Public Document Pack

Health and Social Care Committee

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Meeting Venue:
Committee Room 3 - Senedd

Meeting date:
8 December 2011

Meeting time:
09:30

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Agenda

1. Introductions, apologies and substitutions

2. Update on EU policy issues relevant to the Health & Social Care Committee (09.30 - 09.45) (Pages 1 - 16)
HSC(4)-13-11 paper 1

Gregg Jones, Research Service (by video link)

3. Inquiry into Residential Care for Older People - Committee work plan (09.45 - 10.00) (Pages 17 - 22)
HSC(4)-13-11 paper 2

4. Organ Donation White Paper - Technical Briefing from Welsh Government officials (10.00 - 11.00) (Pages 23 - 44)
HSC(4)-13-11 paper 3

Chris Jones, Medical Director NHS Wales and Deputy Chief Medical Officer
Grant Duncan, Deputy Director Medical Directorate, Welsh Government

5. Papers to note (Pages 45 - 48)
Minutes of the meetings held on 16 and 24 November
HSC(4)-11-11 minutes
HSC(4)-12-11 minutes

5a. Inquiry into the contribution of community pharmacy to health services in Wales - Additional information from BMA Cymru Wales (Pages 49 - 50)
HSC(4)-13-11 paper 4

5b. Inquiry into the contribution of community pharmacy to health services in Wales - Additional information from the Royal College of General Practitioners (Pages 51 - 55)
HSC(4)-13-11 paper 5

5c. Inquiry into the contribution of community pharmacy to health services in Wales - Additional information from Aneurin Bevan Community Health Council (Pages 56 - 77)
HSC(4)-13-11 paper 6

5d. Inquiry into the contribution of community pharmacy to health services in Wales - Additional information from Community Pharmacy Scotland - Changing patient consultation patterns in primary care (Pages 78 - 85)
HSC(4)-13-11 paper 7

5e. Inquiry into the contribution of community pharmacy to health services in Wales - Additional information from Community Pharmacy Scotland - Review of the Community Pharmacy Public Health Service for Smoking Cessation and Emergency Hormonal Contraception (Pages 86 - 176)
HSC(4)-13-11 paper 8

6. Motion under Standing Order 17.42(vi) to resolve to exclude the public from the meeting for items 7 & 8 (11.00)

7. Inquiry into Stroke Risk Reduction - Draft report (11.00 - 11.30)

8. Preparation for scrutiny session with the Minister for Health and Social Services (11.30 - 11.45)

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Research Service
Y Gwasanaeth Ymchwil

Health and Social Care Committee

HSC(4)-13-11 paper 1

EU policy issues relevant to Health and Social Care Committee

Committee briefing

Date of session:	08 December 2011

This briefing has been produced by the Research Service for members of the Health and Social Care Committee.

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Research Service

Enquiry no: 11/1185/Gregg Jones

29 November 2011

Cynulliad Cenedlaethol Cymru National Assembly for Wales

Contents

1. **Introduction** 3
2. **EU policy-making process** 3
2.1. Health and Social Care 3
2.2. Food Safety 4
2.3. EU policy-making and legislative process 5
2.4. European Commission 6
2.5. Council of Ministers 7
2.6. European Parliament 7
2.7. Committee of the Regions 8
2.8. EU networks 8
3. **Potential priority areas of interest to Wales** 8
3.1. Europe 2020 Strategy 8
3.2. EU Health Strategy 2008-2013 9
3.3. EU Health for Growth Programme 2014-2020 9
3.4. eHealth Action Plan 10
3.5. Active and Healthy Ageing 11
3.6. Modernising the Professional Qualifications 12
3.7. Revision of the Working Time Directive 12
3.8. Implementation of the Directive on Patients Rights' to Cross-border Healthcare 13
3.9. Health inequalities 13
3.10. Children and health 14
3.11. Public Procurement directives 14
3.12. Information to patients 14
3.13. Package on innovation in health (medical devices) 15
3.14. Communication on long-term care (to come out in 2013) 15
4. **Potential follow up actions for Committee to consider** 15

1. Introduction

Under the new Committee structures for the fourth Assembly agreed by Business Committee in June 2011, Europe and EU related matters are to be mainstreamed across all relevant Committees rather than having a dedicated European and External Affairs Committee.

