National Services Scotland Information Services Division. Prescribing and dispensing summary statistics for Scotland. http://www.isdscotland.org/isd/information-and-statistics.jsp?p_service=Content.show&pContentID=2226&p_applic=CCC& 2009Available from: URL: http://www.isdscotland.org/isd/information-and-statistics.jsp?p_service=Content.show&pContentID=2226&p_applic=CCC&.
[23] Scottish Executive. Urban rural classification. Office of the chief statistician. Environment and Rural Affairs Department; 2004.
[24] Hassell K, Rogers A, Noyce P. Community pharmacy as a primary health and self-care resource: a framework for understanding pharmacy utilization. Health & Social Care in the Community 2000;8(January (1)):40–9.
[25] Porteous T, Ryan M, Bond CM, Hannaford P. Preferences for self-care or professional advice for minor illness: a discrete choice experiment. British Journal of General Practice 2006;56(December (533)):911–7.
[26] Stewart DC, George J, Diack H, Bond CM, McCaig D, Cunningham I, et al. Cross sectional survey of the Scottish general public's awareness of, views on, and attitudes toward nonmedical prescribing. Annals of Pharmacotherapy 2009;43(June (6)):1115–21.
[27] Dhippayom T, Walker R. Impact of the reduction of the prescription charge in Wales on the prescribing of non-sedating antihistamines in primary care. Health Policy 2008;87(September (3)):309–15.
[28] Scottish Executive. The Right Medicine. A strategy for pharmaceutical care in Scotland. Scottish Executive; 2002.
[29] Huttin C. A critical review of the remuneration systems for pharmacists. Health Policy 1996;36:53–68.
[30] Bernsten C, Andersson K, Gariepy Y, Simoens S. A comparative analysis of remuneration models for pharmaceutical professional services. Health Policy 2010;95:1–9.

Please cite this article in press as: Wagner A, et al. Changing patient consultation patterns in primary care: an investigation of uptake of the Minor Ailments Service in Scotland. Health Policy (2010), doi:10.1016/j.healthpol.2010.07.002

Health and Social Care Committee
HSC(4)-13-11 paper 8

The Scottish Government

Review of the Community Pharmacy Public Health Service for Smoking Cessation and Emergency Hormonal Contraception

Health and Community Care

social research

REVIEW OF THE COMMUNITY PHARMACY PUBLIC HEALTH SERVICE FOR SMOKING CESSATION AND EMERGENCY HORMONAL CONTRACEPTION

Imelda Hametz
Fiona Hodgkiss
Christine Sheehy

Scottish Government Social Research
2011

The views expressed in this report are those of the researcher and do not necessarily represent those of the Scottish Government or Scottish Ministers.

Table of Contents

ACKNOWLEDGEMENTS

We would like to thank our ISD colleagues for supplying the information on the number of items and claims for the services and for the information from the minimum data set for information on the users of the smoking cessation service.

Our thanks also go to all those community pharmacy and Health Board staff who responded to the online survey and the users of the smoking cessation service who gave their views on the service.

1 EXECUTIVE SUMMARY

1.1 This report summarises findings of an evidence review which was carried out to inform a review of the community pharmacy services provided under the Public Health Service (PHS)[1] element of the Community Pharmacy Contract introduced in August 2008. There are two patient-focussed services provided under PHS by Community Pharmacies:

- A smoking cessation service to help those who wish to stop smoking by providing a course of up to 12 weeks nicotine replacement therapy (NRT) and advice; and
- A sexual health service which provides free access to Emergency Hormonal Contraception (EHC).

1.2 These public health services have been developed following the publication of The Right Medicine: A Strategy for Pharmaceutical Care in Scotland (Scottish Government 2002) where a commitment was made to further develop the public health role of community pharmacy contractors and their staff. The Public Health Service was initiated in July 2006 and is one of four core services which are provided as part of the new community pharmacy contract. The other three are: a Minor Ailment Service (MAS); an Acute Medication Service (AMS); and a Chronic Medication Service (CMS).

1.3 In 2008/9 national PHS specifications were adopted for smoking cessation and a sexual health service for emergency hormonal contraception. Given that these services have been in existence for over three years, it was agreed to review their operation to ensure that any future provision best meets the needs of users in Scotland.

1.4 To assist with the review, Health Analytical Services Division of the Scottish Government undertook a review of the evidence on the operation of the smoking cessation and sexual health services. The work included: a small scale review of the literature on the role of community pharmacists in delivering public health services for background information; analysis of routine PHS service data; surveys of community pharmacy and NHS Board staff; and interviews with smoking cessation services users which was carried out by IPSOS MORI.

1.5 A summary of the findings is detailed below.

Background

1.6 Over the last ten years there has been considerable international interest and activity in the development of the role of the pharmacist in the promotion of healthy lifestyles. This has led to the development of a range of specialised, extended or enhanced pharmacy services relating to health care and promotion other than routine provision of prescribed and non-prescribed medicines.

[1] In operation as part of the community pharmacy contract since August 2008

1.7 Examples of the types of public health roles for pharmacists have been documented in a range of literature include: self care; advice to young mothers; support to develop effective parenting skills; health promotion campaigns; drug misuse awareness; needle exchange schemes; AIDS awareness; sexual health support; unplanned teenage pregnancy support; support for patients with chronic illness; advice on how medicines work; out of hours services; collection and delivery services; domiciliary visits; disposal of waste medicines (Bush et al 2009).

1.8 Since the move to the provision of enhanced pharmacy services, research has been carried out looking at the operation and implementation of such services. Some studies have explored the facilitators and barriers to provision of enhanced services. For example one Australian study found that facilitators to providing enhanced services were: dedicated study time; accreditation; closed counselling areas; and access to patient notes. Barriers tended to be: a lack of time, space and skills; shortage of pharmacists; no extra remuneration; and lack of opportunities for meeting with local GP and health workers (Berbatis, et al., 2007). One Scottish study found that those who supported the provision of 'extended services' were more likely to be younger and have a postgraduate qualification (Inch, et al., 2005). However this study was conducted a while ago, not long after the introduction of the Right Medicine in 2001.

1.9 Studies have also examined public perceptions and experience of using enhanced services. Although the research suggests that pharmacists tend to be seen as 'drug experts' advising on medicines rather than illness and health, actual users of community pharmacy based health development initiatives express a high level of satisfaction with such services.

1.10 Much of the evidence on patient experience of using enhanced service suggests that both emergency hormonal contraception (EHC) and smoking cessation services are well received.

Response

1.11 There were 121 responses to the community pharmacists' survey from across 13 of the 14 health boards in Scotland. This is a small proportion of approximately 2500 registered community pharmacists in Scotland (although not all these will be providing services) and therefore the findings should be treated with caution. A total of 61 responses were received from NHS Board staff. Almost half (48%) of these respondents had a responsibility or interest in the PHS smoking cessation service only, over a third (36%) had a responsibility or interest in both services and 15% had an interest in the EHC service only.

The PHS Smoking Cessation Service

Analysis of routine smoking cessation data

1.12 Analysis of routine data collected on the number of smoking related items (NRT) dispensed through the PHS smoking cessation service suggests that

the PHS service can be seen to have contributed to an increase in the number of people attempting to quit smoking using NRT across Scotland to the levels experienced around the smoking ban in 2006. The total number of smoking items dispensed by all smoking cessation services across Scotland rose from 162,000 items in 2007/8 to over 330,000 items in 2010/11.

1.13 Community pharmacies can claim a fee for each month of the three months a client is receiving the service. The figures suggest that there are large falls in the number of items claimed between month 1 and month 3 for PHS smoking cessation service: in the period July 2010 to June 2011, over 88,000 claims were for clients receiving the service in month one, almost 36,000 were for clients in month two and just over 21,000 were for clients in month three. It is clear that a large number of clients leave the service without completing the 12 week course but it is difficult to say whether they have left the service having quit or whether they have given up the attempt to quit.

1.14 Analysis of patient characteristics – age, gender and deprivation decile, was undertaken using the smoking cessation minimum dataset. This data shows that the majority of people making a quit attempt with the PHS smoking cessation were female (59%), that most were in the middle age groups 35-59, (53%)and most were from the most deprived areas in Scotland (41% in SIMD 1-2 and 23% in SIMD 23%). This is not dissimilar from the client characteristics of other smoking cessation services overall but a greater proportion of people using the community pharmacy smoking cessation service tend to be younger and from more deprived areas than those using non-pharmacy services.

1.15 Information on quit outcomes is recorded at 1, 3, and 12 month 'follow up' of PHS clients. Analysis of this data suggests that while a large number of clients express a willingness to quit smoking using the PHS service, many do not in the end quit via the service. Thirty two per cent of those people who had set a quit date when they first visited the pharmacy, self-reported that they had quit smoking at 1 month compared to 52% of those using non-pharmacy services.[2.] At three month follow-up, 11% of those setting a quit date reported that they were not smoking compared to 23% of those using non-pharmacy services.[3]

1.16 It appears that fewer quit attempts were successful via the community pharmacy PHS service than other non-pharmacy smoking cessation services in Scotland. Caution should be taken when reviewing these results as some users of the service are lost to follow-up and their quit status is unknown. More users of the PHS pharmacy service were lost to follow-up than users of non-pharmacy services, 55%:25%.

[2] Quit status and quit dates are not recorded for all smoking cessation patients.
[3] Based on ISD figures which are based on total 'quit attempts', rather than total number of 'clients' with a quit attempt, so could include repeat quit attempts for the same client.

Views of Community Pharmacists and NHS Board Staff

1.17 The views of the community pharmacy staff on the smoking cessation service were in the main positive. Many felt that that the smoking cessation service offered a valuable way for people to attempt to quit smoking. Providing the PHS smoking cessation service led to real job satisfaction for some community pharmacy staff. However a small number felt that the service would be better provided by others.

1.18 The main concerns about the service were the paper work, workload and the support needed to provide the service. Many of community pharmacy staff felt that the scope of the service should be extended in terms of the products that were available. Some also felt that there were issues with clients who were not motivated to quit accessing the service and a small number suggested that a small charge might avoid this problem.

1.19 Views were also expressed by a small number of respondents that support should be offered to help reduce smoking not just to quit, and that the length of time support is offered should be more flexible to assist those who were making progress but needed further support.

1.20 Overall NHS Board staff had mixed opinions about the PHS smoking cessation service. Some staff felt that the smoking cessation service allowed more people to access NRT and that locally the service successfully complemented other more intensive smoking cessation services. Others felt that pharmacies did not have the time or skill to offer the support needed to help people quit smoking and there was not enough evidence around quit rates from the service to be seen to be successful. Many Board staff recognised that the paperwork that pharmacies had to complete was over complicated but also that it was poorly or not completed by community pharmacies. There was a widely held view that completion of data forms should be linked to payment.

Views of Service Users

1.21 The findings from the IPSOS MORI study, suggested that participants were very positive about the smoking cessation service provided by community pharmacies. Satisfaction was high among almost all service users who participated in the research, even those who were unsuccessful in their quit attempt. This suggests that many aspects of the service appear to work well and should be continued, particularly the accessibility and flexibility of the service, the interaction with pharmacy staff and the provision of free NRT. However, there are some aspects of the service which could be improved or developed further, these include:

- Advertising of the key aspects of the service.
- Ensuring a relationship with the staff providing the service is built up and there is continuity of care.
- Providing additional support after 12 weeks.
- Allowing those who fail in their attempt to continue to try and quit or return to the service earlier.

- Helping users access other support options during their quit attempt e.g. to Smokeline.
- Providing further information, advice and tips to users to help them in their quit attempt.
- Ensuring private rooms or areas out of earshot of other customers are used for consultations.
- Ensuring that CO testing is available and machines are working.

1.22 Further details of this study can be found at: www.scotland.gov.uk/PHSsmokingcessationusersviews

Emergency Hormonal Contraception Service (EHC)

Analysis of routine EHC data

1.23 Since its introduction in 2008, the PHS EHC service has increased in size and in 2009/10 it dispensed just over 82,000 items. The quantity dispensed in 2010/11 reduced slightly to just over 81,000 items. The number of items being dispensed monthly over the 2009/10 – 2010/11 remaining relatively constant at 7,000 items per month. The service can be seen to have increased access to EHC and to complement the service provided at other sexual health services where EHC is given out without prescription.

1.24 Between July 2010 and June 2011 there were just over 70,000 claims recorded for the PHS EHC service. Although the period for patient claims data is different from the period for the data on the number of dispensed items, the data suggest that there is a discrepancy between the number of claims made and the number of items dispensed. This discrepancy is being examined.

Views of Community Pharmacists and NHS Board Staff

1.25 Overall the PHS EHC seems to be working extremely well from the point of view of NHS Board and community pharmacy staff who responded to the on-line survey. In particular the community pharmacy staff felt that the EHC service was a valuable community service which needed very little adjustment. It was also clear from the analysis that respondents felt that for remote and rural locations, the PHS EHC was the only easily accessible service available and it therefore fulfilled a crucial role.

1.26 There were however some areas for improvement suggested. These included: the expansion of the service to include pregnancy testing; longer term contraception; and new drugs which can be prescribed up to 5 days; removal of religious exemptions; using pharmacy technicians in providing the service; integration with other services; more data to be collected about the service; and governance and quality assurance of the service.

Views of Service Users

1.27 It was felt that interviewing users of the service would not be appropriate due to the issues around keeping client confidentiality and the sensitivities around the service.

Discussion

1.28 Responses from both NHS board and community pharmacy staff and users of the smoking cessation services were in the main positive about both services. The following highlights the possible policy and delivery implications of the findings.

Smoking cessation

1.29 Although the figures from this research show that uptake of the smoking cessation service had increased the findings suggest that consideration should be given to improving promotion of the service via; other professionals such as GPs; providing promotional materials outlining the flexibility of the service; the support offered by staff and the availability of NRT.

1.30 Interactions with community pharmacy staff were an important feature in the effectiveness of the service and consideration should be given to ways that community pharmacies can provide continuity of service provision while maintaining flexibility for service users. It is also important to ensure that pharmacy staff delivering the service are competent in the necessary skills and knowledge and have access to appropriate training.

1.31 The research revealed that many service users do not return for subsequent visits. Ways of reducing the number of failed quit attempts needs to be considered as well as ways of continuing support to those who require this beyond the initial 12 weeks of the service. Widening the scope of the service to include other treatment options also needs to be considered.

1.32 The research suggests that links between the different smoking cessation service providers need to be encouraged so that users have access to the most appropriate package of support.

1.33 Service users found CO monitors a valuable tool in encouraging and motivating them to quit. Consideration should therefore be given to ensuring availability of CO monitors as part of the service and providing support to maintain the monitors.

1.34 A key theme emerging from this research was the complexity and duplication of the paperwork associated with the service. In addition, NHS board respondents were keen to see payment linked with data collection. Consideration should be given to simplifying the paperwork and the potential for merging and integrating data and payment systems explored.

1.35 Although a number of NHS boards had developed quality improvement programmes for the service others highlighted difficulties in providing local

quality assurance believing there was insufficient recognition of this in the service specification. In the light of this it is suggested that the PHS Directions and service specification should be reviewed taking into account quality assurance aspects. Sharing best practice at NHS Board and community pharmacy level could also be encouraged.

EHC service

1.36 Overall it was felt that the EHC service offered a valuable service across the country, particularly in rural areas and that it required little adjustment.

1.37 Over the last year (2010/2011) the number of EHC items dispensed has remained relatively stable. Some respondents suggested that there was a need for better promotion of the service including highlighting one of its key features – confidentiality. Consideration should also be given to ensuring that promotional materials include information on the benefits and convenience of the service.

1.38 The majority of community pharmacy staff had received training and 97% felt it was very useful or useful. Most respondents also felt supported by their NHS board but a significant minority (18%) did not and cited a lack of communication with NHS board and poor communications. On the back of this, consideration should be given to:

- increasing access to training and support for community staff ensuring they have good knowledge and understanding of the service and
- making use of community pharmacy champions for example in supporting newly qualified pharmacists and those new to an area.

1.39 The EHC service was generally felt to be effective. However, there were various suggestions as to how it could be improved for users. These included extending the provision of services to include other forms of contraception and pregnancy testing, direct referral to other specialist sexual health services and using other pharmacy staff such as technicians to provide the service.

1.40 As with the smoking cessation findings many NHS boards reported the development of local quality assurance programmes including regular visits to the pharmacies, provision of toolkits and provision of performance data. It is suggested that the PHS Directions and service specification should be reviewed taking into account quality assurance aspects. Sharing best practice at NHS Board and community pharmacy level could also be encouraged.

1.41 Previous discrepancies between the number of claims made and the number of items dispensed for the EHC service are being resolved. Once this has been addressed consideration should be given to improving systems to record EHC dispensed and claimed e.g. by underpinning the service with IT support through the ePharmacy Programme which would allow community pharmacists to print and electronically claim EHC prescriptions.

1.42 Consideration should also be given to collecting more information on patient characteristics such as age range and post code area again using standardised pro formas underpinned electronically through the ePharmacy Programme.

Conclusions

1.43 The findings from this review suggest that both the PHS smoking cessation and EHC services are considered valuable services by both community pharmacy and NHS Board staff and in the case of the smoking cessation service, by the users as well.

1.44 However there are a number of suggestions as to how the smoking cessation service in particular could be improved with respect to increasing quit rates and enhancing the service such as follow up of users, extending the range of products available, training, further integration with other local smoking cessation services and linking completion of paperwork with payment.

1.45 Similarly improvements suggested with respect to the EHC service included; enhancement of the service e.g. community pharmacists providing other contraception and support, the use of pharmacy technicians, better links and referrals to other sexual health services, improving governance and quality assurance and improving data collection.

2 INTRODUCTION

2.1 This report summarises findings of an evidence review which was carried out to inform a review the community pharmacy services provided under the Public Health Service (PHS)[4] element of the Community Pharmacy Contract. The review, which focuses on the smoking cessation service and emergency hormonal contraception (EHC), part of the sexual health services, was commissioned by the Scottish Government Primary Care Division of the Primary and Community Care directorate.

Aims and Objectives of Evidence Gathering Exercise

2.2 The objectives of this evidence gathering exercise were to:

- Explore successful approaches to providing smoking cessation and emergency hormonal contraception services through the community pharmacy;
- Examine uptake of the service, users of the services, drop-out levels (from smoking cessation) and overall effectiveness;
- Explore users' views on the accessibility of the current service (for smoking cessation only), their level of satisfaction with the service and what improvements could be made to provide a better service;
- Explore community pharmacists' views of delivering the service and their views on how the service could develop to better meet patients' needs;
- Explore the views of NHS Boards on the provision of the service at a local level, seeking views from Board managers of smoking cessation and sexual health services.

2.3 This report explores each of these objectives in turn, presenting and exploring the available evidence in order to assess the delivery and effectiveness of these elements of the PHS.

Background

2.4 Over the last ten years there has been considerable international interest and activity in the development of the role of the pharmacist in the promotion of healthy lifestyles. Internationally this has led to the development of a range of specialised, extended or enhanced pharmacy services relating to health care and promotion other than routine provision of prescribed and non-prescribed medicines. The promotion of healthy lifestyles is one of the five core pharmacist's roles defined by the Royal Pharmaceutical Society of Great Britain (1996).