This means that the Health and Social Care Committee has responsibility for dealing with those European issues that fall within its portfolio.

There are two main ways in which this is likely to occur:

- dedicated sessions focused on priorities/issues on the EU policy agenda in Brussels;
- scope to look towards Europe (and the international dimension) in terms of comparing practices in Wales, identifying witnesses and experts to bring an external dimension to the other areas of work undertaken by the Committee.

This paper provides the Committee (in section 3) with information on relevant policy developments that are ongoing or planned for 2012 at EU level.

Before going into the detail on these actions, some background information is provided in section 2 on the EU policy-making process, to explain:

- the competences at EU level in the area of health and social care and types of actions coming out of the EU as a result of exercising these competences;
- the relevant organisations and structures operating in Brussels (including the formal EU Institutions and some EU networks) with responsibilities for issues affecting health and social care.

Actions for the Committee:

Section 4 sets out a number of potential areas of action for the Committee to consider and agree in terms of follow up work on EU-related matters.

2. EU policy-making process

2.1. Health and Social Care

Health and social care are areas of **exclusive national competence**, which means that the powers for the EU to act in these areas is limited, and is restricted primarily to undertaking actions that support, co-ordinate or supplement the work of Member States (i.e. national and as appropriate sub-state/regional Governments) in this area.

Consequently the power of the EU to influence and shape health policy within Wales is very limited. It also means that Wales potentially has an interest in being involved directly in policy debates and discussion at EU level where these could be useful in terms of helping support or add value to the work undertaken in Wales.

The EUs role in health policy is focused in particular on the following three areas:

- protecting people from health threats and disease
- promoting healthy lifestyles
- helping national authorities in the EU cooperate on health issues.

To give a strategic focus to this the Commission adopted a five-year **EU Health Strategy** in 2008, which is due to come up for review during 2012 (although the European Commission's 2012 Work Programme makes no reference to this review, so there is no indication yet of the timing of the review).

The European Commission also provides financial support to the implementation of the EU Health strategy, to which organisations in Wales (including the National Health Service) are eligible to participate. This includes support from a dedicated EU Health funding programme, the current one running from 2008-2013, which will be succeeded by a new programme *Health for Growth Programme 2014-2020* – for which proposals were published in November. More details on this are included in section 3.3 below.

Health also features as a theme in other EU funding programmes: for example, there is some scope to support health-related initiatives within the EU Structural Funds programmes, mobility actions under the EU education and youth programmes; and health-related research within the EU Framework Research Programme (in particular funding support for clinical trials). In each of these areas the European Commission has published new proposals for the period 2014-2020, which will go through a negotiation process in Brussels before finally being agreed (probably sometime in 2013). The Enterprise and Business Committee is undertaking an inquiry into EU Structural Funds and will also look at the future EU Research Programme (Horizon 2020), whilst the EU education and youth mobility proposals (Erasmus for All) would most naturally fall within the remit of the Children and Young People Committee (and they considered this as part of an EU update at their meeting on 1 December).

Finally, there are a number of other areas where the EU has competence to make legislation, and these could potentially impact on provision of health and social care services in Wales. This includes, in particular:

- **Employment and social protection legislation:** this covers a range of areas including workers' rights, health and safety, working conditions, equalities and equal opportunities. Such legislation is developed in the context of ensuring a smooth functioning of the EU single market, to enable free movement of workers across national boundaries.
- **Public procurement legislation:** provision of goods, works and services exceeding minimum thresholds set by the EU legislation must go through an open tendering process. The directives set out requirements on the rules to be followed to ensure an open fair process, where entities from across the EU can potentially participate.

2.2. Food Safety

With regard to food safety, the EU has a stronger remit to take action.

This includes scope to develop EU legislation and undertake other types of actions that are focused on assuring effective control systems and evaluating compliance with EU standards in the areas of: food safety and quality, animal health, animal welfare, animal nutrition and plant health sectors within the EU and in third countries in relation to their exports to the EU.

Some of these areas fall outside the remit of the Health and Social Care Committee and would fall within the remit of the Environment and Sustainability Committee (e.g. animal welfare, animal nutrition and plant health sectors).

To support the preparation and implementation of EU legislation in this area there are a number of EU level committees and agencies in place. These merit mention as important decisions affecting the shape of future policy as well as the implementation of existing EU legislation can be made by these bodies.

Those of most relevance to the work of the Health and Social Care Committee are:

- **Scientific Committee on Food**: its mandate is to answer scientific and technical questions concerning consumer health and food safety associated with the consumption of food products. In particular questions relating to toxicology and hygiene in the entire food production chain, nutrition, and applications of agrifood technologies, as well as those relating to materials coming into contact with foodstuffs, such as packaging. As with all the Scientific Committees its work is managed by the European Commission but its membership is comprised of independent experts.
- **European Food Safety Authority (EFSA)**: set up in 2002, EFSA provides independent scientific advice and communication on existing and emerging risks associated with the food chain, which is aimed at ensuring the protection of the health of European consumers and the safety of the food and feed chain. EFSA's work covers all matters with a direct or indirect impact on food and feed safety, including animal health and welfare, plant protection and plant health and nutrition (including genetically modified crops).
- **European Centre for Disease Prevention and Control**: established in 2005 and based in Stockholm, its mission is to identify, assess and communicate current and emerging threats to human health posed by infectious diseases.
- **Standing Committee on the food chain and animal health (SCFCAH)**: Standing Committees are regulatory committees that are set up to ensure practicable and effective implementation of EU legislation. They are 'technical' committees, comprised of the European Commission plus experts from the Member States, in the case of the SCFCAH this will be DEFRA officials plus relevant officials from the UK Permanent Representation in Brussels.

2.3. EU policy-making and legislative process

For those areas referred to in sections 2.1 and 2.2 where the EU is able to make legislation, there is a formal negotiating process through which such laws are adopted. The National Assembly for Wales can play a role in influencing this process, both during the pre-

legislative phase (i.e. policy formulation – which is led primarily by the European Commission) and during the legislative process itself.

Where the EU has powers to develop legislative proposals (including areas covered in section 2.1 and 2.2 – such as food safety, employment law, patients' rights, and EU funding programmes), such proposals will be prepared through the ordinary legislative procedure, which requires the European Parliament and the Council of Ministers (i.e. Member State Governments) to agree on the final text of the proposed law (on the basis of a legislative proposal from the European Commission) before it can be formally adopted. This process can take anything from around one year to several years, and in some cases agreement may not be possible (e.g. recent attempts to revise the Working Time Directive failed in 2009).

Once legislation has been adopted there is a requirement on all Member States to **implement EU legislation on the ground**, and the legislation will include provisions on deadlines by which transposition (i.e. creation of new domestic legislation as relevant) must take place at national/regional level. In Wales, the Welsh Government will have responsibility to ensure implementation and transposition of relevant EU legislation falling within devolved competences. Where it fails to do this it will bear the brunt of any fines imposed by the European Commission.

For those areas where the EU does not have legislative competence, policy formulation takes place in a number of ways. This includes communications from the European Commission aimed at encouraging common approaches by national governments in particular areas, e.g. promoting use of e-health, and other follow up action involving stakeholders such as the newly established *European Innovation Partnership on Healthy and Active Ageing* (see section 3.5). It also includes inter-government co-operation through the *Open Method of Co-ordination* (see section 2.5). Within all of these areas there is no binding requirement on Member States to take actions, and the only power at EU level is peer pressure through naming and shaming of Member States that do not deliver on commonly agreed actions.

2.4. European Commission

The European Commission has the main role in taking forward initiatives, both policy and legislative proposals, on health, social care, and food-safety issues.