2.5 The Scottish Government policy document 'The Right Medicine: A Strategy for Pharmaceutical Care in Scotland (Scottish Government 2002) focused on

[4] In operation as part of the community pharmacy contract since August 2008

the extended healthcare roles for pharmacists in the future NHS Scotland. This strategy stemmed from commitments set out in *Our National Health: A plan for action, a plan for change* to improve healthcare in the NHS relating to several priorities: improving health; improving access; helping patients make better use of their medicines; service redesign; and partnership with staff (Scottish Executive 2000*)*. Similar moves have taken place across the UK and new NHS community pharmacy contracts include a move away from technical supply to inclusion of a professional clinical role (Department of Health 2004, Scottish Executive 2004).

2.6 The new contract arrangements are part of a long-term strategy to move pharmacists (and their remuneration) away from a focus purely on the dispensing of prescriptions to the provision of patient-centred care as part of the wider primary care team. Together these services aim to play an important part in shifting the balance of care by:

- Improving access for the public as they do not need an appointment to see their pharmacist for a consultation;
- Decreasing workload on GP and nursing colleagues therefore freeing up their time to see patients with more serious complaints;
- Helping to address health inequalities; and
- Making better use of the workforce by more fully utilising the skills of community pharmacists.

2.7 Examples of the types of public health roles for pharmacists have been documented in a range of literature include: self care; advice to young mothers; support to develop effective parenting skills; health promotion campaigns; drug misuse awareness; needle exchange schemes; AIDS awareness; sexual health support; unplanned teenage pregnancy support; support for patients with chronic illness; advice on how medicines work; out of hours services; collection and delivery services; domiciliary visits; disposal of waste medicines (Bush 2009).

2.8 There have been several studies on public perceptions, use and experience of extended services. A systematic international literature review on feedback from community pharmacy users on the contribution of community pharmacy to public health, found that consumer use of pharmacies is almost universal, especially for prescription supplies and over-the-counter medicines (Anderson et al 2004). Evidence from one study suggested that usage was low for general health advice and pharmacists were generally seen as 'drug experts' advising on medicines rather than illness and health (Hassell 1998 cited in Anderson et al 2004)

2.9 Some studies suggest that while many people believe that it is the community pharmacy role to provide public health services, in practice they hadn't used them themselves. For example, in one study (Anderson 1998) 40% agreed it was the community pharmacists 'usual job' but only 15% said that they ever sought such advice. A Scottish study of 600 customers of 30 community pharmacies found that there was a clear distinction in the proportion of people willing to seek advice on medicine related and non-medicine related topics (Coggans et al 1998 cited in Anderson 2004).

2.10 Some studies have looked at usage of such services within the population. For example, usage of general health advice tends to be higher among women, respondents with young children and C2DE groups[5]. This study suggests those more likely to take up services are generally people who already use the service for prescribed medicines. Harder to engage are those who may currently be healthy

2.11 Despite this perception among the public, evidence suggests that users of community pharmacy based health development initiatives express a high level of satisfaction with the services(e.g. see Blenkinsopp et al 2000 cited in Anderson et al 2004).

2.12 In Scotland, the contract includes the provision of four pharmaceutical care services: a Minor Ailment Service (MAS) which provides advice, treatment and referral of people who register with the service; an Acute Medication Service (AMS) which dispenses acute or 'one-off' prescriptions supported by the electronic transfer of prescription forms; and a Chronic Medication Service (CMS) which uses the professional skills of community pharmacists in the management of long- term conditions, in partnership with the patient and their GP, and the public health service. Within the PHS element, there are two patient focussed services provided by community pharmacies:

- A smoking cessation service to help those who wish to stop smoking by providing a course of up to 12 weeks nicotine replacement therapy (NRT) and advice; and
- A sexual health service which provides free access to Emergency Hormonal Contraception.

2.13 There are approximately 1200 community pharmacies in Scotland providing the PHS service at any one time.

PHS Smoking Cessation Service

2.14 The aim of the smoking cessation service is to provide "extended access through the NHS to a smoking cessation support service, including the provision of advice and smoking cessation products, in order to help smokers successfully stop smoking as part of the Public Health Service (PHS) element of the community pharmacy contract" (Scottish Government 2008).

2.15 As part of the service, the pharmacist and support staff proactively seek out clients for the service, for example patients with cardiac or respiratory disease, people from disadvantaged neighbourhoods, pregnant women and young people. If clients want to quit, a quit date is discussed and an appointment is made for a return visit to see the pharmacist prior to the provisionally agreed quit date.

[5]C2 relates to skilled working class Skilled manual workers, D relates to working class Semi and unskilled manual workers and E to those at the lowest levels of subsistence.

2.16 At the first appointment, the pharmacist discusses treatment and, following an assessment, prescribes the most appropriate form of NRT[6] including the option of dual therapy. At this stage some data is also collected about the patient, including their current smoking and previous quit attempts. The patient is usually given one week's supply of NRT and a prescription is written for four weeks worth of NRT. The patient collects either on a weekly or less frequent basis. The pharmacist must make the initial supply, however subsequent supplies can be made by a trained pharmacy support staff.

2.17 At four weeks, a follow up appointment is undertaken with the patient and they are asked if they have smoked in the last two weeks. If they report that they have smoked, no further NRT is supplied and the quit attempt is recorded as unsuccessful. The patient is informed that they can make another quit via the service after a period of time specified locally by the Board – which typically tends to be three months (six months in Greater Glasgow and Clyde)[7]. If the patient reports that they are not smoking, another prescription for NRT is provided.

2.18 At the 4 week follow up appointment, data is collected on how the quit attempt is progressing and a CO monitor[8] may be used to confirm smoking status. The cycle of four week follow-up appointments and prescriptions then continues as part of the service for up to 12 weeks, when the course is completed. The pharmacist may refer the patient to other NHS board smoking cessation services according to an individual's needs and locally agreed patient pathways.

2.19 Each patient can therefore have up to 12 weeks supply of NRT and three follow up appointments as part of the PHS with NRT being prescribed on a weekly or less frequent basis. The pharmacy claims a payment of £25 for each patient for each month they are using the service by submitting a claim form to NHS National Services Scotland (NSS)[9]. The pharmacy is also required to submit a completed National Minimum Dataset Form [10]to their Board for each patient for inclusion in the national monitoring of smoking cessation services.

---

[6] NRT includes nicotine gum, patches, micro tabs, lozenges, nasal spray.

[7] Current official guidance is that "If a smoker's attempt to quit is unsuccessful using NRT, Varenicline or bupropion, prescribers/specialist smoking cessation advisers should not offer a repeat prescription within six months (unless identified, specific circumstances have hampered the person's initial attempt to stop smoking, in which case it may be reasonable to try again sooner" (NHS Health Scotland & ASH Scotland, 'Guide to Smoking Cessation in Scotland 2010 – Planning & Providing Specialist Smoking Cessation Services' p.32).

[8] A simple breath test using a CO monitor measured the level of carbon monoxide (CO) inhaled from tobacco smoke. CO monitors are used during smoking cessation programmes to give the smoker visible proof of the damaging CO levels and to help motivate by charting the progress during a quit attempt.

[9] http://www.communitypharmacyscotland.org.uk/_resources/files/legislation/PHS%20Smoking%20Cessation%20SOP.pdf

[10] The Minimum Dataset (MDS) is for recording the core data required for anonymous national monitoring of clients who access Scottish NHS Board specialist smoking cessation services, take part in a stop smoking intervention, and who set a quit date with the service during the course of the intervention. The data is analysed by NHS Boards and ISD.

2.20 The pharmacist or member of support staff should attempt to follow up the client if a client does not present as anticipated. The NHS Board undertakes follow up of clients at 12 weeks and 12 months after the agreed quit date unless it has been agreed that the pharmacist should do this. In this case, the data relating to the follow up should be sent to the NHS Board.

2.21 More information on the smoking cessation service can be found on Community Pharmacy Scotland website: http://www.communitypharmacyscotland.org.uk/nhs_care_services/public_health_service/phs_smoking_specifications.asp

PHS Emergency Hormonal Contraceptive Service (EHC)

2.22 The EHC service is one of four elements of the PHS sexual health service. The other three elements are: testing for Chlamydia infection, treatment of Chlamydia infection, where clinically appropriate and referral to another health care practitioner.

2.23 This review focuses on the free provision of EHC service which aims to "provide, where clinically indicated, a free supply of emergency hormonal contraception (EHC) as specified within a Patient Group Direction (PGD)." (Scottish Government 2008).

2.24 The EHC service is available to any female client aged 13 years or over and must be provided by the pharmacist in person. The pharmacist takes a client history (including asking for information on medical history, current medication and the possibility of current pregnancy) to ensure that they have sufficient information to assess the appropriateness of the supply. If the client is under 16 years of age, the pharmacist follows local child protection (LCP) guidelines to ensure the scenario is managed appropriately. If the client is over 13 and under 16, following the LCP guidelines, EHC can be prescribed. If the client is aged under 13, EHC is not prescribed and they are referred to their GP. There is an ethical opt out which allows pharmacists to choose not to offer this service, but in such circumstances they must refer patients requesting the service to another pharmacy who provides it.

2.25 If a client is assessed as being eligible for the service, the pharmacist prescribes Levonorgestrel 1.5mg tablet and counsels the patient. The supply of EHC is recorded by the pharmacist who then claims a payment of £25 for each client by submitting a claim form to NHS National Services Scotland (NSS)[11].

2.26 More information on the EHC service can be found on Community Pharmacy Scotland website:

http://www.communitypharmacyscotland.org.uk/nhs_care_services/public_health_service/phs_sexual_health_specifications.asp

[11] http://www.communitypharmacyscotland.org.uk/_resources/files/legislation/PHS%20Smoking%20Cessation%20SOP.pdf

3 METHOD

3.1 The evidence review comprised:

- a brief review of the literature on PHS;
- analysis of data collected routinely on the PHS e.g. data on number of claims, patient data;
- on-line surveys of community pharmacy and NHS Board staff;
- interviews with users of the smoking cessation service carried out by IPSOS MORI.

3.2 Please note that interviews were not carried out with EHC service users as it was felt that in doing so it may be perceived by users as compromising some of the important features of the EHC around quick and easy access, confidentiality etc. Instead we used information from the review of previous research to gain some insight to users' views on EHC services.

3.3 The methods used in each element of the review are described in more detail below.

Review of Literature

3.4 A brief review of the literature on pharmacy delivered public health services was undertaken to complement the analysis in this review and to provide further background.

Analysis of Routine Data

3.5 Practitioner Services Division, part of National Services Scotland[12]collects data on the PHS smoking cessation and EHC services in connection with their role in the payment of community pharmacies for delivering the services. Information on the number and type of patient claims and the pharmaceutical items provided as part of the services are collected. Information Services Division[13] (ISD) analyse this data and regularly provide monitoring reports to policy officials. These reports are also publicly available. Data used in review covered both the pre and post introduction of the PHS patient services, from April 2006 to June 2011.

[12] National Services Scotland is a national is a non departmental public body, accountable to the Scottish Government, providing national strategic support services and expert advice to NHS Scotland.

13ISD delivers effective national and specialist intelligence services to improve the health and wellbeing of people in Scotland.

3.6 Other data on the PHS service relating to patients comes from the Smoking Cessation Minimum dataset[14] which community pharmacists should complete for each client, available via ISD at the time of this research for the period January to December 2010. This data includes information on smoking status, number of quit attempts, quit date for this attempt, intervention used, smoking status at follow up, CO readings, demographic data and consent for follow up and for anonymised data to be used in the national dataset.

3.7 It should be noted that data recorded for the minimum dataset has to date been less well completed than data recorded for claims for payment. Caution is therefore needed in the interpretation of data from these two sources about the patients who use the services.

3.8 For the purpose of the analysis, data relating to both claims and items dispensed has been analysed for the most recent (at the time of writing) full year's data, July 2010 to June 2011 has been provided by ISD and extracted from the Prescribing Information System. Data on national smoking cessation figures are provided for the calendar year 2010 from the National Minimum dataset provided by ISD. Smoking prevalence rates are available for 2009/10 from the Scottish Household Survey. Microsoft Excel was used to analyse the data and to provide summaries and basic descriptive statistics.

On-line Survey of Community Pharmacists and NHS Boards

3.9 Questback software was used to conduct online questionnaire surveys of community pharmacists in Scotland and NHS Board staff in each of the 14 territorial Boards who had an interest or responsibility for either the smoking cessation and/or EHC service. Whilst much was done to promote community pharmacist awareness of and participation in the online survey, the response was low. Almost all territorial Health Boards and all types of pharmacy (ranging from multiples to single outlets) were represented amongst the respondents, it is difficult to know how representative the views expressed in the survey are of community pharmacists more generally. The data provided in this report must therefore be treated with caution.

3.10 Similarly, responses from a wide range of Health Board staff were obtained but again it is difficult to know how representative these views are of all the staff that might have responded.

Survey of Community Pharmacy Staff

3.11 Community Pharmacy Scotland distributed the link to the community pharmacy survey to all its members. Directors of pharmacy at Health Boards were also asked to pass on the link to pharmacies in their area. The survey asked about which pharmacy staff were involved in the smoking cessation service; training they had received, details of the service offered; facilities for consultations; views on effectiveness of the service; and suggestions for improving the service.

[14] Each NHS Board has adapted the national dataset form. This may lead to difficulties where a pharmacist has pharmacies in more than one Board area.

3.12 One hundred and twenty one community pharmacy staff from 13 out of the 14 NHS Boards in Scotland participated in the survey.

3.13 Over two thirds of respondents (68%) were pharmacists employed by the pharmacy, 24% were community pharmacy contractors, 7% were locum pharmacists and 2% were 'others' including practice managers and employee/shareholder.

3.14 Table 1 shows the type of pharmacy that respondents worked in. Over a third of respondents worked in a pharmacy which was part of a large multiple.

Table 1: Type of pharmacy

Type of pharmacy respondent works in	
	%
Multiple outlet (16+ pharmacies)	36
Medium outlet (6-15 pharmacies)	13
Small outlet (2-5 pharmacies)	26
Single outlet	24
N	***121***

3.15 The majority of respondents worked in pharmacies which did not open on Sundays or after six pm (Table 2). Of the 15 respondents (12%) who did open late in the evenings, the majority (between 13 and 14 respondents) opened late on a weekday evening; six opened late on a Saturday; and three opened late on a Sunday. Another respondent reported that they opened early in the morning.

Table 2 – Community pharmacy opening hours

Pharmacy open	**Yes**	**Yes – but only on a rota**	**No**
	%	%	%
On Sundays	10	5	85
After 6 pm	12	0	87

N = 121

3.16 The overwhelming majority of respondents (97%) worked in pharmacies providing both smoking cessation and EHC services, 2% only offered the smoking cessation service, and 1% provided neither service. The pharmacy which did not provide either service explained that the reason for this was that there was:

"No private area or consultation room to offer privacy and confidentiality to patients. Shop floor area measures 8 ft x 8 ft, cramped, scruffy, unprofessional and unfit for purpose." [CP 67]

3.17 Of those pharmacies who did provide a PHS service (either smoking cessation or EHC) 90% provided it in a separate private consulting room, 5% provided it in a designated area of the pharmacy, and 5% provided it in another location such as a quiet area, a consultation room without a door,

temporarily over the counter, or different locations depending on which pharmacist was present.

3.18 The majority of those who provided one or both PHS services (92%) reported that there was no problem with providing suitable facilities - 8% did have problems providing facilities.

3.19 Problems listed by respondents included lack of space, the need to provide two consulting rooms for other services such as methadone supervision separately from the PHS service, lack of wheelchair access and consultation rooms having to double as staff rooms.

"One pharmacy I work in does not provide a consultation area therefore no privacy which is awkward for EHC - should be a requirement of EHC provision that there is a separate consultation area." [CP 91]

3.20 A majority of respondents had been providing smoking cessation and EHC services prior to the introduction of PHS in Scotland. Over two thirds (68%) had been providing a smoking cessation service and 62% the emergency hormonal contraception service (Table 3)

Table 3 - Length of time providing a service before the introduction of PHS

	Smoking Cessation Service	**Emergency Hormonal Contraception**
	%	%
More than 2 years	40	44
Between 1- 2 years	18	7
Less than one year	10	11
Did not provide a service	31	38
N	***116***	***111***

Survey of NHS Board Staff

3.21 The survey of NHS Board staff was sent to Directors of Public Health; Directors of Pharmacy; Smoking Cessation Coordinators; Sexual Health Strategy Leads and Lead Clinicians. The survey asked respondents' views of the effectiveness of the services, support for training, how the PHS services linked with other services in the Board, governance and quality assurance arrangements.

3.22 Sixty one NHS Board staff from across 13 of the 14 NHS Boards in Scotland completed the NHS Board questionnaire on the PHS Service between 24 January and 28 February 2011.

3.23 Almost half of respondents (48%) had responsibility or interest in the PHS smoking cessations service only. Just over a third (36%) had an interest or involvement in both services (Table 4).

Table 4 – Respondents by type of PHS service

Respondent with interest/responsibility in:		
	%	N
Both services	36	22
Smoking cessation only	48	29
EHC only	15	9
Neither service	1	1

3.24 The roles of those completing the survey were wide ranging and included smoking cessation coordinators, stop smoking nurse specialists, tobacco health improvement leads, vascular nurses, sexual health nurses, sexual health/ GUM consultants, sexual health leads, data entry staff, health promotion specialists, community pharmacy advisors, community pharmacy business managers, public health pharmacists, consultants in pharmaceutical public health, directors of pharmacy, and directors of public health.

Interviews with Smoking Cessation Service Users

3.25 The views of a sample of people using the PHS smoking cessation service in October 2010 were sought by means of telephone interviews. Ipsos Mori was commissioned to undertake this work.

3.26 Services users were recruited using a three-stage sampling process. Initially a sample of community pharmacies offering the PHS smoking cessation service were identified across a range of NHS Board areas ensuring a spread of types of pharmacy; urban and rural locations, levels of deprivation and numbers of service users.

3.27 The selected pharmacies were provided with invitations to send to people who had used the service in October 2010. The invitation asked them to take part in a telephone interview on their experience of using the service. The invitations also contained demographic questions and questions on their current smoking status and previous attempts to quit. Using this data, a sample of 24 users was selected to be interviewed.

3.28 A number of criteria were used to ensure a spread of participants. The criteria included type of pharmacy attended; length of treatment; age; gender; number of quit attempts; number of cigarettes smoked per day; mode of NRT/support; pregnancy; and geographical area.

3.29 Telephone interviews were conducted between February and March 2011. Participants were asked about their decision to quit smoking; previous attempts to stop, seeking help to quit smoking; and the smoking cessation service they received in their community pharmacy. A full report of the findings is available at: www.scotland.gov.uk/PHSsmokingcessationusersviews

3.30 The next five chapters report on the findings from the data analysis and data gathering exercise. Findings relating to smoking cessation services are presented first, followed by findings on the EHC service. Chapter 9 presents a

discussion of the findings from the report. A copy of the questions used in the surveys can be found in Appendix A.

4 FINDINGS - PHS SMOKING CESSATION SERVICE: RESULTS FROM ANALYSIS OF ROUTINE DATA

Introduction

4.1 This chapter presents results on the PHS smoking cessation service and comprises analyses of routine data and of the surveys of pharmacists and NHS Board staff.

Smoking Rates and Services in Scotland

4.2 Data for 2009/10 from the Household Survey (Scottish Government, 2011) reveals that 24% of all adults aged 16 and over were current smokers in Scotland. Smoking rates were higher amongst men than women (men 26%, women 25%).