The European Commissioner responsible for Health and Consumer Affairs is John Dalli.

The lead directorate-general (DG) within the European Commission for health-related matters, including food safety is DG Health and Consumer Affairs (often shortened to DG SANCO, from the French version).

For issues falling into the broader policy areas (such as research, employment) then these would be covered by the relevant thematic department, e.g. DG Employment and Social Affairs.

2.5. Council of Ministers

Membership of the European Union (EU) is structured around national Governments or Member States, which means that Wales is represented in the EUs formal Government structures (Council of Ministers and the European Council) through the UK Government.

Health and food safety issues fall across two Council formations within the Council of Ministers:

- Employment, Social Policy, Health and Consumer Affairs Council
- Agriculture and Fisheries Council

These two Councils will be involved in the negotiations on any relevant legislative proposals falling within their remit. They will also engage in policy formulation, adopt *Council Conclusions*, including adoption of *Recommendations* (i.e. soft EU law – non-binding) on particular issues or subjects. For health care related issues this is largely structured in terms of the *Open Method of Co-ordination* (an inter-governmental approach), where Member States (with supporting role from the European Commission) share best practice and benchmarking, which is focused on improving the access, quality and sustainability of national healthcare services.

Wales is represented in the Council of Ministers by the UK Government, however, an arrangement has been agreed with the devolved administrations that devolved ministers can attend meetings of Council (acting as representative of the UK) on issues where they are of particular interest to the devolved administration (e.g. Education and Culture Council meetings have been attended by Welsh Ministers).

The UK Government has also agreed a **Memorandum of Understanding** with the devolved administrations – the latest version was signed in June 2011 – which includes within its scope the approach to European affairs. In terms of policy content/issues the UK Government and Ministers from the devolved administrations meet through the format of the Joint Ministerial Committee (Europe). The devolved administrations are also consulted in the preparation of explanatory memoranda by the UK Government on EU proposals and policy documents, in all areas of devolved competence and where there is a devolved interest in the respective dossiers.

2.6. European Parliament

Wales is represented in the European Parliament by its four Welsh MEPs: John Bufton (UK Independence Party); Jill Evans (Plaid Cymru); Dr Kay Swinburne (Conservatives); and Derek Vaughan (Labour).

The lead Committee for health policy and for food safety issues is:

- **Environment, Public Health and Food Safety Committee**, which is chaired by German MEP Jo Leinen (Socialists and Democrats Group – same political group as Welsh MEP Derek Vaughan). Welsh MEP Jill Evans is a member of this Committee.

Other relevant committees would be:

- **Employment and Social Affairs Committee:** Chaired by French MEP Pervenche Beres (there are no Welsh MEPs on this Committee), has responsibility for all employment policy and all aspects of social policy such as working conditions, social security and social protection. It would be the lead Committee on revisions to the Working Time Directive (covered below)
- **Internal Market and Consumers Protection Committee:** Chaired by UK Conservative MEP Malcolm Harbour (there are no Welsh MEPs on this Committee), will be the lead Committee for the revision of the Public Procurement Directives (covered below) and is also the lead committee on state aid issues.

2.7. Committee of the Regions

Wales also has representatives on the two consultative bodies (that are located in Brussels), the *Committee of the Regions* (including Christine Chapman AM and Rhodri Glyn Thomas AM) and the *Economic and Social Affairs Committee*. These two bodies are consulted on all EU policy developments, although they do not have power to force changes in draft EU legislation.

2.8. EU networks

Within these policy areas there are a number of EU networks actively engaged on health and social care related issues.

Some examples would include (this list is for illustrative purposes only):

- **National Health Service European Office:** the Brussels office of the NHS Confederation.
- **British Medical Association Brussels Office**
- **European Public Health Alliance:** a not for profit network of voluntary organisations working in the area of public health.
- **EuroHealthNet:** a not for profit network of 35 organisations, agencies and statutory bodies (including Public Health Wales) from 27 European countries, that are all working to promote health and equity by addressing the factors that determine health directly or indirectly. Its current President is David Pattison, Head of International Development with NHS Health Scotland.
- **AGE Platform Europe**: a European network of around 165 organisations of and for people aged 50+ representing directly over 30 million older people in Europe. The Older People's Commission Wales is a member of the network.