4.3 NHS Scotland offers a range of smoking cessation support to help smokers quit, this includes:

- Smokeline – the national telephone helpline service which gives advice on smoking cessation and signposts callers to appropriate support;
- support from GP or other health professional;
- support from a pharmacist through the PHS service; and
- support from a local specialist smoking cessation service.

4.4 Data from the NHS Smoking Cessation Service Statistics (Scotland) show that during 2010 there were 79,672 quit attempts made with the help of NHS smoking cessation services in Scotland. This compares with 74,038 quit attempts in 2009 (revised 2009 figures), an increase of 5,634 (or 7.6%) (ISD, 2011). An estimated 7.4% of smokers in Scotland made a quit attempt with an NHS smoking cessation service during 2010 (6.9% in 2009). Pharmacy services accounted for 63% of quit attempts made (around 80% in some NHS Boards - Greater Glasgow and Clyde, Grampian and Ayrshire& Arran).

Characteristics of Users of the PHS Smoking Cessation Service

4.5 Table 5 shows the characteristics of people using the pharmacy PHS smoking service compared to those using other NHS smoking cessation services. For both services women are more likely than men to make a quit attempt. Also those in older age groups were more likely to attempt to quit than those in younger age groups. The pharmacy PHS smoking cessation service appears to be more attractive to younger people with the number of people making a quit attempt in the pharmacy PHS smoking cessation service in age groups under 25 to 44 higher than in the non-pharmacy services. However in the age group 45-59 and upwards, more people are making a quit attempt with non-pharmacy smoking cessation services. In contrast, the 2009/10 Scottish Household Survey, shows the highest smoking prevalence (at 29%) was in the 25-34s and 35-44s age groups.

Table 5 – Uses of smoking cessation services by age and sex - all NHS services and PHS service

	Users of PHS smoking cessation services	**Users of non PHS smoking cessation services**
Sex		
	%	%
Male	41	42
Female	59	58
Age group*		
Under 25	11	8
25-34	21	15
35-44	25	22
45-59	28	34
60+	15	21
Unknown age	<1	<1
SIMD*		
1-2	41	30
3-4	23	26
5-6	16	19
7-8	12	14
9-10	7	8
Unknown age	1	3
N =	***49,928***	***29,744***

* Percentages may not add up due to rounding.

Source: National Smoking Cessation System, ISD Scotland

4.6 Scottish Household Survey estimates (2009) reveal that the largest numbers of smokers in Scotland, and the highest smoking prevalence, to be in the most deprived areas. Analysis of quit attempts by SIMD[15] show the largest number were made by people living in the 'most deprived' areas in Scotland (ISD, 2011). Those living in the most deprived communities (equivalent to SIMD 1-2) account for an estimated 31% of total smokers in Scotland and they account for 37% of quit attempts made in NHS cessation services in 2010.

4.7 Comparing the PHS smoking cessation service with other NHS smoking cessation services shows that the PHS service appears more attractive to those in the lower deprivation deciles. A higher proportion of quit attempts (41%) were made by those in the two most deprived deciles (SIMD 1-2) compared to 30% of quit attempts in non-PHS services.

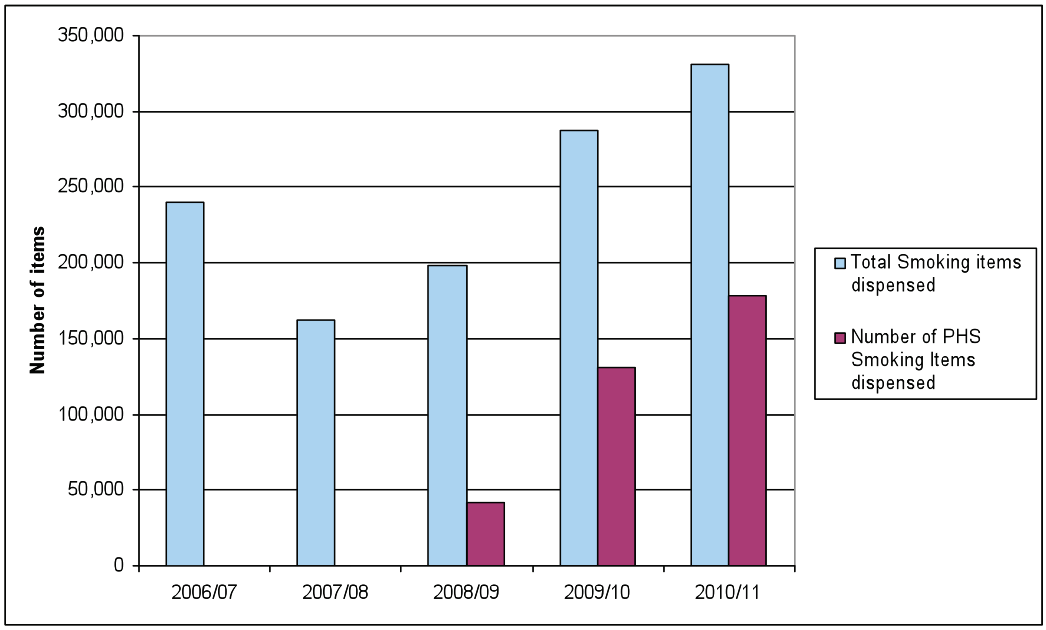
Claims for Smoking Related Items

4.8 Figure 1 shows the number of smoking items dispensed by all smoking cessation services and the number which were dispensed through the PHS

[15]SIMD is a relative measure of area deprivation. It combines deprivation information on income, employment, health and disability, education, skills and training, and geographical access to services. SIMD ranked wards are assigned to population weighted deprivation quintiles, and the most deprived wards containing 20 per cent of Scotland's population are assigned to deprivation quintile.

smoking cessation service in each year[16]. Since its introduction in August 2008, the number of smoking related items (NRT) dispensed through the PHS smoking cessation service has steadily increased to over 170,000 items in 2010/11. Over the same period there was an increase in the total number of smoking items dispensed by all smoking cessation services across Scotland from 162,000 items in 2007/8 to over 330,000 items in 2010/11. The take-up of smoking cessation services overall across Scotland was greater than the levels experienced around the time of the smoking ban in 2006 when over 284,000 items were dispensed. By 2010/11 the PHS service accounted for 54% of all smoking items dispensed (nicotine only) by all practitioners in Scotland.

Figure 1 – Number of smoking items dispensed, April 2006 – March 2011

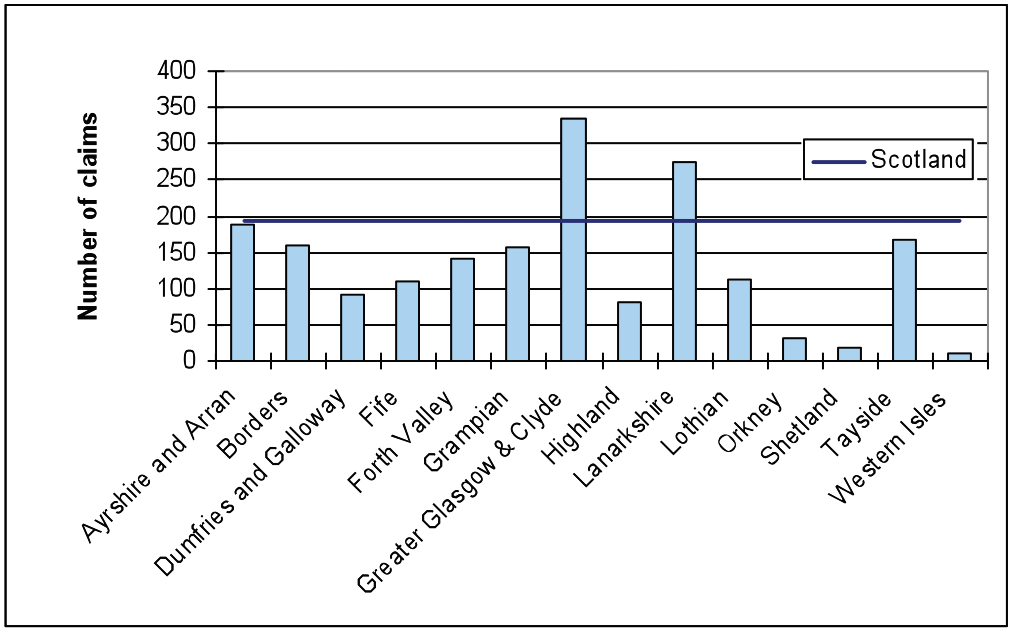


Note: Data is based on Nicotine only.
Excludes items not dispensed using a prescription e.g. in hospital.
Source: Prescribing information system, ISD Scotland.

4.9 Figure 2 looks at the breakdown of PHS smoking cessation items dispensed across all 14 NHS Boards by population (over the age of 12 years) and the average number of items dispensed across Scotland for the last year for which data is available. The rate of claims for was greatest in Greater Glasgow followed by Lanarkshire.

[16]Data is based on Nicotine only.

Figure 2 - Rate per 10,000 population of smoking cessation claims by NHS Board, July 2010 - June 2011 (population 12+ years)

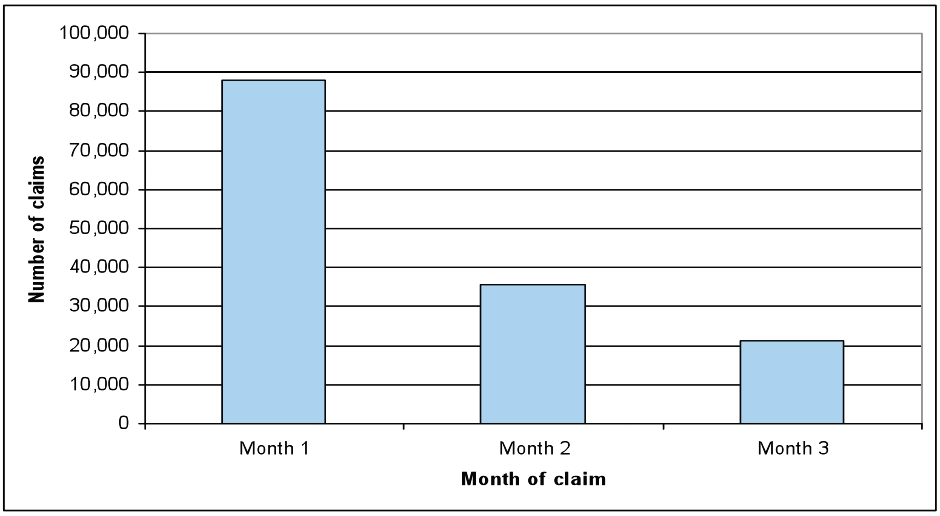


Source: Based on data from Prescribing Information System, ISD Scotland.

4.10 The Island Boards have the lowest rate of claims for PHS smoking cessation. It is likely that this lower rate is linked to the number of dispensing GP practices in these NHS Boards and the lower number of community pharmacies.

4.11 Community pharmacies can claim a fee for each month a patient is receiving the service. In the period July 2010 to June 2011, just over 88,024 claims were for patients receiving the service in month one, almost 36,000 were for patients in month two and just over 21,000 were for patients in month three (see Figure 3). These claims are the total amount of claims at each month and do not track one patient's claims across the three months they participate in the service. However they indicate a reduction in the number of individuals remaining with the service at months two and three. Of the 88,024 people receiving a service at month one, 24% were still receiving the service at month three. It is clear that a large number of clients leave the service before the end of the 12 week course but it is difficult to say whether they have left having quit smoking or whether they have given up the attempt.

Figure 3 Number of smoking cessation claims – July 2010 – June 2011

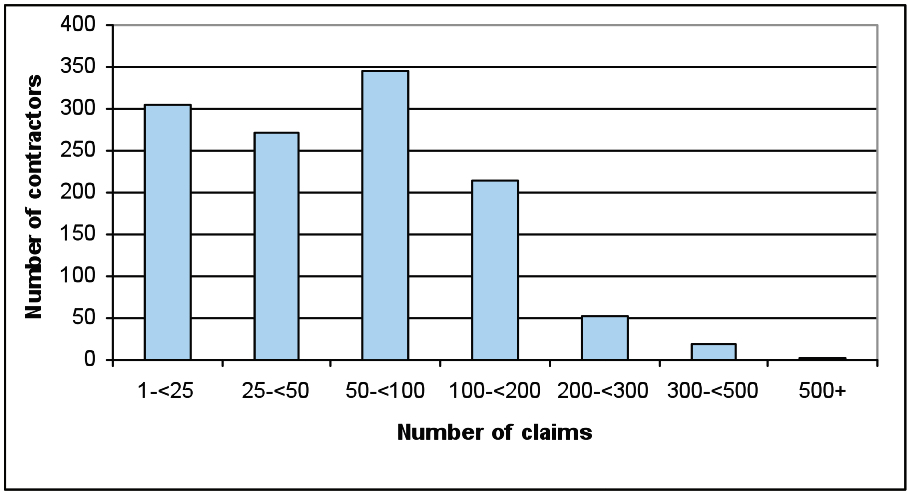


Source: Prescribing Information System, ISD, Scotland

4.12 In 2009/10 there were 1,267 community pharmacy codes in operation in Scotland. Fifty eight of these did not have any claims against them for any items as part of the PHS smoking cessation service between July 2010 and June 2011.

4.13 Figure 4 shows the number of month one claims by contractor. A quarter of the community pharmacies (305) made less than 25 claims a year as part of the PHS smoking cessation service. Twenty nine per cent (345) made 50 to less than 100 claims. Eighteen contractors (1%) made between 300 - <500 claims and two contractors made over 500 month one claims.

Figure 4 – Number of contractors by number of month 1 claims July 2010 – June 2011



Source: Prescribing Information System, ISD, Scotland

Self Reported Quit Outcomes

4.14 At follow up appointments, clients of the PHS service are asked if they have smoked. At one month they are asked if they have smoked at all in the last two weeks (even a puff) and at three month follow up, whether they have

smoked since the one month follow-up. This is recorded on the minimum dataset form. Table 6 shows the outcome at one month for PHS smoking cessation services and non-pharmacy based services.

Table 6 – Self reported quit outcomes at one month follow-up for pharmacy and non-pharmacy based smoking cessation services

	PHS smoking cessation services	**Non-pharmacy smoking cessation services**
	%	%
At one month follow-up:		
Not smoking	32	52
Smoking	13	23
Lost to follow-up/smoking status unknown	55	25
N =	***49,928***	***29,744***

Source: National Smoking Cessation System, ISD Scotland.

4.15 Between January and December 2010, 16,029 (32%) people on the PHS service reported that they had quit smoking at one month. Over a half of clients (55%) were lost to follow-up or their smoking status was unknown at this stage (month 1). In contrast, in the non- pharmacy NHS smoking cessation services, 15,427 (52%) people reported that they were not smoking at the one month follow-up and 7,534 clients (25%) were lost to follow-up or unknown smoking status.

4.16 For the pharmacy based smoking cessation services, 11% of those setting a quit date at their first visit reported that they had not smoked at three months compared to 22% for those using non-pharmacy based services.

4.17 This would suggest that less people quit successfully via the PHS service than other smoking cessation services in Scotland where for example 19% of primary care smoking cessation patients had not smoked at 3 months and 21% of smoking cessation patients using services in a community venue had not smoked at three months, and the average across all services is 14% not having smoked at three months). However, caution should be taken when reviewing these results as not all patients on the PHS service self reported whether they had smoked since quitting, and over 54% of those who had self reported at 1 month that they had quit were lost to follow-up or their quit status was unknown at three months.

Summary

4.18 From the data on smoking items dispensed and claims, the PHS service can be seen to have contributed to an increase in the number of people attempting to quit smoking using NRT across Scotland to the levels experienced around the time of the introduction of the smoking ban in 2006. However, there are large falls in the number of items claimed between months one and three for PHS smoking cessation service. It is difficult to say whether they have left having quit smoking, given up the attempt or left the service for some other reason.

4.19 The analysis of the characteristics of services users shows that more females than males use the PHS service, are middle aged or older and are from the most deprived areas in Scotland.

4.20 In terms of self reported quit rates the data suggests that a large number of clients expressing a willingness to quit smoking using the PHS service are not successful in quitting. The data also indicates that less people quit successfully via the PHS service than through other smoking cessation services in Scotland. However caution should be taken when reviewing these results as many patients are lost to follow-up and their quit status is unknown.

5 FINDINGS - THE VIEWS OF COMMUNITY PHARMACISTS AND NHS BOARD STAFF ON THE PHS SMOKING CESSATION SERVICE

Introduction

5.1 This chapter of the report summarises the findings of the on line surveys of community pharmacists and NHS Board staff. The questions used in each survey can be found in Appendix A.

5.2 Community pharmacists were asked about how clients found out about the service; provision of the service; the therapies offered; facilities provided and the follow up of clients. They were also asked their views on the effectiveness of service; NHS Board support; links with other services; improvements they would like to see and data collection.

5.3 NHS Board staff were asked more specifically about the Scottish Government specification, training, governance and quality assurance.

5.4 A total of 120 community pharmacy staff (out of about 2,300 registered community pharmacists registered in Scotland) and 51 NHS Board staff responded to the two online questionnaires.

The Smoking Cessation Service

How clients find out about the smoking cessation service

5.5 Community pharmacists reported that most of their clients found out about the smoking cessation service they offered from pharmacy staff or material within the pharmacy promoting the service (Table 7). Health professionals were also an important source of referrals to the service. Clients also found out about the service from friends and family; TV, newspapers or radio; Smokeline; Facebook; local advertising; or NHS Board events.

Table 7- How clients found out about the smoking cessation service

	%
Pharmacy staff	83
Health promotion material in pharmacy	73
Referred to service by other health professionals	71
Other routes	28
Don't know	3
N	***120***

Staff involved in providing the service

5.6 Not surprisingly almost all pharmacists were involved in delivering the smoking cessation service (Table 8). Dispensing technicians and counter assistants were involved to a lesser extent. Others involved in delivering the service included pre-registration pharmacists, pharmacy students and dispensing assistants.

Table 8 - Staff involved in providing the smoking cessation service

Staff groups	
	%
Pharmacists	99
Dispensing technicians	63
Counter assistants	43
Others	4
N	***120***

What the consultations covered

5.7 There was considerable uniformity in what community pharmacists included in smoking cessation consultations (Table 9). Almost all community pharmacists (93%) also reported that they recorded data for the minimum dataset and/or HEAT target at the consultation.

Table 9 -Content of consultations

	%
Discussion of previous quit attempts	99
Discussion of current tobacco use	99
Current smoking status	99
Quit date agreed	97
Information on different types of NRT	96
Motivations to quit	94
Provision of information on different methods of quitting	89
Use of CO monitor	85
Advice/signposting to clients about other smoking cessation services in the area	67
N	***120***

Nicotine therapy offered to clients

5.8 Eighty three per cent of all community pharmacy staff reported that clients were given a choice of which type of smoking cessation therapy they were given, 16% sometimes gave clients a choice of therapies and 1% never gave clients a choice.

5.9 A range of NRT and other products were offered to clients to help in their quit attempt. Ninety nine per cent of community pharmacists offered nicotine patches, 98% nicotine inhalers, 96% offered nicotine gum, and 89% offered nicotine lozenges. Only 62% offered nicotine nasal spray. A total of 15% of respondents reported that they offered other products including microtabs, mints and sublingual tablets. Several respondents were independent prescribers and reported that they prescribed varenicline[17].