3. Potential priority areas of interest to Wales

3.1. Europe 2020 Strategy

Europe 2020, the EUs job and growth strategy which is focused on delivering 'smart, sustainable and inclusive growth' and which was adopted in 2010, provides the overarching framework through which all other EU policy developments (as relevant) are being aligned.

The *Europe 2020* strategy sets out five headline targets for the EU to be delivered over the coming decade (covering employment, climate change, research and development, poverty and education). Health is not one of these, however, it is viewed by the European Commission as one of the themes that can contribute to delivery of the overarching targets (e.g. through active ageing, supporting innovation in the economy, healthy workforce etc.) as is clearly evident in the title of the proposed new health funding programme *Health for Growth Programme 2014-2020*.

Europe 2020 is implemented through a combination of EU level action and actions undertaken at Member State level (national, regional and local).

EU level action, as well as including financial support through the various EU funding programmes, also includes a series of themed flagship initiatives to provide a coherent framework for actions by Member States on the ground. Those most relevant to health related issues are:

- Digital Agenda (including actions on eHealth – see section 3.4).
- Innovation Union (including actions focused around active ageing – see section 3.5).
- European Platform Against Poverty and Social Exclusion (including actions aimed at addressing health inequalities and poverty/social exclusion).
- An Agenda for New Skills for Jobs (which identifies a shortage of 15 per cent of the healthcare workforce needed in the EU by 2020, i.e. a shortfall of around two million jobs, of which half would be healthcare professionals).

At the national level (UK level) there is a requirement on Member States to prepare each year a National Reform Programmes (NRPs) setting out the actions planned and underway to deliver the *Europe 2020* targets. The **UK's NRP** this is prepared by the UK Government in consultation with the devolved administrations (including the Welsh Government). Health is mentioned in one context in the Welsh sections of the NRP, in terms of child poverty and addressing health inequalities. In the English context it is mentioned in reference to research and addressing healthcare challenges through stimulating business activity and innovation in the health sector.

3.2. EU Health Strategy 2008-2013

As noted in section 2.1 the EU has a mandate to complement national action on health and this is undertaken through the EU Health Strategy. This is due to be reviewed before the end of 2013, however, there are no details yet available of the anticipated timing of this review.

3.3. EU Health for Growth Programme 2014-2020

On 9 November 2011 the Commission published proposals for a new ***EU Health for Growth Programme 2014-2020***, with a budget of €446 million. This would replace the current Programme of Community Action in the Field of Health, which runs from 2008-2013.

These proposals will be adopted through the ordinary legislative procedure, which (as described in section 2.1 above) means Council and European Parliament must agree on the final text in order for the programme to be adopted.

The European Commission has proposed that the new *Health for Growth Programme 2014-2020* will support and complement the work of Member States to achieve four objectives:

- **Developing innovative and sustainable health systems:** action to facilitate uptake of innovation in healthcare through eHealth, expertise on healthcare reforms and support to the European Innovation Partnership on Active and Healthy Ageing. Action under the programme will also contribute to forecasting demand for health professionals and help Member States secure a solid health workforce.
- **Increasing access to better and safer healthcare for citizens:** action will aim at increasing access to medical expertise and information for specific conditions; developing solutions and guidelines to improve the quality of healthcare and patient safety through actions supporting patients' rights in cross-border healthcare, rare diseases, prudent use of antibiotics and high standards of quality and safety for organs and substances of human origin used in medicine.
- **Promoting health and preventing disease:** to promote good health and prevent diseases by addressing the key risk factors of most diseases, namely smoking, alcohol abuse and obesity. This will involve fostering the identification and dissemination of best practices for cost-effective prevention measures; as well as specific action aimed at preventing chronic diseases including cancer.
- **Protecting citizens from cross-border health threats:** action will contribute towards developing common approaches for better preparedness coordination in health emergencies, e.g. improving risk assessment capacity and joint procurement of medical countermeasures.

Three types of actions would be funded through the programme to deliver these objectives:

- **Joint actions:** grants for action co-financed by the competent authorities responsible for public health in the Member States and with international health organisations.
- **Grants to support NGOs working in the area of public health** who play an effective role in civil dialogue processes at EU level and contribute to at least one of the specific objectives of the programme.
- **Procurement contracts**

In most cases, the EU grants would contribute up to **60 per cent** of the costs of the action or project. NHS Wales and other bodies involved in healthcare in Wales could participate in this programme.

3.4. eHealth Action Plan

The European Commission is expected to publish the *eHealth Action Plan 2012 – 2020* in early 2012.

This is a follow-up to the *2004 eHealth Action Plan*, which was the first initiative at EU level aimed at encouraging the widespread adoption of eHealth technologies across the EU.

One project that has been highlighted by the European Commission is **RENEWING HEALTH, REgioNs of Europe WorkINg toGether for HEALTH**, which is an eHealth project supported under the EU's *ICT Policy Support Programme*. It brings together health care providers from nine European countries that are described as the 'most advanced European regions in the implementation of health-related ICT services'. These are regions where services are being provided at local level for the tele-monitoring and the treatment of chronic patients suffering from diabetes, chronic obstructive pulmonary or cardiovascular diseases. The services are designed to give patients a central role in the management of their own diseases, fine-tuning the choice and dosage of medications, promoting compliance to treatment, and helping healthcare professionals to detect early signs of worsening in the monitored pathologies.

3.5. Active and Healthy Ageing

The European Commission has identified active and healthy ageing as a major societal challenge common to all European countries, and views it as an area with potential for Europe to lead the world in developing innovative responses.

To support achieving this goal it has launched, as one of the actions identified in the Innovation Union flagship initiative (Europe 2020 Strategy), a pilot ***European Innovation Partnership on Active and Healthy Ageing***. EU Member States gave their backing to the initiative in February 2011, and in November 2011 the High Level Steering Group (set up to develop the pilot) published a ***Strategic Implementation Plan***, which sets out a common vision and a set of operational priority actions to address the challenge of ageing through innovation. It is described as a stakeholder-driven plan and the European Commission invites national Governments and other stakeholders to become involved in delivering a range of actions that will be launched in 2012, which include:

- Innovative ways to ensure patients follow their prescriptions – a concerted action in at least 30 European regions.
- Innovative solutions to prevent falls and support early diagnosis for older people.
- Co-operation to help prevent functional decline and frailty, with a particular focus on malnutrition.
- Spread and promote successful innovative integrated care models for chronic diseases amongst older patients, such as through remote monitoring. Action should be taken in a number of the EU's regions.
- Improve the uptake of interoperable ICT independent living solutions through global standards to help older people stay independent, mobile and active for longer.

Linked to this, the theme of the 2012 European Year will be ***Active Ageing and Solidarity between Generations***, which will include a number of awareness raising activities across the EU. The *European Year 2012* web-site includes details of planned initiatives, and at the moment none are listed for Wales.

3.6. Modernising the Professional Qualifications

The European Commission is undertaking a review of the *EU Directive on the Recognition of Professional Qualifications*. This Directive aims to facilitate the free movement of EU citizens by making it easier for professionals qualified in one Member State to practise their profession in another, as part of the efforts to strengthen the single market within the EU. The Directive covers all professions, including healthcare professionals.

In January 2011 the European Commission launched a public consultation and in June 2011 it published a Green Paper, which was also the subject of a stakeholder consultation. The main proposals outlined in the Green Paper included a professional card, partial access, reviewing the scope of regulated professions and making information and applications procedures available online.

Concerns have been expressed about the existing Directive, in particular in terms of the competence of some European health professionals - both their clinical competence and their communication (English language) skills, which were highlighted by the House of Commons Select Committee in April 2010.