[17] Currently varenicline is prescribed outwith the PHS service through a pharmacist led prescribing clinic or through a local arrangement with the Board

Arrangements for consultations and follow up

5.10 The majority of community pharmacists said that they saw smoking cessation clients on demand (Table 10). Just under a third (32%) of respondents said they offered an on demand and appointment service. A small number of community pharmacists saw clients on an appointment only basis. This was the case for both the first and follow-up visits.

Table 10 – Pattern of consultation arrangements

	First visit	**Follow-up visits**
	%	%
Clients seen on demand	60	69
Offered mixture of on demand and appointments	32	26
Clients seen by appointment only	8	5
N	***120***	***120***

5.11 Few community pharmacists estimated that more than 75% of clients returned for their second or third visit. There was a further drop off in the numbers returning for a third visit (Table 11).

Table 11 – Estimate of clients returning for a second and third visit

Estimate of clients returning for subsequent visits	**Second Visit**	**Third visit**
	%	%
More than 75%	10	2
Between 50-74%	39	18
Between 25-49%	30	33
Less than 25%	14	40
Could not give an estimate	7	7
N	***120***	***120***

5.12 Community pharmacists were asked to estimate what proportion of returning clients they thought had made a serious attempt to quit. Two thirds of community pharmacists estimated that more than 50% of clients had made a serious attempt by the time of their second visit (Table 12). In addition, 95% of those who responded saw clients who had made several quit attempts.

Table 12 – Estimate of serious quit attempts

Clients making serious attempt to quit	**Second Visit**
	%
More than 50%	66
Between 25-49%	20
Less than 25%	9
Can't say	5
N	***118***

5.13 As part of the PHS clients should be followed up by:

- the pharmacist or support staff if they do not present for an appointment
- the NHS Board at 12 weeks and 12 months after the quit date to assess progress with their quit attempt (for those who have attended all appointments

and to ascertain their smoking status). If agreed locally, the pharmacist may carry out the 12 week follow-up and the results are sent to the NHS Board.

5.14 Both community pharmacy and NHS Board respondents were asked if there was any follow-up of clients who did not keep subsequent appointments. The majority of respondents in both groups reported that non-returners were followed-up (Table 13). A greater proportion of NHS Board staff than community pharmacy staff were aware that clients were followed up.

Table 13 – Awareness of follow-up of smoking cessation clients who did not return

	Community Pharmacy Staff	**Health Board Staff**
	%	%
Clients were followed-up	64	78
Clients were not followed-up	31	6
Did not know if clients were followed-up	5	16
N	***120***	***50***

5.15 Follow-up could take the form of telephone calls, texts, questionnaires, letters and sending stop smoking literature. In some cases NHS Boards contract out the follow-up service. Follow-up was seen as patchy by a few of the health board respondents due to the fact that some clients do not give consent to be contacted. In addition, resources were not always made available by Health Boards to follow-up clients.

"The worst part is going through the paperwork! Many clients have not given consent therefore are lost. Many clients have not completed course. Many clients have been followed up before their 4 week quit! The paperwork is so late being sent in that we are contacting clients who have already gone through other quit attempts and we have no idea which one they are on. If we cannot follow up clients by telephone we send them a letter." HB 80

Effectiveness of the PHS Smoking Cessation Service

5.16 Both community pharmacy and NHS Board staff were asked how effective they thought the PHS service was in helping people to stop smoking. The majority of both groups felt the service was or '*very effective'* or '*quite effective'* (Table 14).

Table 14 – Effectiveness of PHS smoking cessation service

	Community pharmacy staff	*NHS Board staff*
	%	*%*
Very effective	27	20
Quite effective	62	61
Not very effective	10	12
Not at all effective	1	2
Can't say	0	6
N	***120***	***51***

5.17 There were a number of reasons as to why community pharmacy staff felt the service was effective. These are outlined below.

Ease of access

5.18 The ease of access to the service was the most frequent reason given for why community pharmacists felt the service was effective. A number of respondents mentioned that clients preferred the 'drop in' and 'on demand' nature of the service and that no appointment was needed.

5.19 The longer opening hours of pharmacies and pharmacies being open on Saturdays was also considered to be attractive to clients particularly those that worked or had other commitments and were unable to get to stop smoking clinics that were held at specific times.

5.20 Some respondents mentioned that clients were more likely to approach them for help to stop smoking than GPs as appointments were not necessary. Furthermore it was felt that some clients did not want to bother GPs but were happy to approach pharmacists for help.

"Personal and quick service which is adaptable to the patient's work and home life." [CP 38]

"They like the convenience of being able to come in at evenings and weekends." [CP 64]

"Very convenient for patient as a pharmacy easier to access than GP or specific stop smoking clinic." [CP 98]

Support

5.21 Some community pharmacy respondents mentioned that they were able to give more regular and face-to-face support (for up to 12 weeks) to clients than GPs.

5.22 The additional support from other pharmacy staff was also considered an important factor in helping people quit successfully. Some community pharmacists felt that some clients preferred this weekly individual support to group sessions. In some cases clients were encouraged to call in whenever they wanted and staff would give them encouragement and support which was particularly important when clients were having a '*bad day'*. The rapport built up between client and staff was felt to be important in supporting quit attempts.

"Using motivational support by staff who are ex-smokers along with CO monitoring helps." [CP 38]

5.23 Some community pharmacy respondents felt they also offered a friendlier and less judgemental service than GPs and several commented that they had an

increasing number of clients who were referred to them by word of mouth and took this as evidence of a *'good/friendly/accessible'* service.

5.24 It was also felt by some that quitting with a pharmacy enabled clients to have informal contact regarding progress with their quit attempt when they visited the pharmacy for other products or services:

"We encourage clients who have used the service to drop in to let us know, informally, how they are getting on. We get positive feedback from several people on a regular basis, and take the opportunity to reinforce how pleased we are with their success." [CP 113]

"Patients get regular individual support and are encouraged to return on a weekly basis. Previously they only saw the smoking cessation advisor once a month or received a prescription from the doctor for a month's supply." [CP 33]

Product/service features

5.25 Other features of the service offered by community pharmacists which respondents felt contributed to the effectiveness of the service were:

- the range of NRT products they were able to offer - one respondent felt that CPs had more up to date knowledge of the products available than GPs who tended to prescribe more traditional products.
- The service was low or no cost to patients.
- The use of CO monitors was a useful motivational tool.

Other comments on the effectiveness of the service

5.26 One respondent felt that most clients did quit even if they occasionally relapsed and others who did not quit were able to make '*a significant reduction in their smoking'.*

5.27 Several community pharmacist respondents commented that other health professionals did not seem aware of the service or that community pharmacists can prescribe the NRT products under the Patient Group Directive (PGD).

Ineffectiveness of service

5.28 Lack of motivation by clients was the reason cited by many community pharmacy staff as the reason why they felt the service was not effective. They recognised that success in quitting smoking was almost entirely dependent on smokers' motivation to quit. There was a view held by some community pharmacy staff that some people did not want to use will power to stop smoking:

"A lot of people are not motivated enough they think that the medication is all they need to stop smoking" [CP121]

5.29 One respondent reported that the initial selection process focused on motivation to quit and they felt they had a ‘good feel’ as to whether an individual would be successful or not. If the motivation was questionable then the client was not enrolled in the service.

5.30 In the view of one respondent the provision of the service was ’very shaky’ with large variations in the quality of provision between pharmacies. There was also concern expressed at the significant investment in the service despite the quit rates achieved.

Views of NHS Board staff on effectiveness of service

5.31 The reasons given by Board staff as to why they thought the service was effective were similar to those of community pharmacy staff i.e. the accessibility to clients and that it appealed to clients who did not want, or could not attend, stop smoking groups.

Strengths of the PHS Smoking Cessation Service

5.32 Many of the features of the service which community pharmacy staff and NHS Board staff felt worked well were very similar to the reasons given in the previous question as to why they felt the service was effective. These features included:

- Ease of access to the service
- Support from pharmacy staff
- One-to-one, flexible support
- Service free of charge to clients exempt from prescription charges and low cost to others and so avoiding high over the counter charges for products.

5.33 In addition to these strengths community pharmacy staff also reported that being able to supply more than one NRT product and being able to tailor these to people’s needs was also a great advantage.

“Freedom to prescribe a wide variety of aids and the ability to combine if necessary more than one form of NRT.” [CP 45]

“Multiple therapy has made a big difference to our ability to better manage patient’s cravings and thus positively influence the outcome of quit attempts. [CP 56]

5.34 Other strengths of the service mentioned by pharmacy staff included:

- The recognition that remuneration gave to pharmacists for their work.
- Improvement in the status of pharmacies within their communities and greater use of the abilities of pharmacists.
- Staff satisfaction in helping someone to stop smoking.
- Good training and good support from local Health Board.
- Less rigidity in the regulations than when the service was introduced initially.
- The weekly checklist to monitor progress or lack of progress.

- New, easy to follow MDS forms introduced (locally) in January 2011.
- Posters and cards advertising the service.

Areas where service works better

5.35 NHS Health Board staff were asked whether they thought the PHS smoking cessation service worked better in some areas rather than others for example in rural or urban areas. There was a mix of opinions. Many suggested that the motivation and skill of staff in providing the service was more important than the location.

"It works best where there are well trained and committed staff. Geography appears to have little to do with it."[HB 33]

5.36 Others suggested that in smaller rural communities, pharmacy staff may be less busy and will be able to spend more time on face to face contact with potential quitters. However, several respondents said that uptake was more to do with volume of prescriptions i.e. uptake was higher in pharmacies with low prescription volumes and lower in pharmacies with high prescription volumes regardless of the location of the pharmacy.

5.37 The service was thought to be more important by some, in rural pharmacies where there was likely to be fewer smoking cessation services within easy reach and more problems with transport to travel to other services.

5.38 Some respondents felt that quit rates were better in more socially advantaged areas, although there was huge potential in more deprived areas where smoking rates were higher.

Continuing to offer the service

5.39 The majority of community pharmacy staff (88%), who responded, said that, given a choice, they would like to continue to offer the smoking cessation service, 4% would like to stop providing it and 8% were undecided.

5.40 Those who wanted to continue the service said this was because it was a valuable service appreciated by clients and easily accessible to them. Many respondents reported that they and the pharmacy staff involved found the work satisfying and professionally rewarding. However there was sometimes a downside to this when it was felt that clients did not attempt to quit. Several respondents also considered the service beneficial to the community and a good way to tackle a serious health issue. The service was also thought to be cost effective in comparison to other smoking cessation services.

"I enjoy offering the service and have had success with patients, who still come back to tell me how well they are doing which puts a smile on my face. One patient said I'd restored his faith in the NHS as the service was free (he was exempt from Rx charges)" [CP 20]

"Given the health implication for smokers and the prevalence of COPD in this area, smoking cessation is an essential service. I think the low quit rate is more to do with us having hard core smokers who have had a lifelong habit" [CP 120]

5.41 Workload was an issue for those who were undecided about continuing the service some felt there was little reward for all their hard work.

5.42 Those who said that did not want to continue to provide the service said this was because it did not seem to work, were uncertain if this was the best therapy and doubted whether people really did want to quit smoking. Others felt they were providing a service which GPs should be providing *'for no reward or thanks whatsoever'*. One respondent wanted to end the service because:

"I feel that sometimes people need more support to help quit and maybe more interaction with other people attempting to quit." [CP 28]

Links with other Local Smoking Cessation Services

5.43 Community pharmacists were asked a series of questions about how they worked with other smoking cessation services in their area. Just under half of the respondents (47%) reported that they had links with other smoking cessation providers in the area (Table 15). These included:

- links with other services using the pharmacy to provide specialist services
- links with independent prescribers who can prescribe varenicline
- links between different health professionals and the pharmacy service such as GPs, stop smoking nurses, midwives and the service
- sharing clients between pharmacies. Several respondents mentioned the role of coordinators to initiate these links.

Table 15 – Links and referrals to other smoking cessation services

Community pharmacists who	**Yes**	**No**	**No other services in area**	**Not sure**
	%	%	%	%
Link with providers in area*	47	42	2	10
Refer to other smoking cessation services**	71	25	0	3

Note: * N=120, **N=119

Referral to other smoking cessation services

5.44 The majority of community pharmacy respondents (71%) reported that they referred clients to other services (Table 15). The main reasons for referral were to provide group support for clients who needed this type of support, to provide additional prescribed medication not currently available via the

service, to provide treatment past the 12 week period, to refer people who did not meet the PHS service criteria, and to provide specialist support for complex cases. The services people were referred to included:

- GP services.
- Group therapies.
- One to one counselling.
- Specialist services for people with complex issues.
- Self help groups.

NHS Board staff views on integration of smoking cessation services

5.45 NHS Board respondents were asked more generally how well integrated were the smoking cessation services in their area. A majority of these respondents (61%) agreed that the PHS smoking cessation service integrated *very well*, *quite well* or *well* with other services while 29% did not agree. Ten per cent did not have a view on integration.

5.46 The reasons why it was felt the service integrated well were mainly to do with the commitment of NHS Boards and other organisations locally. For example:

"We have a referral mechanism into Fresh Airshire, our specialist service, for those requiring more intensive 1:1 or group support. This information is available to all pharmacies. Pharmacists also dispensed the vouchers used by Fresh Airshire for their clients, thus building up the local relationship. We also have a service in place to prescribe Varenicline (Champix) through a number of independent and supplementary pharmacist prescribers based in areas outlined by Fresh Airshire, usually deprived areas. We have had major success in quit rates from this service. Again it links the pharmacist and the specialist service. "[HB33]

5.47 The lack of referrals to other smoking cessation services was the main reason why some NHS Board staff felt that services were not well integrated. There were also some comments that pharmacists were not well represented at information evenings and training.

"Not many people say they come to the specialist service as a direct referral from a community pharmacy" [HB 6]

5.48 Other respondents reported that some pharmacies viewed the service as an income stream and did not want to refer people on as they would lose income. Other services were often seen as competitors rather than as providing a specialist service:

"Each service is paid separately Looking to maximise own income stream No incentive for joined up working" [HB 16]

5.49 One respondent, a smoking cessation specialist, felt very strongly that community pharmacists were presenting themselves as specialists but did not

have the training or knowledge required. They therefore did not know when it was appropriate to refer someone on to another service.

Data Collection

5.50 Community pharmacy staff are asked to collect a range of data as part of the smoking cessation service. A quarter of respondents(25%) said it was easy to collect and over half (55%) said it was quite easy to collect. These respondents reported that the forms used locally had recently been improved including improved layout. A fifth (20%) said data collection was difficult or very difficult. Suggested improvements to data collection included:

- Simplifying paperwork, reducing the number of forms to be completed and not duplicating information within and between forms.

"Is there a need to enter same date several times as referral date, initial appointment date, quit date, signing date are often the same in our situation." [CP 76]

- Reducing the information required to be collected e.g. expiry dates of products, sensitive data such as social status and ethnicity.

- Collecting information electronically.

- Allowing pharmacists to keep the forms for 12 weeks so they can track patients rather than return them monthly.

5.51 Fifty six per cent of pharmacy staff who responded said the data collected was *quite useful* to them and 10% said it was *very useful*. A small number (14%) felt that the information could be made more useful to community pharmacies. Suggestions included:

- Providing feedback on our percentage quit rates and follow-up rates and comparing with regional and national averages.

- Adding more questions about lifestyle/health concerns/motivation.

The Scottish Government PHS Smoking Cessation Specification

5.52 Community pharmacy respondents were asked if they felt the smoking cessation specification was helpful. Of those who responded 29% felt it was *very helpful,* 56% said it was *quite* helpful and 4% had not read the specification.

5.53 Only 84% (42 respondents) of the NHS Board staff who responded to this question were familiar with the Scottish Government specification for the smoking cessation service.

5.54 Improvements to the specification included:

Data collection and payment

- Although a few community pharmacy respondents suggested linking pharmacy payment for providing the smoking cessation service to completion and return of minimum data set forms, this view was held more widely held amongst NHS Board staff.

- Respondents from both groups also suggested that electronic completion and return of forms would make the process easier and quicker.

  The claims for payment and return of data need to be much more closely linked. This is vital for patient care and if Boards are to fully demonstrate their progress towards the HEAT target [HB 61]

  Link the return of paperwork at week 4 to payment directly, rather than pharmacy claiming to Scot Govt and the MDS forms going for local compilation and inputting. Electronic completion and transmission of MDS would be a great help. [HB 19]

- There were also suggestions from NHS Board staff that payment should be linked to results for example that payments should be made for providing the service, for the number of clients receiving the service and the number of clients who remain quit after a year. Others suggested that there should be incentives to keep people engaged with the service for the full 12 weeks.

- One community pharmacy respondent suggested that clients should pay a small charge for the service as an indicator of their motivation to quit.

Changes to the service provided

- One respondent suggested introducing a week zero in which patients were given time to think about their quit attempt and could return a week later to sign up to the service. The respondent felt that this approach worked well in their pharmacy and did not deter those who were serious about quitting.

- There were several suggestions about people making another quit attempt. One respondent wanted to reduce the length of time clients have to wait before they try again. Another suggested an additional attempt could not be made until a certain time had elapsed. There was no suggestion as to what this length of time should be.

- There were several suggestions by community pharmacy respondents on ways that they could reduce their time commitment to providing the service, these included: more emphasis on pharmacy staff providing the service rather than the pharmacist; ancillary staff completing the administration for the service and health boards being responsible for follow up rather than community pharmacies.

- One NHS Board respondent suggested that the service should be available during all contracted hours.

Quality of the service

- Quality of service and training of staff delivering the smoking cessation service were a concern for several NHS Board respondents. There were concerns that staff had not undertaken the necessary professional development e.g. the NHS National Education for Scotland (NES) pharmacy training or PATH (ASHScotland) training. It was felt that the quality of the service should be specified with minimum quality standards incorporated into the specification, which should also include advice about training.

  There also should be a quality element built in to the service. The variation in quit rates seems to suggest uneven service provision. There should be a requirement to attend training if the quality of service (i.e. quit rates) indicate such. HB 11

  Make training for at least one member of a pharmacy team mandatory and ensure all people effectively signpost. Better still unless there is good evidence that it works- scrap the scheme- it would help local services and they are the experts in the field. HB 39

- A small number of NHS Board respondents felt that the PHS service was not a specialist Stop Smoking Service and should not be referred to as such. They also felt that unless PHS smoking cessation worked as well as other specialist services it should be scrapped and potential quitters referred to specialist services by pharmacies with a small referral fee as this would give them the best chance of quitting. Some suggested that referral criteria should be specified.

Widen the scope and flexibility in the service

- Three community pharmacy respondents wanted to be able to supply Champix or varenecline as part of the service and some NHS Board respondents suggested that pharmacotherapy beyond NRT should be included.

- Allowing leeway on the 12 week timeline for the supply of medication for those patients who had difficulties coming off treatment.

- Taking on patients who have already quit smoking at another service e.g. those who attended a group for 1 or 2 weeks but wish to continue their quit at a pharmacy.

Additional conditions of service such as:

- That the services will be available during all contracted hours.

- Making CO monitoring mandatory.

Training and Support

Support from NHS Boards

5.55 Community pharmacy staff was asked if they felt supported by their NHS Board in the delivery of the smoking cessation service. Of those who responded 86% felt supported while 14% did not. Support on offer from the NHS Boards included:

- Advising and helping with completion of forms
- Providing training, support materials and updates on changes to service.
- Service coordinators who were accessible and helpful.
- Setting up networks of support with specialist support.
- Visits to pharmacies to offer support.