The revision of this Directive is high on the priority list of the **NHS' EU Office in Brussels**, which submitted responses to the consultation and Green Paper on behalf of the NHS. This highlighted the need for the minimum qualification standards required for professionals to practice across Europe to be updated, for regulatory bodies across Europe to have access to a shared electronic system to exchange information about professionals and their qualifications. It called for the introduction of a more rigorous warning system that requires regulatory bodies across Europe to alert their counterparts if they take action against fraudulent or incompetent doctors or healthcare professionals; called for all EU countries to ensure they require health professionals to keep their skills up to date, rather than being admitted to a professional register for life; and called for the avoidance of any relaxation on checks for migrating professionals, for example by allowing those who are qualified in one specialised area to practice in general areas of medicine.

3.7. Revision of the Working Time Directive

The 2003 *Working Time Directive* provides the framework for EU law on the maximum number of hours that employees can be expected to work during a week (48 hours). It includes definitions of working time and also provides the possibility for employees to agree to 'opt out' of the 48-hour limit.

The European Commission sought to revise the Directive in light of European case law, but these efforts failed in 2009 when the European Parliament and Council could not reach a compromise agreement on the proposed revisions. The UK Government was one of the blocking minority of Member States within the Council that prevented an agreement being reached.

The ***NHS Employers*** expressed its concerns about the potential impact of any changes to the application of the *Working Time Directive* to health workers, in particular in terms of the potential costs of including non-worked on call time as part of the working week.

The Commission was originally expected to bring forward proposals during 2011 having already carried out during 2010 two consultations to prepare the revision. However, these have been delayed and it is as yet unclear as to when they will be published, and the 2012 European Commission Work Programme did not mention an anticipated timeline.

3.8. Implementation of the Directive on Patients Rights' to Cross-border Healthcare

In March 2011 a new EU Directive on patients' rights in cross-border healthcare was adopted, following almost three years of negotiations in Brussels. The draft Directive was the subject of a short inquiry by the **European and External Affairs Committee** during the third Assembly. The deadline for transposition of the Directive into national law in the UK (and across the EU as a whole) is 25 October 2013.

This Directive was adopted on 31 March 2011 after almost three years of negotiations in Brussels. The Directive:

> …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… (Article 1.1)

It sets out:

- the responsibilities of Member States in provisions of cross-border health care (from the perspective of the Member State where treatment is given and the Member State of origin of the patient treated);
- the principles on which costs of cross-border treatment will be reimbursed;
- addresses a number of issues around the practicalities of authorising and administering cross-border healthcare services;
- looks more broadly at ways of facilitating mutual co-operation in healthcare such as e-health, setting up European reference networks (e.g. in area of rare diseases), and co-operation in technology assessments.

The Directive includes a transposition date of 25 October 2013 for the Member States (including the UK) to

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

The European Commission will prepare a first report on compliance with the Directive by the same date (25 October 2013) and every three years after that date.

The European and External Affairs Committee undertook an inquiry during the third Assembly, to assess the potential impacts of the (then draft) Directive in Wales.

3.9. Health inequalities

The European Commission published a communication in 2009, *Solidarity in Health: Reducing Health Inequalities* in the EU setting out actions it proposes to take to help address health inequalities. This is based on collaboration with national and regional

authorities, production at EU level of regular reports and statistics, assessing impact of EU policies on health inequalities and so forth.

3.10. Children and health

On 2 December the EU Health Ministers adopted *Council Conclusions* on two health problems affecting children:

- **Chronic respiratory diseases in children:** calling for continued and strengthened action for the prevention, early diagnosis and treatment of these diseases, in particular through promotion of best practices, support for research, smoking prevention, improvement of air quality and stronger cooperation.
- **Communication disorders (hearing, vision and speech impairments) in children:** stressing the need for early detection and treatment of these disorders and pointing to the importance of raising public awareness, exchanging information, knowledge and experiences, and using e-Health tools and innovative technologies in order to improve healthcare in this field.