5.56 A number of reasons were given as to why some community pharmacies did not feel supported by their NHS Board. For several respondents their complaints centred on a lack of communication, for example, local GP services being unaware of what pharmacies can offer while pharmacies are asked to publicise GP smoking cessation services.

5.57 Some felt there was poor understanding about pharmacists' workload and how the smoking cessation service fitted into their day.

5.58 It was also felt by some community pharmacists that the Health Board were only interested in the paper work and phoning the pharmacy if their success rate was not high enough.

5.59 Other issues raised were

- Lack of funds to maintain and support use of CO monitors.
- Problems with providing face-to-face training in remote and rural areas.
- Too many changes to forms.

Training

5.60 Community pharmacy staff were asked about what training they had undertaken to help them deliver smoking cessation advice. Almost three quarters had undertaken 'brief intervention' training provided by their local NHS Board and over a half had undertaken in-depth training from the same source (Table 16). Distance learning packs provided by NHS NES were used by over two thirds of respondents. Few had made use of the ASH Partnership Action on Tobacco and Health (PATH) training. One respondent having received the brief intervention training and none reported using the PATH/ASH in-depth training.

Table 16 – Training in smoking cessation

Training received	
	%
Local NHS Board training - brief intervention	73
NES distance learning pack	68
Local NHS Board training - in-depth advice training	53
NES local training course	31
Path/ASH Scotland training – 'Raising the issue of smoking'	3
Path/ASH Scotland training – brief intervention	2
Other training	10
No training	1
N	***120***

5.61 Other training mentioned included pharmacy champion/ smoking co-ordinator training, training on specific groups such as young people. Some had attended manufacturers' training events and others reported that they had read journals. One respondent had not received any training.

5.62 Fifty eight per cent found the training they had received very useful and a further 38% quite useful, the remainder, 4%, felt that the training they had received was not very useful.

5.63 Suggestions for revising or further training included:

- Adding more information on how to tailor support for different types of smoker and situations e.g. tips on dealing with difficult smoking cessation clients and ; chain smokers versus occasional smokers,
- Providing training on specific methods e.g. Neural Linguistic Programming, aversion therapy, motivational training (to be mandatory) and brief interventions.
- Training around the client journey and on patient experience.
- Providing training jointly with frontline pharmacists.
- NES training for pharmacy assistants and funding to allow staff to attend training.
- More information being provided about paper work and claim process.
- Providing training on new products and multiple therapy approaches.
- Shorter more concise training.
- Providing a national NHS Board helpline or contact person if there are any questions post training.

5.64 Board staff were asked what support they gave to community pharmacies to help them with training. Almost all provided training events and provided information on accessing specialist services (Table 17).

5.65 'Other" forms of support for training included posters, newspapers, toolkits, websites including NES[18]online training, use of pharmacy champions and pharmacy facilitators, visits to pharmacies, direct contact with pharmacists, and support with CO monitors.

Table 17 – Support offered by NHS Boards for training

Support offered	
	%
Training events	92
Information on accessing specialised services	82
Information leaflets	76
Other support	28
No support offered	6
N	***50***

5.66 Other comments from NHS Board staff around training included the need to: train counter assistants; provide refresher training; have training budgets; provide locum cover for pharmacists so they can attend training; and making training compulsory. Ongoing issues around training included: the difficulties of providing training across large areas of the country; the fact pharmacy staff don't have much time to attend training; and the problems of high staff turn over in pharmacies making training difficult.

5.67 Other advice and support offered by NHS Boards to community pharmacies on smoking cessation included:

- Funding sessional pharmacists or public health facilitators to mentor those pharmacies that did not have a particularly high throughput.
- Targeting pharmacies which were returning poor quality data or no data.
- Provision of training within pharmacies for support staff.
- Providing calibration or repair of CO monitors.
- Incentive schemes for additional payments if targets are exceeded.
- Offering access to training on the provision of varenicline to pharmacists as part of the PHS service.

Governance and Quality Assurance Arrangements

5.68 NHS Board staff were asked about what sort of governance arrangements were in place for the PHS smoking cessation service. Analysis of the minimum data set was the governance arrangement most likely to be in place followed by quality improvement programmes such as training and monitoring of the service (Table 18). Seven respondents did not know what governance

[18] NHS Education Scotland.

arrangements there were and another 2 respondents thought governance arrangements should be in place at a national level, as it was a national programme. These respondents reported that they had not been aware that local governance was expected.

Table 18 – Governance of PHS smoking cessation

Arrangements in place	
	%
Analysis of minimum data set	84
Development of quality improvement programmes for service	65
Procedures to identify and remedy poor performance	55
Clear lines of responsibility and accountability	45
Processes for managing risk	27
Unaware local governance was expected	4
Don't know	14
N	**49**

5.69 NHS Board staff listed the following local quality assurance activities:

- Regular visits to pharmacies.
- Employment of sessional pharmacy mentors and pharmacy practitioner champions.
- Providing annual update sessions, pharmacy specific smoking cessation packs and guidance and local toolkits.
- Monitoring levels of unallocated CPUS forms, completion of NES Smoking Cessation training, use of CO monitors, complaints and concerns.
- Providing feedback to pharmacies on performance compared to others in the CHP.
- Monitoring return of minimum data set forms against payment and highlighting discrepancies to relevant pharmacies and offering them support.
- Monitoring quit rates and conducting three month follow up of clients

5.70 Several NHS Board staff highlighted difficulties with providing local quality assurance as this is not explored adequately within the service specification. For example:

"No quality assurance in place, its not about quality its about getting paid for a service, quality is not part of that service." [HB 21]

"We try to ensure a quality service where possible by identifying poor performance but there is no potential course of action within the specification to allow serious action to be taken." [HB 33]"

"The arrangements suggested in the contract are weak and it's not clear who can hold pharmacies to account." [HB 12]

5.71 In terms of arrangements for dealing with problems or complaints many NHS Board staff reported that the NHS Complaints Procedure was used. Some had specialist routes for complaints through pharmacy leads or other pharmacy/ medicine teams or units. Some respondents mentioned that they were considering withholding payment to pharmacies who did not complete paperwork satisfactorily.

Improving the PHS Smoking Cessation Service

5.72 Both community pharmacy and NHS Board staff suggested a number of improvements which could be made to the smoking cessation service. Many of these have already been covered in previous sections on the specification and training. The main areas for improvement mentioned included:

Paperwork and administration

5.73 There was a widespread view amongst community pharmacists that there should be less and simpler paperwork associated with the service. Many also suggested that data should be collected electronically and that something similar to the electronic minor ailment prescription forms could be used.

5.74 Many NHS Board staff also felt there was too much paperwork associated with the service and that it was unnecessarily complicated – easier paperwork would allow more timely completion and better tracking of outcomes for individuals. However, many of this group also commented that the paperwork was poorly or not completed and would like to see payment linked to timely and better quality completion of the MDS form and in the view of a few, linked to success rates.

"Paperwork is time consuming, cumbersome and is either not completed at all or completed and not submitted. Pharmacy staff not checking patient status each month - in-pharmacy processes poor Confusion over Annex E claims leads to potential overpayments." [HB23]

"The submission to minimum dataset forms requires to be linked to payment somehow for this work." [HB 32]

5.75 There was a suggestion that more detail should be included in the service specification to allow NHS Boards to hold pharmacies to account. For example:

"Having payment claims detached from the return of patient information (MDS) has caused Boards endless problems. The specification also allows little recourse to address this situation. It is too vague." [HB 33]

Changes to the service

5.76 Many community pharmacy respondents wanted to be able to provide a greater range of products as part of the service. Varenecline (Champix) in particular was mentioned and it was suggested this could be supplied through a PGD. There was also some support for this from Health Board staff with one suggesting this could be supplied to those who have failed to quit with NRT. One community pharmacy respondent wanted NRT products to be limited to patches.

5.77 There was a suggestion by a few community pharmacy respondents that clients should be charged for the service. It was felt that this would not be a deterrent to using the service if clients were motivated to quit.

5.78 One respondent wanted some flexibility in the period that patients could receive the service so that they could be 'weaned off' over a longer period if required while another respondent felt that patients should be weaned off the service by steadily reducing the frequency of visits. There was some support from Health Board staff for more flexibility in the service to '*facilitate the patient's journey'* as clients would otherwise end up going back to GPs for continuation of supply of NRT for example community pharmacists wanted some discretion in not having to ask clients to leave the scheme if they admit they have smoked or provide a high CO reading when their progress has been good.

5.79 In contrast, some community pharmacy respondents wanted there to be a minimum period of time between one attempt and the next one – it was felt allowing quit attempts in quick succession reduced people's motivation to quit.

Payment

5.80 Some community pharmacists suggested that funding should be made available to allow them to employ a second pharmacist to allow them to undertake all the tasks they are being asked to do in addition to '*the efficient and professional running of our pharmacies'.*

'Consultation time needs to be reimbursed at a better rate than the allowance given. Some follow-ups can be 20 minutes long'. [CP 35]

5.81 Some NHS Board respondents felt that there should be sufficient staff to effectively provide and deliver the smoking cessation service but they did not suggest additional payment for this. There was a suggestion by one NHS Board respondent that an appropriate payment should be given for the initial contact session which could take up to 45 minutes if explanations and motivational counselling were given.

Advertising and information

5.82 It was widely felt among community pharmacy respondents that continual advertising of the service at a national level and more information on what clients could expect from the service was required e.g. that clients sometimes can't be seen on demand if the pharmacy is busy.

Training, support and recognition for staff

5.83 Although some community pharmacy respondents felt more training was required e.g. motivational training, the view that more training was required was more prevalent amongst Board staff and much more strongly expressed:

There should be mandatory training to deliver smoking cessation support. [HB 57]

"Stop using staff with no stop smoking training" [HB 21]

5.84 Some respondents felt that there was a lack of knowledge of NRT, cessation support and little use of CO monitors by those providing the smoking cessation support. In addition, there was no requirement to take up Health Board offers of training and information.

Support for clients

5.85 There was a view that only those pharmacies that have the time and skills to provide the service should do so. Several NHS Board respondents felt that some pharmacies were too busy dispensing prescriptions to give the time needed to give a quality service to smoking cessation clients.

"Spend more time with clients. Clients often report that they just get their product and very little support within some pharmacies." [HB 38]]

Better signposting and referral

5.86 Greater integration with other smoking cessation services and signposting for clients to the most appropriate support, particularly if they have had several unsuccessful attempts with a pharmacy. One community pharmacist suggested giving pharmacists incentives for referring appropriate clients to specialist services. Another suggested providing the smoking cessation service in health centres.

5.87 However, there were mixed views amongst community pharmacists about the role of GPs and other health professionals. Some respondents felt GPs should be encouraged to refer patients to them but not, in the view of another respondent, before the clients were ready to quit. Another felt that clients should be referred to GP if they failed to quit after two attempts.

Summary

5.88 The views of the community pharmacy staff on the smoking cessation service were in the main positive. Many felt that that the smoking cessation service offered a valuable way for people to attempt to quit smoking and providing the PHS smoking cessation service led to real job satisfaction. However a small number of community pharmacy staff felt that the service would be better provided by others.

5.89 The main concerns about the service were the paper work, workload and support needed to provide the service. Many of community pharmacy staff felt that the scope of the service should be extended in terms of the products that are available, to offer support to help reduce smoking not just quit, and to provide support for longer than 12 weeks. Some also felt that there were issues with clients, who were not motivated to quit, accessing the service and that a small charge might avoid this problem.

5.90 Overall NHS Board staff had mixed opinions about the PHS smoking cessation service. Some staff felt that the smoking cessation service allowed more people to access NRT and that locally the service successfully complemented other more intensive smoking cessation services. Others felt that pharmacies did not have the time, training or skill to offer the support needed for supporting smoking cessation. Some commented that the paperwork for the service was onerous but many suggested that payment should be linked to the completion and return of paperwork. Several commented there was not enough evidence on successful quit rates for the service to be considered to be successful.

6 FINDINGS: USERS' VIEWS OF SMOKING CESSATION SERVICES PROVIDED IN COMMUNITY PHARMACIES

Introduction

6.1 This chapter presents the key findings from interviews with users of the PHS smoking cessation service undertaken by Ipsos Mori between February and April 2011. The sample was designed to obtain a range of views and experiences and was not intended to be representative of pharmacies and/or service users. The key findings from this work are presented here. The full report of this element of the study can be found at www.scotland.gov.uk/PHSsmokingcessationusersviews

Key findings

Accessibility of the Service

6.2 The most common way for participants to find out about the service was in the pharmacies themselves, either through advertising posters or discussion with pharmacy staff. Participants also became aware of the service through referrals by GPs and word of mouth.

6.3 The accessibility of the service was one of its key attractions for participants because of the flexibility and convenience it afforded them. They liked the fact that they could enrol in the service immediately and then 'pop in' each week at a time that suited them.

6.4 The availability of NRT products on prescription increased the appeal of the service because the cost of buying these had previously been a disincentive to using NRT for participants.

Satisfaction with the Service

6.5 Participants who took part in the research were overwhelmingly positive about the service and reported very high levels of satisfaction with almost all aspects. Service provision was broadly similar across most pharmacies, although there was some variation between those that were very busy and those that were less so.

6.6 Participants were particularly satisfied with the high levels of customer service provided to them by pharmacy staff. They described staff in very positive terms and particularly liked their friendly and informal approach.

6.7 Participants also expressed satisfaction with the confidentiality and privacy of the service. They were aware that pharmacies had a responsibility to ensure their details would be kept confidential. Where consultation rooms were used to hold discussions, participants tended to like the privacy this afforded them. However, not all pharmacies used consultation rooms, which made participants uncomfortable because other customers could potentially see that they were receiving the service or hear what was being discussed.

6.8 Satisfaction with the advice and information offered to participants was relatively high. However, there was some variation in the nature and extent of provision and some found the advice more useful than others. Few participants were given information about the health benefits of stopping smoking or the affect on their overall fitness. Others did not receive, or could not remember receiving, any information, advice or tips.

6.9 The choice of NRT products available and the ability to combine products was one of the main attractions of the service. Participants were given information about each of the products and decisions on which to use were made jointly between them and the pharmacist. This added to the flexibility and personalised nature of the service.

6.10 Participants were generally happy about the duration of the programme, although some felt that 12 weeks was not long enough to kick a lifelong habit. Regardless of whether or not they felt 12 weeks was long enough, participants said they would have liked the opportunity to attend a follow-up appointment or receive additional support if required.

6.11 Almost all participants said that they would recommend the service to other people who wanted to quit smoking and many had already done so.

Effectiveness of the Service

6.12 A number of aspects of the service appeared to have an impact on its effectiveness, including the interaction with staff, the personalised and flexible service offered, the availability of NRT products on prescription and carbon monoxide testing.

6.13 The interaction with pharmacy staff and their availability on visits was important because it allowed participants to build relationships with staff. This provided a great deal of motivation to participants because they did not want to let staff down, while the encouragement and genuine interest they received from staff helped to motivate them further.

6.14 The availability of NRT products on prescription allowed participants to access products they may not have considered before and also provided them with the opportunity to use more than one product at a time. The perceived high cost of buying NRT products had previously been a disincentive to using NRT for participants.

6.15 Carbon monoxide (CO) testing provided participants with additional motivation by allowing them to prove to pharmacy staff that they had not smoked. It also gave them a tangible measure of progress because they were able to see how much CO was leaving their system as a result of not smoking.

Recommendations for Service Development

- Many aspects of the service appear to be working well and should be continued. However, the research also identified some areas for improvement:

- Advertising of the service should be focused on the key aspects of the service to highlight the benefits. This should focus on the aspects that people do not expect from the service, such as its convenience and flexibility, the support, encouragement and advice provided by pharmacy staff and the provision of NRT on prescription.

- Pharmacies should try to ensure continuity in the member of staff users' are seen by, particularly in busier pharmacies. This would enable service users to build up relationships with staff, which would result in them feeling more supported and encouraged.

- At the end of the 12 weeks, pharmacies should develop a follow-up support plan with users to check their progress and to provide additional support if they need it. This would be tailored to suit the needs of the service user based on their past quit attempt experiences, their progress since enrolling in the pharmacy service and what they think might help them in the period after they finish.

- Users who fail in their quit attempt should be allowed to re-enrol in the service straightaway to allow them to continue in their quit attempt. However, pharmacists should retain some discretion to prevent abuse of the system.

- There should be increased link-up between smoking cessation services provided by pharmacies and other support services, such as *Smokeline* and specialist NHS services. Pharmacy staff should play a more active role in encouraging uptake of these services, which would help service users who are struggling with cravings or going through a particularly stressful period.

- In addition, pharmacy staff could provide more information to service users about specific health benefits of stopping smoking, such as reducing their risk of cancer and other diseases and the likely impact on their overall fitness. Staff could also provide advice on how to deal with side effects, such as weight gain.

- Any perceptions that the service lacks privacy may discourage some people from using the service or being open and honest about how they are progressing. Pharmacies should try to use consultation rooms where possible to ensure discussions are confidential.

- Pharmacies should also be encouraged to have CO testing machines available – and try to ensure that they are maintained and working at all times.

Summary

6.16 Overall, smoking cessation services provided by community pharmacies were viewed very positively by service users. The accessibility and flexibility of the service, the personalised service provided by pharmacy staff and the provision of NRT products on prescription were found to be particularly important in shaping user satisfaction.

7 FINDINGS - PHS EMERGENCY HORMONAL CONTRACEPTIVE SERVICE (EHC): RESULTS FROM ANALYSIS OF ROUTINE DATA

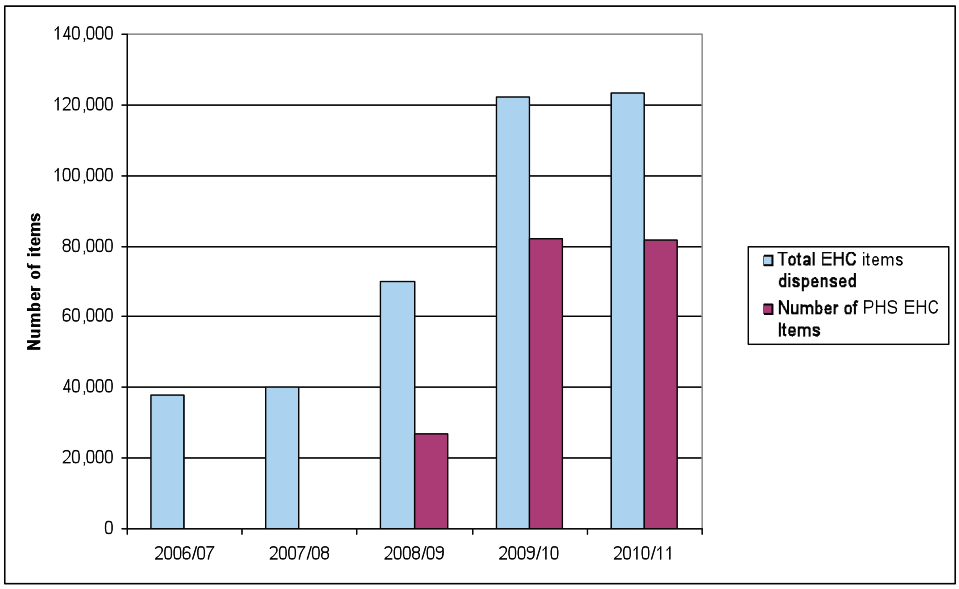
Introduction

7.1 The chapter present results around the PHS Emergency Hormonal Contraception Service (EHC), first for routine data and then for the results of the surveys of pharmacists and NHS Board staff.

Number of EHC Items Dispensed

7.2 By 2010/11 the PHS EHC service was dispensing just over 81,000 items in a year (see Fig 5), this was 66% of the emergency hormonal contraception items dispensed in Scotland using a prescription. As this graph does not include EHC given out at sexual health clinics it is not possible to ascertain whether the service has increased the amount of EHC accessed in Scotland, or whether there has been a transfer of clients to the PHS service from other parts of the NHS. Since 2009/10 however, the amount of EHC dispensed by the PHS EHC service has remained relative constant at about 7,000 items per month. The PHS service can therefore be seen as improving access to EHC and complementing the service provided by sexual health services in Scotland who also provide EHC but without a prescription.

Figure 5 - Number of EHC and PHS EHC items dispensed April 2006 to March 2011



Source: Prescribing Information System, ISD Scotland.

Note: Includes all items dispensed using a prescription pad but excludes items given out by sexual health services without a prescription. Data for 2008/09 is for the 8 months that the service was operating.

Number of EHC Claims

7.3 Within the PHS EHC service, there were just over 70,000 patient claims recorded between July 2010 and June 2011. Although the period for this patient claims data is different from the period for the data on the number of

dispensed items, the data would suggest that there is a discrepancy between the number of items dispensed and the number of claims being made. ISD investigated the discrepancy for 2009/10 using a small number of contractors in the Western Isles. This area was chosen as it has the smallest number of pharmacies participating in the PHS and therefore made the investigation manageable. Caution should however be applied and more work is needed on this discrepancy to check if other areas of Scotland are experiencing similar issues. The investigation revealed that:

- On occasion a claim for a patient has been made when there is no corresponding prescription; and
- On multiple occasions a prescription has been dispensed, but no claim for a patient.

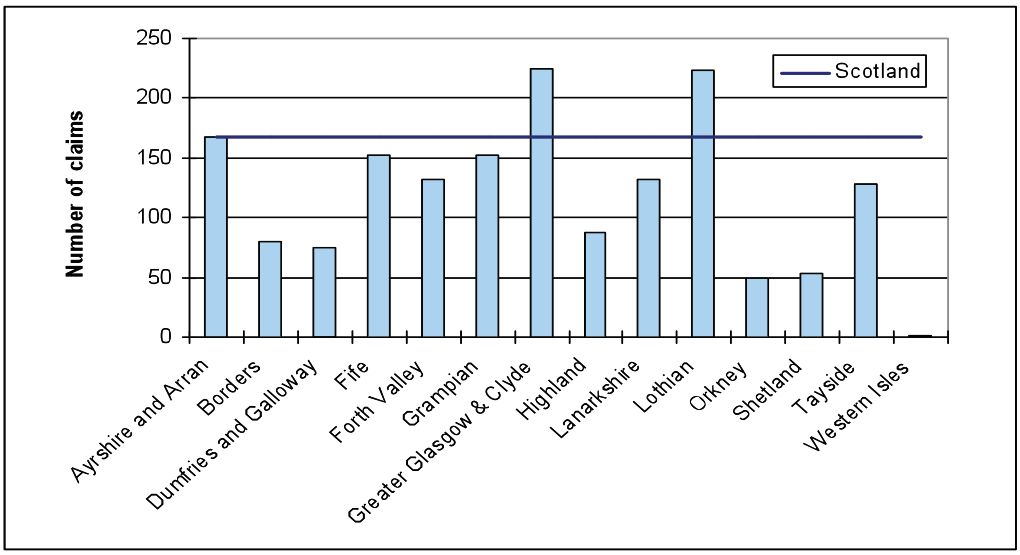
Other potential reasons, for the discrepancy, might be:

- Late submissions of the prescriptions, but the patients are claimed within the correct month.
- Pharmacies completing paperwork incorrectly.
- Issues around the central scanning of forms and their reconciliation. In particular where the serial numbers of prescription forms are not recorded leading to discrepancies in the data e.g. where the data shows one patient and four EHC items but there have actually been four individual patients.

7.4 Some of these problems are currently being addressed e.g. the issue around central scanning and reconciliation, others would need to be further explored and rectified in light of the findings in this report.

7.5 Figure 6 shows the rate of patient claims recorded across Scotland for the PHS EHC service, between July 2010 and June 2011. The rate of claims was much higher in the largely urban areas of NHS Lothian and NHS Greater Glasgow and Clyde.

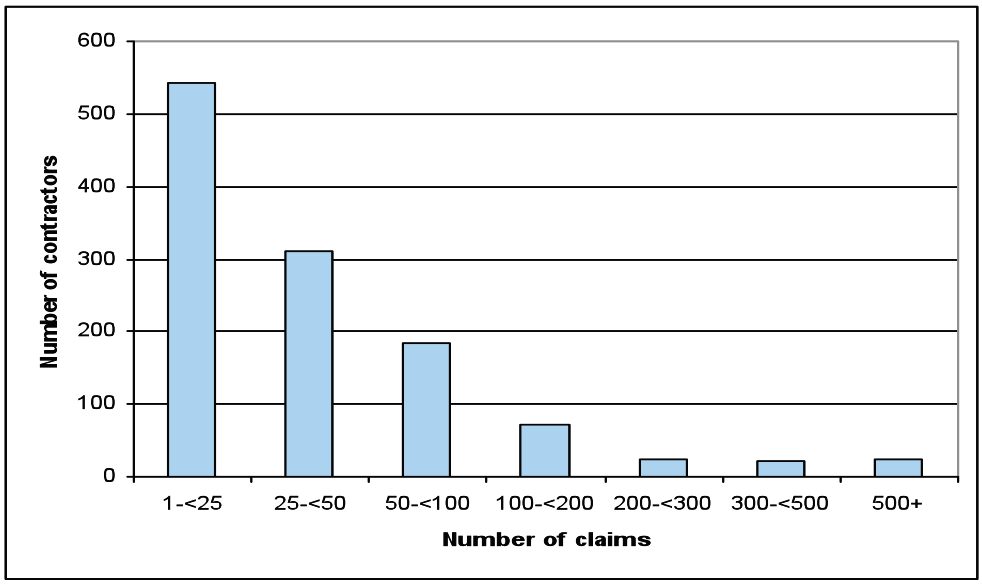
Figure 6 – Rate of EHC patient claims per 10,000 population by NHS Board July 2010 – June 2011



Source: Based on data from Prescribing Information System, ISD Scotland.

7.6 In 2010/11 there were 1,267 community pharmacies codes in operation in Scotland, 89 of which did not make claims as part of the EHC service between and July 2010 and June 2011. Almost a half of contractors had less than 25 EHC claims, as part of the PHS EHC service. A further 26% submitted between 25 and 50 claims for the year (see Figure 7). Two businesses, who made claims for over 500 items for the year were in NHS Ayrshire and Arran (660 claims) and NHS Fife (835 claims)

Figure 7- Number of contractors by number of EHC patient claims, July 2010 – June 2011



Source: Prescribing Information System, ISD Scotland.

Patient characteristics

7.7 Unlike the PHS smoking cessation service, data on the characteristics of women who use the EHC service is not routinely collected due to the sensitive and confidential nature of the service. Therefore an analysis cannot be undertaken of who uses the service from ISD data sources.

Evidence on service users' experiences of community pharmacy EHC services

7.8 Unlike the PHS smoking cessation review, the EHC review did not include research with service users. It was felt that interviewing users of the service would not be appropriate due to the issues around keeping client identity confidential and the sensitivities around the service for women. However there have been a number of published studies exploring the use and experience of community pharmacy-based EHC services.

7.9 In a systematic review of studies of users of Community Pharmacy PHS Services, Anderson 2004 suggested that EHC schemes have generally been well received (Anderson 2004). One EHC study found high levels of satisfaction among women using EHC service in south London (Lambeth, Lewisham and Southwark Health Action Zone 2002 cited in Anderson 2004). In a national survey of women receiving treatment on prescription, community pharmacies were rated highly as a place to obtain and discuss EHC (Pharmacy Alliance 2002 cited in Anderson C 2004). Reasons cited included the desire for anonymity.

7.10 Concerns of people using EHC services in the literature included: the open pharmacy environment; confidentiality; and what records would be kept afterwards on the supply of EHC (Anderson 1998). However Anderson's 2004 systematic review suggested that pharmacies are perceived by women to be suitable places to obtain and discuss EHC. The review concluded that many women find it acceptable to discuss this sensitive subject in community pharmacies.

8 THE VIEWS OF NHS BOARD AND COMMUNITY PHARMACY STAFF ON THE PHS EMERGENCY HORMONAL CONTRACEPTION (EHC) SERVICE

Introduction

8.1 Thirty one NHS Board staff and 118 community pharmacy staff (from 13 NHS Boards) gave their views on the PHS EHC service via two separate online questionnaires. The questions used in the survey can be found in Appendix A.

8.2 This section of the report summarises the findings of these two surveys. Community pharmacy staff were asked how clients found out about the service; returning clients; what consultations covered; who was involved in providing the service; effectiveness; possible improvements; data collection; support; links with other services; the Scottish Government specification; training; governance; and quality assurance.

8.3 NHS Board staff were asked whether they thought the service was effective about the support they offered community pharmacies in delivering the service, whether the service integrated with other services providing contraception services, what data was used to monitor the service, what governance and quality assurance measures were in place.

The EHC Service

How clients find out about the EHC service

8.4 People were more likely to find out about the EHC from 'other health professionals' (Table 19). The 'other ways' mentioned as to how clients found out about the service included, NHS 24, friends and family, school or college, TV and press advertising.

Table 19 - How clients find out about the PHS EHC service

	%
From other health professionals working in the area	64
From health promotion materials in the pharmacy e.g. posters or leaflets	54
From pharmacy staff	53
Other ways	22
Don't know	13
N	***118***

Returning clients

8.5 Community pharmacists were asked whether they saw the same people returning for the service. Ten per cent said they did see the same people returning for the service and over half (53%) said they sometimes saw the same people returning for the service (Table 20). Note: pharmacists were only asked whether in their view the same people returned for the service, not how often they returned.

Table 20 – Clients returning to the EHC service

Do you see the same clients returning:	
	%
Yes, see the same people returning	10
Sometimes	53
Rarely	31
Never	4
Can't say	2
N	***118***

8.6 When people did return, 98% of the community pharmacy staff (107 respondents) offered further support at least sometimes in relation to contraception. Only 3 respondents said they did not offer any further support.

8.7 The type of support given included: suggesting or referring for an appointment to see their GP or family planning clinic about contraception; discussion on sexually transmitted infections; giving them information on pharmacy contraception; liaising with district nursing; providing leaflets on contraception options and services not available at the pharmacy; or offering free condoms where this service is provided. Additional support was seen as particularly important for young people who were still learning about contraception methods.

8.8 Those who did not offer further support for returning clients felt it was not their place to do this. In some cases returners had drug addiction issues and in others the person had experienced a contraception failure e.g. a split condom and further support was not needed.

What the service and consultations covered

8.9 Ninety three per cent of the community pharmacy staff who responded said the consultation included advice on other contraception services in the area, 86% said that the service included information on different methods of contraception, and 77% said it covered advice on longer acting reversible contraception (LARC).

Who was involved in providing the service?

8.10 All the community pharmacy staff who responded (100%) said that pharmacists were involved in delivering the EHC service. Pharmacy technicians (4%), counter staff (3%) and pre-registration pharmacists (3%) were also involved in providing the service under supervision.

Offering the service

8.11 Ninety seven per cent of community pharmacy staff who responded wanted to continue to offer the service, 1% did not want to continue and 2% were undecided.

8.12 The reasons given for wanting to provide the service included:

- that it was a valuable service, particularly out of GP hours and was appreciated by clients;
- it prevented unwanted pregnancies, particularly in young girls;
- it allowed people to access the service at no cost;
- it provided an opportunity to discuss contraception in a relaxed atmosphere;
- it improved pharmacies' status in their local communities and enabled pharmacists to use a wider range of their skills;
- the financial incentive
- the service was cost effective.

8.13 Those who did not want to continue or were undecided about continuing to provide the service, said this was because the service was time consuming or was not appropriate.

8.14 Two respondents who did provide the service reported that they did not like providing it particularly to 'minors' as they felt they may be encouraging under age sex.

Effectiveness of the PHS EHC Service

8.15 The majority of NHS Board staff (81%) who responded thought the PHS EHC service was either '*very effective*' or '*effective*'. None of the respondents felt the service was '*not effective*' but 19% could not say if it was effective or not.

8.16 In general there was considerable agreement between community pharmacy staff and NHS Board staff in what they considered worked well regarding the service. The main reasons cited by both groups as to the reasons the PHS EHC service was effective were that:

- The service was available on the high street, easy to access with no appointment necessary and available in the evenings and at weekends.
- It enabled women to get access to EHC and avoided the necessity of GP appointments.
- It reduced the number of women falling outside the 72 hour window for treatment.
- The service was free to clients.

"The ability to use the PGD to supply Levonelle free of charge - cost would put some patients off." [CP 87]

- The service was supportive, non judgemental, confidential and discrete and the visit was not recorded on their GP notes.

- Information on other forms of contraception and local services was available.
- Paperwork was easy to complete.
- The guidelines were helpful and clear.

8.17 These factors were summarised by two respondents:

"Accessibility beats all other services hands down. Much more attractive location for service user as more anonymous e.g. patients attend pharmacy for a wide range of reasons so no stigma. Privacy and confidentiality maintained. Patients are usually very honest with their information. Very professional service and surgeries refer patients as we will see them right away so improved treatment efficacy. The longer the patient waits to be seen, this increases the chance of treatment failure." [HB 68]

"This service is free to women and we have enhanced it by also offering free condoms when they access EHC. Pharmacies offering this service do so in a supportive and non judgmental manner and offer them advice on more reliable contraception." [HB 5]

Support and training

8.18 Information on accessing specialist advice or services, providing training events, and providing information leaflets were the most frequently mentioned ways that Health Board staff offered support to community pharmacies (Table 21). Other support offered included: PGD support; provision of condoms; child protection and support in determining capacity to consent; NES distance learning packs; and one to one support/ mentoring.

Table 21 – Support offered to pharmacies on EHC

Support offered:	
	%
Provision of information on accessing specialist advice or services	87
Provision of training events	81
Provision of information leaflets	77
Other support	23
No support offered	3
N	***50***

8.19 Comments on the support provided include:

"We developed a pharmacy support pack that covered sexual health initiatives including the EHC, some child protection issues and the provision of condoms. Pharmacies were given training on the application of this pack." [HB 5]

"We run support sessions once or twice a year with specialists from the sexual health services updating on new developments and providing an opportunity for pharmacists to share best practice and discuss ethical dilemmas." [HB 32]

8.20 Suggestions made by NHS Board staff on support included:

- A new governance framework for the service should be developed in consultation with NHS Boards.
- It should be made clear that it was the contractors' responsibility to keep their staff up-to-date around training and the service, this was seen as particularly important where there was high staff turnover.
- Helpful to integrate pharmacy services with specialist sexual health services.

8.21 Some (40%) NHS Board staff also offered additional support. This additional support was mainly provided by telephone or email and covered issues such as child protection and PGD's.

8.22 In the view of community pharmacy staff, over four fifths (82%) felt supported by their NHS Board in delivering the EHC service. Respondents felt supported through the training they had received, the clear guidelines NHS Board's provided, the support given by family planning and NHS Board Pharmacists and Medicines units, the ease of referral, the support given around child protection and help received with filling in forms. In some cases, NHS Boards provided help via the telephone.

8.23 Those who did not feel supported (18%), said this was because of poor communication, the wrong forms being sent to them, lack of leaflets, lack of an EHC coordinator, and some had had no contact with the NHS Board.

"There doesn't seem to be a co-ordinator as in the Smoking Cessation service, whom you can access freely if you encounter an issue." [CP 46]

8.24 Some respondents did not feel they needed any support and others said they were not aware of any support offered by their Health Board. One respondent commented:

Don't think they ever asked the question if pharmacists were happy to supply EHC to under 16s. [CP 90]

Training

8.25 The majority of respondents had received local NHS Board training (75%), or had used the NES distance learning training pack (72%).Over a half (52%) had received child protection training (Table 22).Other training mentioned included manufacturer's training, family planning training or in house training by another pharmacist.

Table 22 – Source of training undertaken

Training source:	
	%
Local NHS Board training	75
NES distance learning training pack	72
Child protection training	52
NES training course	30
Other training	9
No training	1
N	***118***

8.26 More than two thirds (68%) said the training was *very useful* and 29% that it *was quite useful* while 3% said it was *not very useful*. The only improvements to the training suggested was to: include technicians and pre registration pharmacists in the training; provide annual refresher training; provide more on child protection and under 16's; update the NES training pack; do more around the PGD; and to include information on what to do about difficult client situations.

8.27 Other support community pharmacy respondents wanted following the training included:

- Providing a guide for pharmacies to keep in the pharmacy as a reference.
- Providing the opportunity for role play.
- Further support around child protection.

The Scottish Government PHS EHC Service Specification

8.28 Ninety four per cent of the Health Board staff were aware of the Scottish Government Service Specification for the EHC service, 6% were not. A total of 88% thought it was very or quite helpful (Table 23)

Table 23 – Usefulness of PHS service specification

The specification was considered:	%
Very helpful	35
Quite helpful	53
Not helpful	7
Not helpful at all	0
Haven't read the specification	5
N	**116**

8.29 Most respondents were happy with the specification and did not suggest any changes. Some respondents from both NHS Boards and community pharmacies however felt there was some room for improvement and suggested that:

- The religious exemption should be removed to avoid people in rural and remote areas having to drive long distances to access the service.

- All pharmacies should offer the service to under 16's.

- The service could be extended to include free condoms, other forms of contraception and pregnancy testing.

- That products that can be used for up to 5 days should be available (if alternatives such as IUD or ullipristal are not an option) e.g. ellaOne.

  "Bring it into keeping with national guidance that Levonelle be given out until 120 hours as causes an inequity ... and also further delay" [HB 28].

- Pharmacy technicians should be able to provide some of the service where appropriate.

- Training should be specified more clearly in the specification.

- Clearer guidelines on audit should be included

Integration and Links with Other Services

8.30 NHS Board staff was asked how well they thought the PHS EHC service integrated with other services locally. Seventy three per cent of those who responded felt that the service integrated very well, quite well or well, 13% felt it did not integrate well and 13% could not comment.

8.31 Examples of good integration from the point of view of NHS Board staff included links with wider contraception services and free condom schemes. Several areas reported that local services referred to each other effectively and shared information materials. For example:

"See community pharmacy as a key element of how young people can access pregnancy testing, chlamydia testing and free condoms". [HB 42]

8.32 Aspects where integration did not work so well from the point of view of NHS Board staff included difficulties in areas with dispensing GP practices and no easy access to pharmacies, integration with sexual health services, and linking with Chlamydia testing. For example:

"…tried to tie this into chlamydia testing, but that aspect of it wasn't welcome by the women". [HB 5]

"Most of the activity generated for EHC is from a small number of city centre pharmacies. Very few clients are referred to specialist services for LARC or for STI screening". [HB 53]

8.33 There was a suggestion by NHS Board staff that it would be helpful if appointments to family planning could be made by the pharmacy as part of

the EHC service. This was seen as particularly important for young people. However, where pharmacies had tried to help people access family planning there was some suggestion that it was difficult getting through on the phone/ contacting the appropriate services.

8.34 Community pharmacy staff were asked about their links with other local contraception services. Over a third of respondents (35%) had links with other services but the majority (54%) did not (Table 24).There was little further information as to the nature of these links.

Table 24 – Links and referrals to other services offering help with contraception

Community pharmacists who	**Yes**	**No**	**No other services in area**	**Not sure**
	%	%	%	%
Link with providers in area*	35	54	1	10
Refer to other services**	94	3	2	1

*N= 117
**N= 117

8.35 The vast majority of respondents reported that they referred clients to other services (Table 24). Clients were referred to GPs; family planning clinics; Genito-Urinary Medicine (GUM); minor injury clinics; Brook and the Caledonian Youth Service (providing support and advice on sexual health to young people); Wellwoman services; Sandyford (Sexual Health Services in NHS Greater Glasgow and Clyde) and Contraception and Sexual Health Clinics (CaSH). The reasons for referring were to provide long term support to clients around sexual health or contraception, for people who fall outside the service specification e.g. need an IUD or has had multiple use of Levonelle in cycle and for young people who need specialised help or advice.

EHC Data Collection

8.36 NHS Board staff were asked what data they used to monitor the uptake and costs of the EHC service. Some respondents received data from local data sources and others used centrally administered data such as PRISMs[19]. For example:

"Pharmacies provide us with uptake data, ages of women and payment requests. This gives us some usable data in terms of trends." [HB 5]

8.37 Suggestions for how data could be improved included:

- Collecting additional data such as age range, post code area and data on repeat requests
- Providing trend data by day of the week, time of the day and across the year.

[19]PRescribing Information SysteM for Scotland (PRISMS) — It is a web-based application, giving access to prescribing information for all prescriptions dispensed in the community for the past five years

- Enabling comparison of services e.g. national, CHPs, localities and pharmacies.

- Recording information on cases where EHC was not dispensed.

8.38 Suggestions for how this data could be made available centred on more information being provided via PRISMs, using CHI etc, and using NASH.[34] There was a suggestion that if more data was available there would be scope for an annual audit which is needed for the PGD[5] and a sexual health clinical indicator.

Governance and Quality Assurance Arrangements

8.39 The majority of NHS Board staff indicated that they had a variety of governance arrangements in place (Table 25). Most of those who said they had other governance arrangements in place, explained that they did not know much about them as these were not their responsibility e.g. they were the responsibility of the CHP.

Table 25– Governance arrangements for the PHS EHC service

Arrangement	**%**
Clear lines of accountability	66
Quality improvement programmes	62
Procedures in place to manage risk	45
Procedures in place to identify and remedy poor performance	35
Other governance arrangements in place	21
No arrangements in place	3
N	***29***

8.40 Some NHS Board staff who responded were not aware of any quality assurance arrangements being in place for the EHC service. Others however explained that pharmacies worked to a PGD which offered some quality assurance and that information on the use of the PGD was reported to Boards overseeing the service and in annual reports. About a quarter of respondents were planning audits, used mystery shoppers to check quality, looked at complaints data, identified poor performance from the available data, and where needed, offered support to poorly performing community pharmacies.

8.41 When it came to problems or complaints about the PHS EHC service most NHS Board respondents explained that complaints were dealt with through the NHS Complaints procedure. Some said that complaints would be flagged up to the pharmacy advisor or team. A small number said that complaints were dealt with locally by the pharmacy team. Several respondents reported that they had never had a complaint.

Improving the EHC Service

8.42 There were a wide range of suggestions for improving the EHC service. Some of these have already been mentioned in earlier sections of this chapter. Improvements suggested by NHS Board and community pharmacy staff included:

Staffing

- All pharmacies should provide the service and the religious exemption should be removed.
- Ensuring all locums should provide the service.
- Including provision for double cover in pharmacies with high numbers of requests for the service.

Extension of the service

- Consideration of off-label use for up to 5 days alternative such as ellaOne[20]within the service if an IUD[21] or ullipristal are not an option.
- Provision of free condoms as part of the service.
- Including the option to provide regular contraception as part of the service.
- Provision of pregnancy testing and long term contraception follow-up appointments as part of the service.
- Access to the emergency care summary.
- Enabling direct referral to sexual health services particularly for multiple users with a small referral fee for pharmacists.

Guidance and support

- Improving the PGD.
- Developing better guidance and a detailed protocol around child protection.
- Providing regular refresher training or set protocols.
- Providing guidance on what to do if a client is registered with an English GP.
- More information should be given on issues around age of clients

[20] ellaOne is new form of emergency contraception which can be taken up to five days after sex. Before ellaOne was introduced in 2009, morning after pills only allowed women to prevent pregnancy within three days of having unprotected sex.

[21] Intrauterine device which is a form of contraception which prevents a fertilised egg implanting.

Information and advertising

- Providing a larger range of contraception and service leaflets.
- Better advertising of the service and what it can offer and highlighting the confidential nature of the service.

Data collection

- Moving to electronic data collection like eMAS. This included giving community pharmacists access to the IT "Nash[22]" to provide a more integrated recording of information.
- Undertaking better evaluation of the service, including mystery shopping.

8.43 Other comments made by community pharmacy staff included: that the NES training pack was quite old and could be refreshed; that community pharmacists would need different support and funding if the number of services they provided increased in the future; and that there might be a need to document more around the service to justify a particular decision if required.

Summary

8.44 Overall the PHS EHC seemed to be working well from the point of view of NHS Board and community pharmacy staff. In particular the community pharmacy staff who responded to the survey felt that the EHC service was a really valuable community service which needed very little adjustment. It was also clear that particularly in remote and rural locations the PHS EHC was the only easily accessible service available and fulfilled a crucial role.

8.45 There were however, some suggestions for improvement including the expansion of the service to include pregnancy testing, longer term contraception and new drugs which can be prescribed up to 5 days**;** removal of religious exemptions; the use of pharmacy technicians; integration with other services; data collection; and governance and quality assurance of the service.

[22]NaSH – the NHSScotland National Sexual Health IT system project aims to provide a common IT system to support specialist sexual health services across NHSScotland

9 DISCUSSION AND CONCLUSIONS

Introduction

9.1 Over the last ten years there has been considerable interest and activity in the development of the role of the pharmacist in the promotion of healthy lifestyles. Internationally this has led to the development of a range of specialised, extended or enhanced pharmacy services relating to health care and promotion other than routine provision of prescribed and non-prescribed medicines. In Scotland a range of policy initiatives have been implemented to develop and promote extended health care roles for pharmacists in Scotland in line with developments across the UK. Against this backdrop, the Scottish Government and partners are currently reviewing the services provided under the PHS element of the community pharmacy contract. To inform the work, this evidence review was carried out to explore the operation of the smoking cessation and emergency hormonal contraception services. This chapter discusses some of the key findings to emerge from the review and highlights possible policy and delivery implications arising from findings.

Limitations of data

9.2 Whilst much was done to promote community pharmacist awareness of and participation in the online survey, the response was low. Although almost all territorial Health Boards and all types of pharmacy (ranging from multiples to single outlets) were represented amongst the respondents, it is difficult to know how representative the views expressed in the survey are of community pharmacists more generally. The data provided in this report must therefore be treated with caution.

9.3 Similarly, responses from a wide range of Health Board staff were obtained but again it is difficult to know how representative these views are of all the staff that might have responded.

9.4 However, having acknowledged the limitations of the surveys they do provide insights into the views of community pharmacy and health board staff with regard to these two PHS services. The analysis suggests that there are common themes to emerge from responses while in some cases clear differences in the views of the two groups.

Smoking Cessation

9.5 The evidence review found that overall the service appears to be working well. Service users who participated in the research were very positive about the service provided by community pharmacists; even those who were unsuccessful in their quit attempt were positive about the service. Responses from both NHS board and community pharmacy staff were in the main positive. However there were some elements of the service that were identified by both service users, community pharmacy and NHS board staff as requiring improvement or further development.

Access to and promotion of the service

9.6 The findings from the routine data collected on the number of smoking related items dispensed suggest that there has been an increase in the number of people using the smoking cessation service offered by pharmacists. While these figures suggested increased take-up of the service, the research with users highlighted some problems in promotion of the service.

9.7 Users of the service tended to 'stumble across' it if they happened to be visiting a pharmacy or they were recommended by family or friends. Many felt that the service was poorly advertised generally. Furthermore, referral by GPs was the 'exception rather than the rule'; in some cases GPs had provided a prescription for NRT products but had not mentioned the pharmacy service which as well as providing NRT products also included regular (normally weekly) face-to-face support. Participants in the research also suggested that the advertising should reflect some of the highly valued features of the service, including benefits of the service, the convenience and flexibility, support from staff and the availability of NRT on prescription.

9.8 The view that the service should be better promoted was also shared by some community pharmacists and NHS boards respondents to the survey. For example, some community pharmacists suggested there was a lack of support from boards to promote the service in the board area. There was also a suggestion that the service should be promoted at a national level.

9.9 Taken together these findings on access and advertising suggest consideration should be given to:

- Doing more to ensure that the community pharmacy smoking cessation service is promoted via other professionals including encouraging GP referrals;
- Developing strategies for promoting the pharmacy smoking cessation service more widely e.g. on a national and or regional basis including specific action where appropriate aimed at target groups of smokers; and
- Providing promotional materials which include information on the benefits, convenience and flexibility of the service, support from staff and the availability of NRT on prescription.
- Exploring appropriate opportunities to link the availability of pharmacy smoking cessation services to other pharmacy and primary care promotional activity and marketing campaigns, e.g. in relation to long-term conditions, screening etc.

Continuity of staff

9.10 The research with users as well as with community pharmacies and NHS boards suggested that staff interaction is seen as an important feature in the effectiveness of the service. In particular the users found it helpful if there was a degree of continuity in the staff member who they saw on a weekly

basis as it enabled them to build up a relationship with staff and as a result feel more supported and encouraged.

9.11 The research with service users concluded that community pharmacies should try to find ways to:

- provide continuity whilst allowing for flexibility for service users to access the service when they like;
- ensure pharmacists and support staff are offered access to training;
- ensure smokers are supported to quit by staff with appropriate skills and knowledge.

Follow-up of those lost to the service and access for those who fail first time round

9.12 Community pharmacists responding to the survey suggested that many initial users of the service are lost to follow-up. The estimated proportions of users returning for second and third visits were around half for the second visit and one fifth for the third visit. There was some suggestion that more could be done to follow-up on users who had not completed the course.

9.13 For those who fail in their first quit attempt or in cases where service users have smoked while using the service, there appears to be variation in practices between NHS boards around whether users can continue to use the service. For example while some users who had failed in their first quit were allowed to continue the service, others were told they had to wait for six months before trying with the service again.

9.14 Consideration should therefore be given to:

- ways of reducing the number of failed quit attempts;
- providing clarity and consistency on the evidence-base for whether service users can continue to use the service if they fail in their first quit attempt or if they have smoked during the course of the service ; and
- agreeing a length of time before a service user can use the service again after an unsuccessful quit attempt in keeping with evidence-based good practice and efficient use of scarce resources.

Additional support beyond 12 weeks

9.15 A key improvement suggested by users of the service was the provision of follow-up beyond the 12 weeks to assist service users in their quitting journey. This view was shared by a number of NHS board and community pharmacy staff. A variety of suggestions were provided by users such as: being able to visit the pharmacy weeks or months after finishing the service; speaking to the pharmacist face-to-face or over the phone; being able to collect a one-off prescription; and a proactive call from the pharmacist.

9.16 Building on this finding, the report on service users recommended that 'pharmacists help service users develop an exit plan or follow-up support plan on their last appointment'. Within the plan itself there were some suggestions for what should be included such as: information on seeking further support and help from the pharmacy; a follow-up appointment at a specific point e.g. four weeks; and information about other forms of support such as Smokeline and local smoking cessation support groups.

9.17 The responses suggest therefore that consideration be given to:

- the provision of follow-up support (both contact and NRT) beyond the 12 week period;
- evidence-based guidance on the flexibility to extend the 12 week period where appropriate including guidance on the maximum length and other parameters of such an arrangement; and
- the development of an exit/follow up support plan to help service users in their on going effort to stay smoke-free.

Links with other services

9.18 The research with users and the survey of NHS boards and community pharmacists indicated that links with other smoking cessation services could be improved. There was a view from other smoking cessation service providers that there was a need to ensure that those trying to quit can take advantage of other services especially if they are struggling or need additional support once they finish using the pharmacy service. Users reported being only provided with *"basic information about the availability of other services."* In the survey of community pharmacists while over two thirds suggested that they referred people to other smoking cessation services, only around half suggested that they had links with other smoking cessation providers in their area which may explain why users felt that they lacked awareness about other forms of support available to them.

9.19 This review therefore points to the need to:

- do more to improve the links between community pharmacy and other smoking cessation;
- encourage referral between GPs, community pharmacy and specialist smoking cessation service providers including incentives for joined-up working; and
- ensure that community pharmacy is linked in effectively to Health Promoting Health Service objectives on creating effective person-centre smoking cessation pathways in both directions between secondary care and community settings

Advice given to service users

9.20 The advice on quitting provided to service users appeared to vary. While some users suggested that they received helpful advice and tips, other received little or none at all. Suggestions were provided by users about the types of advice which would be useful such as: dealing with cravings, stress and the side effects of quitting such as weight gain.

9.21 Consideration should therefore be given to:

- providing support materials to pharmacists which include information and advice to assist them in their quit attempt; and
- including more information on the services user's experiences.

Use of CO testing machines

9.22 Research with users suggested that where CO testing machines were used, these were found to be a valuable tool to encourage and motivate quitters as they demonstrated tangible evidence of the reducing levels of CO in the body. Users also reported that their use was an incentive not to smoke as they would be 'found out'. The research reported that some users were disappointed when CO testing equipment did not work. The use of the CO monitors was seen as valuable by some community pharmacy and NHS board respondents. However there was a suggestion by some that there was a lack of funds to maintain and support the use of CO monitors.

9.23 The responses suggest therefore that consideration be given to:

- the use of CO monitors as part of the service; and
- ways to maintain the CO monitors.

Training and support for staff

9.24 The majority of community pharmacy staff who responded to the survey had attended or undertaken some form of smoking cessation training. Over half found the training to be very useful. Some suggestions were given to improving training for community pharmacists which ranged from training on multiple therapies and dealing with clients who lapse to role play and motivational training.

9.25 On the back of some of these suggestions, consideration should be given to:

- ensuring staff providing the service (pharmacists and pharmacy staff) are competent in the necessary knowledge and skills including the completion of associated paperwork;
- undertaking a modest review of the training available to support the service involving some community pharmacists, NHS Health Scotland, Partnership Action on Tobacco and Health, NHS board representatives and NHS Education for Scotland (NES);

- providing regular updates on service enhancements and guidelines; and

- making better use of community pharmacy champions to support community pharmacies.

Pharmacy Premises

9.26 Almost all community pharmacies providing the service claimed to do so using a separate consultation room or counselling area within the pharmacy. However a small number of pharmacies reported problems such as availability of the room, space, lack of wheel chair access or no suitable room or space being available. Service users also shared some concerns about the availability and use of a private room; where pharmacies used a room service users tended to like the privacy afforded to them as they did not like others customers in the pharmacy being able to see or hear what was being discussed. On the other hand a couple of service users were uncomfortable about using a room which was also used for methadone clinics. In pharmacies where this may be a problem consideration should be given to advertising the smoking cessation service on the door of the room.

9.27 In view of these comments, consideration should be given to:

- providing community pharmacies with advice about service users' preference to receive the service in a consultation room or counselling area; and

- encouraging community pharmacies to ensure their pharmacy premises have appropriate facilities such as a consultation room or discrete counselling areas available to deliver the service to service users at times when it is needed and provide adequate levels of privacy.

PHS Service Specification

9.28 The research with community pharmacists and NHS boards demonstrated that there was widespread awareness of the smoking cessation specification and many community pharmacists found it to be helpful. Nevertheless there were a large number of suggestions put forward about how the specification could be improved. These centred around a range of areas, including: payments associated with the service; widening the scope to include dual therapy and other products such as varenicline; increasing the flexibility of the service; the role of pharmacy support staff in providing the service; reviewing the terms of condition for the service; clearer guidance; and simplifying the paperwork associated with the service.

9.29 In view of some of these suggestions consideration should be given to a review of the PHS smoking cessation service specification.

Data collection and paper work associated with the service

9.30 NHS boards and community staff made a number of other suggestions to improve the service. A key theme that arose was the paperwork associated with the service, for example the requirement to send three forms to three different places. There was a suggestion that the paperwork associated with

the service should be simplified, minimising the duplication between data collection forms, and consideration be given to providing electronic means to document records. Community pharmacies also requested the ability to electronically generate the prescription forms for NRT. This may also improve CHI capture which is currently very low. There was also a widespread view amongst Health Board respondents that data collection should be linked to payment.

9.31 The review suggests therefore that consideration is given to:

- ways to simplify the paper work associated with the service;
- underpinning the service with IT support through the ePharmacy Programme to support data collection, four week follow up and printing and electronic claiming of NRT prescriptions;
- ensuring pharmacists complete the paperwork timeously; and
- exploring the potential to merge or integrate the data collection and payment systems.

Governance and Quality Assurance

9.32 Many NHS boards reported having developed quality improvement programmes for the service. These include regular visits to pharmacies, use of pharmacy champions / mentors, provision of toolkits and updates, monitoring poor performance, providing performance data and sharing three month quit rates for service users. Some NHS board respondents highlighted difficulties in providing local quality assurance believing there was insufficient recognition of this in the service specification.

9.33 The responses suggest therefore that consideration be given to:

- reviewing the PHS Directions and service specification to take into account quality assurance aspects; and
- sharing best practice in quality improvement programmes, including feedback on performance, between NHS boards.

Emergency Hormonal Contraception (EHC)

9.34 The findings from the review of pharmacy EHC services are based on the analysis of routine data, the survey of NHS boards and community pharmacists. No research was carried out with users of the service due to the sensitivities and confidential nature of the service. Nevertheless the work carried out provided some useful reflections from the perspective of community pharmacists and NHS board staff on how the service is operating in practice.

9.35 Overall it was felt that the community pharmacy EHC provision offered a valuable community service across the country, particularly in rural areas. The service was viewed as working well with little adjustment required from the

point of view of community pharmacy and NHS board staff. Over 90% of community pharmacy staff felt that it should be continued to be offered and over 80% of NHS Board staff felt that the service was effective. However a number of suggestions for improving the service were made and these are discussed below.

Access to and the promotion of the EHC service

9.36 From the analysis of the routine EHC dispensing data, the PHS Emergency Hormonal Contraception (EHC) Service, since its introduction in 2008, has enabled increased access to EHC and complements the service provided at specialist sexual health services and GPs where EHC is given out without prescription and GP practices where EHC is available on prescription. Over the last year (2010/11), the number of items EHC items dispensed in community pharmacies has remained relatively stable.

9.37 No information was collected from users about their views on promotional information as already explained. However, according to community pharmacists who participated in the survey, the main ways users found out about the service was through community pharmacy staff, other health professionals and local health promotion materials. A number of respondents suggested that there is need for better promotion of the service which could include service key features, for example that the service is confidential.

9.38 Taken together these findings suggest that consideration should be given to:

- Continuing to ensure that the community pharmacy EHC is promoted, for example via other health professionals such as school nurses; and

- Ensuring that promotional materials include information on the benefits and convenience of and support offered by the service.

Training and support for community pharmacists in delivering the EHC service

9.39 The vast majority of community pharmacy staff who responded said they received training and 97% felt it was either very useful or useful. There were a number of suggestions for improvements around training which centred on widening access to training to other staff, dealing with difficult clients, information on under 16s and child protection issues and the option of refresher training including eLearning options.

9.40 In the main community pharmacy staff said that they felt supported by their NHS board in delivering EHC services due to the training and support provided as well as NHS board guidelines and contact with other sexual health services. However there was a significant minority (18%) who did not feel supported and cited lack of contact with NHS board and poor communications.

9.41 Taken together these findings on training and support for community pharmacists suggest that consideration be given to:

- ensuring staff providing the service (pharmacists and pharmacy staff) are competent in the necessary knowledge and skills including the completion of associated paperwork;

- undertaking a modest review of the training available to support the service involving some community pharmacists, NHS board representatives and NHS Education for Scotland (NES);

- providing regular updates on service enhancements and guidelines;

- making better use of community pharmacy champions to support community pharmacies for example in providing training and support to newly qualified pharmacists and those new to the area who may not be aware of local networks; and

- ensuring links to local specialist services

Improvements to the EHC Service Specification

9.42 As with the smoking cessation findings, research with community pharmacists and NHS boards demonstrated that there was widespread awareness of the EHC specification and many community pharmacists found it helpful. Nevertheless there were a number of suggestions put forward on how the specification could be improved. These included: removing the religious exemption; the role of other pharmacy staff in the service such as technicians; specifying training and better guidance around the use of Levonelle. However, as already stated, the response to this survey was not high so it is difficult to say how representative these findings are and therefore they should be treated with caution.

Improvements to the EHC Service

9.43 The EHC service was generally felt to be effective. However there were various suggestions as to how the service could be improved for users. These suggestions included better advertising; extending provision of services across all pharmacies; extending provision to include other contraception and pregnancy testing; direct referral to specialist sexual health services; ensuring locums provide service; use of other pharmacy staff such as technicians; improving the links with other services; and better monitoring and evaluation of the services.

9.44 On the back of some of these suggestions consideration should be given to:

- Reviewing those involved in providing advice and the service at community pharmacist

- Considering of extending the service to provide other contraceptive advice and support; provision of contraception and pregnancy testing

- Direct referrals to other services such as specialist sexual health services.

- Engaging with users of the service to explore how the service could be improved.

Governance and Quality Assurance

9.45 As with the smoking cessation findings, many NHS Boards reported having developed quality assurance programmes for the service. These include: regular visits to pharmacies; use of pharmacy champions / mentors; provision of toolkits and updates; monitoring poor performance; providing performance data. This good practice could be usefully shared across NHS Boards in Scotland. Some NHS Board respondents, however, highlighted difficulties in providing local quality assurance data because they believed that there was insufficient recognition in the service specification to address this.

9.46 Similar to the smoking cessation findings, the responses suggest therefore that consideration should be given to:

- reviewing the PHS Directions and service specification to take into account quality assurance aspects; and

- sharing best practice in quality improvement programmes, including feedback on performance, between NHS Boards.

Data collection and paperwork associated with the EHC Service

9.47 The analysis of the routine data for EHC items dispensed as part of this review revealed discrepancies between the number of claims made and number of items dispensed. Further investigation identified that this was likely due to changes in the way that Practitioner Services Division (PSD) now capture prescription data. The findings suggest that consideration should be given to:

- ensuring this discrepancy has been addressed going forward; and

- improving the systems to record EHC items dispensed and claimed e.g. by underpinning the service with IT support through ePharmacy Programme which would allow community pharmacists to print and electronically claim EHC prescriptions.

9.48 Various suggestions were made on how to improve data recorded on the community pharmacy EHC service which would be useful at local and national levels. Based on these suggestions consideration should be given to:

- collecting more information on patient characteristics such as age range and post code area by using a standardised pro formas underpinned electronically through the ePharmacy Programme; and

- better information on individual pharmacy, CHP, NHS board prescribing activity (for NHS boards, and nationally)

Conclusions

9.49 The findings from this review suggest that both the PHS Smoking Cessation and Emergency Hormonal Contraception (EHC) Services are considered valuable by both community pharmacy and NHS Board staff and in the case of the smoking cessation service, by the users as well.

9.50 However there are a number of suggestions as to how the services could be improved to ensure that the services are as effective and efficient as possible.

9.51 However, there are a number of suggestions as to how the smoking cessation service in particular could be improved with respect to increasing quit rates and enhancing the service such as: follow up of users, extending the range of products available, training, further integration with other local smoking cessation services and linking completion of paperwork with payment.

9.52 Similarly improvements suggested with respect to the EHC service included; enhancement of the service e.g. community pharmacists providing other contraception and support, the use of pharmacy technicians, better links and referrals to other sexual health services, improving governance and quality assurance and improving data collection.

REFERENCES

Anderson, C. (1998) Health promotion by community pharmacists: consumer's views. *International Journal of Pharmacy Practice* 6, pp 2-11

Anderson, C., Blenkinsopp, A. and Armstrong, M., (2004) Feedback from community pharmacy users on the contribution of community pharmacy to improving the public's health: a systematic review of the peer reviewed and on peer reviewed literature 1990-2002 Health Expectations 7, pp 191-202

Bush, J., Langley, C.A., Wilson, K.A. (2009) The Corporatization of community pharmacy: Implications for service provision, the public health function, and pharmacy's claims to professional status in the United Kingdom *Research in Social and Administrative Pharmacy* 5, pp 305-318

Berbatis, C. G., Sunderland, V. B., Joyce, A., Bulsara, M., Mills, C. (2007) Enhanced pharmacy services, barriers and facilitators in Australia's community pharmacies: Australia's National Pharmacy Database Project. *International Journal of Pharmacy Practice*15: 185-191

Department of Health (2004) *The New Contract Framework for Community Pharmacy.*London: Department of Health.

Inch, J., Bond, M., Lee, A.J., Scott, A. and Grant, A.M., (2005) Scottish community pharmacists' current involvement in and attitudes towards 'extended service' provision: a national survey. *International Journal of Pharmacy Practice*13, 289-301

Information Services Division 2011. NHS Smoking Cessation Service Statistics (Scotland) 1st January to 31st December 2010.

Barker, R., Kirk, J. and Munday, R.J., 1988. *Narrative analysis.* 3rd ed. Bloomington: IndianaUniversity Press.

Boughton, J.M., 2002. The Bretton Woods proposal: an brief look. *Political Science Quarterly*, 42(6), p.564.

Royal Pharmaceutical Society of Great Britain (1996). *Pharmacy in a New Age, Summary of Responses. London: RPSGB*

Scottish Executive (2000) Our *National Health: a plan for action a plan for change (2000)* Edinburgh: Stationary Office

Scottish Executive (2004) New Community Pharmacy Contract: Update Scottish Executive Health Department: Edinburgh: Stationary Office

Scottish Government (2002) *The Right Medicine: A Strategy for Pharmaceutical Care in Scotland:* Edinburgh: Stationary Office

Scottish Government (2008) *Additional pharmaceutical services minor ailment service & public health service directions, service specifications and payment arrangements.*
http://www.sehd.scot.nhs.uk/pca/PCA2008(P)17.pdf

Scottish Government (2011) *Scotland's People Annual report: Results from 2009/2010 Scottish Household Survey*. Edinburgh: Scottish Government
http://www.scotland.gov.uk/Publications/2011/08/17093111/11

APPENDIX A SURVEY QUESTIONS

Community pharmacists' survey questions

These first questions are about the pharmacy in which you work and the PHS services you offer?

1. Can you say what your role is in the pharmacy?
2. Do you work for a: *multiple outlet (16+ pharmacies); medium outlet (6-15 pharmacies; small pharmacies (2-5 outlets); single pharmacy*.
3. Does your pharmacy open late in the evening (after 6 pm)?
   If yes: On which days is your pharmacy open late in the evening?
4. Is your pharmacy open on Sundays?
5. In which health board area is your pharmacy located?
6. Does your pharmacy provide? both the PHS *smoking cessation and emergency contraception services;* PHS *smoking cessation service only,* PHS *emergency contraception service only; neither*.

For those that do not provide either service:

7. Can you say why you do not provide either of these services? >**end of survey**

For those providing one or both services:

8. What particular facilities do you provide for PHS consultations?
   Designated area in the pharmacy; *Separate, private consultation room; no particular provision – just over the counter; other.*
9. Are there any problems with providing suitable facilities within your premises to carry out these ...
   - Can you comment further?

This next series of questions is about the smoking cessation service you provide.

10. How do clients usually find out about the smoking cessation services offered at your pharmacy? *Pharmacy staff; Health promotion material in pharmacy; Referred to service by other health professionals; Other routes; Don't know*
11. Which of the following do you include in your smoking cessation consultations? (Tick all that apply) *Discussion of previous quit attempts; Discussion of current tobacco use; Current smoking status; Quit date agreed; Information on different types of NRT; Motivations to quit; Provision of information on different methods of quitting; Use of CO monitor; Advice/signposting to clients about other smoking cessation services in the area.*
12. Are clients given a choice as to which type of smoking cessation therapy they try? *Yes; No; Sometimes*.

13. Which of the following nicotine replacement therapies are offered? (Tick all that apply.) *Nicotine gum; nicotine inhaler; nicotine lozenge; nicotine nasal spray; nicotine patch; other*.

14. Which staff are involved in delivering the PHS smoking cessation service? (Tick all that apply.) *Pharmacists; Dispensing technicians; Pharmacy counter assistants; Other.*
15. Before the start of the PHS patient services in August 2008, how long had you been delivering a smoking cessation service? *Less than 12 months; between 12 and less than 24 months; more than 24 months, didn't provide this service.*
16. For smoking cessation services - what arrangements are in place to see clients?
    - **For first visit**: *Clients see on demand but may have to wait or return later if the pharmacist is busy; clients seen by appointment only; mixture of 'on demand' and appointment.*
    - **For follow up visits***Clients see on demand but may have to wait or return later if the pharmacist is busy; clients seen by appointment only; mixture of 'on demand' and appointment.*

    These next few questions are about your views on the effectiveness of the PHS smoking cessation services
17. What proportion of clients would you say, return for a second visit at 2 months? Please estimate*:*
    More than 75%; between 50 and 75%; between 25 and 49%; less than 25%; can't say.

    and what proportion, would you say, return for a final visit at 3 months?
    . More than 75%; between 50 and 75%; between 25 and 49%; less than 25%; can't say.
18. Of those that return for subsequent visits what proportion would you say have made a serious attempt to quit?...
    . More than 75%; between 50 and 75%; between 25 and 49%; less than 25%; can't say.
19. Is there any follow up of clients who do not return for subsequent appointments? Yes; No; Don't know.

    - Is this follow up carried out by: *pharmacy; health board*
    - Can you say more about this?

20. Do you see some people returning to the service and making several attempts to quit? *Yes, No, sometimes*.

21. In your view, how effective do you think the smoking cessation service is in helping people to stop smoking? Very effective, quite effective; not very effective; to not at all effective; not sure.
    Can you please say why you think this?

22. In your view, what has worked well in the PHS smoking cessation service?

23. What changes/improvements would you like to see to the smoking cessation services you offer?
24. If, offered a choice, would you continue to offer the smoking cessation service?
    - Can you say more about this?

Training and support

25. What training have you had in delivering smoking cessation advice? (Tick all that apply.)
    Local NHS Board training - brief intervention; Local NHS Board training - in-depth advice training; Path/ASH Scotland training – 'raising the issue of smoking'; Path/ASH Scotland training – brief intervention; Path/ASH Scotland training in-depth advice training; NES local training course; NES distance learning pack; other training; no training.

26. How useful was the training in enabling you to deliver the smoking cessation service? *Very useful; quite useful; not very useful; not at all useful*.
27. What additional assistance, if any, do you feel you need following this training?
28. If you were asked to revise this training what would you change?
29. Do you feel supported by your Health Board and/or others in delivering the smoking cessation service?...
    - Why do you say that?
30. How useful has the PHS service specification been in helping you deliver the smoking cessation service? *Very useful; quite useful; not very useful; not at all useful*.
31. What additions/changes do you think should be made to the specification?
32. Do you refer clients to other smoking cessation services in your area?
    Can you say which services?
33. Can you say a bit more about this?

Links with other smoking cessation providers

34. Do you have any links with other providers of smoking cessation services in the area?
    Can you say a bit more about this?

Data collection

These next few questions are about your views on the data you are required to collect and maintain...

35. Is the data you are required to collect and maintain for the smoking cessation service easy to collect? *Very easy; quite easy; quite difficult; very difficult*.

36. How could this be improved?

37. Is the data useful to you?

38. Could the data be made more useful to you?
    If yes, how could it be made more useful?

Emergency hormonal contraception services

The next questions are about the Emergency Hormonal Contraception service you provide

39. How do clients usually find out about the EHC services offered at your pharmacy? *Health promotion material in pharmacy; Pharmacy staff; Recommended by other health professionals working in your area;Other; Don't know*

40. The EHC service offered at our pharmacy includes: (tick all that apply) *Provision of information on different methods of contraception; advice/signposting to other contraception services in the area; advice on long term contraception*.

41. Before the start of the PHS in August 2008, how long had you been delivering an EHC service? *Less than 12 months; between 12 and less than 24 months; more than 24 months, didn't provide this service.*

42. Which staff are involved in delivering the PHS emergency hormonal contraception service? (Tick all that apply) *Pharmacists; Dispensing technicians; Pharmacy counter assistants; Other.*

...

43. Do you see the same people returning for this service? *Yes, see the same people returning; Sometimes; Rarely; Never; Can't say.*

44. In these cases do you offer further advice and support in relation to contraception? *Yes; sometimes; No.*
    Can you say a bit more about this?

These next few questions are about your views on the effectiveness of the PHS EHC services you offer.

45. In your view, what has worked well in the PHS EHC service you provide?
46. What changes/improvements would you like to see to the EHC services you offer?
    Can you say more about this?
47. If, offered a choice, would you continue to offer the EHC service? *Yes; No; Undecided.*
    Can you say more about this?

Training and support

48. What training have you had in delivering emergency hormonal contraception? *Local NHS Board training; Child protection training; NES lodal training course/s; NES distance learning pack/s; none; other*.

49. How useful was the training in enabling you to deliver the EHC service? *Very useful; quite useful; not very useful; not at all useful.*

50. If you were asked to revise this training what would you change?

51. What additional assistance, if any do you feel you need following this training?

52. Do you feel supported by your Health Board and/or others in delivering the EHC service? *Yes; No*.
    Why do you say that?

53. How useful has the PHS service specification been in helping you deliver your EHC service. *Very helpful; quite helpful; not helpful; not helpful at all; haven't read the specification*.

54. What additions/changes would you like to see to the specification?

55. Do you refer clients to other services in your area that can offer help with contraception? *Yes, No, not sure, no other services in the area*.
    Can you say which services?
    Can you say a bit more about this?

56. Do you have any links with other providers of EHC services in the area?
    Yes; *No, not sure, no other services in the area*.
    Can you say a bit more about this?

57. Do you have any other comments on any aspect of the PHS smoking cessation and/or EHC services?

58. Do you have any other comments on any aspect of the PHS smoking cessation services?

Health Board Survey questions

This survey aims to explore the views of Health Board staff on the Community Pharmacy Public Health Services.

These first questions are about your role in the Health Board and the Public Health Service patient services.

1. What is your role in the health board?
2. Can you describe your role/interest in the PHS?
3. What is the name of your health board
4. Do you have an interest/responsibility in: *the PHS smoking cessation service only; the PHS emergency hormonal contraception service only; both services; neither.*

For those with an interest in the PHS smoking cessation service

5. How effective do you think the PHS smoking cessation service is in terms of helping people to quit? *Very effective; quite effective; not effective; not at all effective; can't say.*
6. What do you think are the best things about the PHS smoking cessation service?
7. What could be improved?
8. Do you think the PHS smoking cessation service works better in certain areas than others e.g. rural or urban areas?
9. Is there any follow up of PHS smoking cessation users?
10. Who carries out this follow up of users of the service? *The health board; the pharmacy?*
11. What does the follow up involve?
12. What information and support is given to pharmacies in terms of referral to other smoking cessation services in the area?
13. How well do you think the PHS smoking cessation service integrates with other smoking cessation services locally? *Very well; quite well; well; not well; don't know.*
    Why do you say that?
14. What support do you offer to pharmacies in terms of training for smoking cessation? *Information leaflets; training events; information on accessing specialist advice or services; none, other.*
    Any further comments on support for training?
15. Do you offer any other advice/support to community pharmacies for the PHS smoking cessation service? *Yes/no/don't know*
    Can you say a bit more about this?
16. Are you familiar with the Scottish Government's specification on the PHS smoking cessation service? *Yes; no*.
17. Can you suggest what changes could be made to improve the specification?
18. What data do you use to assess uptake and cost of PHS smoking cessation services locally?
19. How could this data be improved?
20. What governance arrangements are in place in the Board for the PHS smoking cessation services? (Tick all that apply). *Clear lines of responsibility*

and accountability; development of quality improvement programmes e.g. training, monitoring of service; analysis of minimum data set; management of risk; procedures to identify and remedy poor performance; none; other; don't know.

21. Can you say what Quality Assurance measures are undertaken locally regarding the PHS smoking cessation service?
22. What arrangements does the Board have in place to deal with problems or complaints about the PHS smoking cessation service?

These next questions are about the PHS emergency hormonal contraception service

23. How effective do you think the PHS emergency hormonal contraception service is? *Very effective, quite effective, not effective, not at all effective; can't say.*
24. What do you think are the best things about the PHS emergency hormonal contraception service?
25. What could be improved?
26. What support do you offer to community pharmacies in terms of training for the emergency hormonal contraception service? *Information leaflets; training events; information on accessing specialist advice or services; none; other, please specify.*

    Can you say anymore about this?
27. Do you offer any other advice/support for the emergency hormonal service?

    Can you say a bit more about this?
28. Are you familiar with the Scottish Government's specification on the PHS emergency hormonal contraception service?*Yes; no.*
29. Can you suggest what changes could be made to improve the specification?
30. How well do you think the PHS emergency hormonal service integrates with other similar services locally? *Very well; quite well; well; not well; don't know.*

    Can you say a bit more about this?
31. What data do you use to assess uptake and cost of PHS emergency hormonal contraception services locally?
32. How could this data be improved?
33. What governance arrangements are in place in the Board for the PHS emergency hormonal contraception service?
34. Can you say what Quality Assurance measures are undertaken locally regarding the emergency hormonal contraception service?...
35. What arrangements does the Board have in place to deal with problems or complaints about the PHS emergency hormonal contraception service?
36. Do you have any other comments on either the PHS smoking cessation smoking or emergency hormonal contraception service?
37. Do you have any comments on the PHS smoking cessation or emergency hormonal service?

Social Research series
ISSN 2045-6964
ISBN 978-1-78045-517-4
web only publication

www.scotland.gov.uk/socialresearch

APS Group Scotland
DPPAS12298 (11/11)