3.11. Public Procurement directives

Proposals to ***modernise the EUs Public Procurement Directives*** are due to be published on 13 December 2011, following a review of the operation of the existing rules including a public consultation earlier this year. This will be of direct relevance to all public authorities in Wales tendering contracts above the EU thresholds, and consequently any changes in the rules will also be of interest to businesses looking to bid for such tenders.

The Enterprise and Business Committee (as noted above) will undertake an inquiry into this issue during the first quarter of 2012.

3.12. Information to patients

The European Commission published on 10 October 2011 revised proposals for a new ***Directive on information on medicinal products*** to be provided to patients on prescription-only medicines.

The European Commission originally brought forward proposals in 2008, aimed at addressing an identified gap in terms of information to patients on prescription-only medicines (based on research in 2007 and a subsequent public consultation). However, these original 2008 proposals met with objections within the European Parliament in terms of the types of information and the way it should be presented to patients. The European Commission has sought to address these concerns in the revised proposals, saying these strengthen consumer rights, and provide clearer obligations and requirements in terms of the way information is to be presented.

The draft proposals will go through the ordinary legislative procedure requiring European Parliament and Council to agree on the final text in order for the proposals to become EU law.

3.13. Package on innovation in health (medical devices)

The *2012 European Commission Work Programme* includes a number of proposals anticipated in the area of medical devices, as well as a communication on innovation policy in medical devices.

3.14. Communication on long-term care (to come out in 2013)

The European Commission is planning to publish a communication on long-term care in the EU in 2013.

4. Potential follow up actions for Committee to consider

Potential Action 1:

Committee to consider holding a dedicated EU update session with some of the organisations active in this area, focusing on a broad range of issues highlighted in this paper. The focus of this session would be to consider how these developments potentially impact in Wales and where priority emphasis could be given in terms of engaging with them.

Potential Action 2:

Committee to hold a session with relevant Welsh Ministers looking at how they participate in the EU policy-making process on health related matters, in particular in terms of making use of the opportunities for benchmarking, sharing information on best practice with other Member State and sub-states/regions within the EU. To clarify how devolved interests are reflected in discussions within the Council of Ministers on health related matters.

Potential Action 3:

Committee to consider holding an inquiry looking at the opportunities under the *Health for Growth Programme 2014-2020* for organisations within Wales working in this area to participate in. [Narrower focused EU funding inquiry]

OR

Committee to consider holding an inquiry looking at how organisations in Wales engage more broadly with EU funding opportunities in the area of health, including some of the other programmes mentioned in the briefing. Particularly in terms of opportunities to secure research funding, to try out new and innovative ways of providing healthcare, and to learn from best practice in other parts of Europe. [Broader EU funding inquiry]

Potential Action 4:

Committee to review *eHealth Action Plan 2012-2020* following publication, and explore potential relevance to developments in Wales, including possibility to look at best practice initiatives in other parts of Europe.

Potential Action 5:

Committee to consider holding sessions on: (i) *Modernisation of Professional Qualifications Directive* (ii) *Working Time Directive* – once the revised proposals for both directives are published.

Potential Action 6:

Committee to consider holding a specific session focused on active ageing in context of the *European Year for 2012* and exploring the potential benefits to Wales of actively engaging in the new *European Innovation Partnership on Active and Healthy Ageing*.

Potential Action 7:

Committee to look at issue of health inequalities in terms of the Communication published by the European Commission in 2009 and looking at comparative practices in addressing health inequalities in other parts of Europe.

Health and Social Care Committee
HSC(4)-13-11 paper 2

To: Health and Social Care Committee

From: Committee Service

Date: December 2011

INQUIRY INTO RESIDENTIAL CARE FOR OLDER PEOPLE: COMMITTEE WORK PLAN

Purpose

1. On Thursday 22 September 2011 the Health and Social Care Committee agreed to undertake an inquiry into residential care for older people. The purpose of this paper is to seek the Committee's agreement to a proposed approach for the next stage of this inquiry.

Background

2. The Committee agreed the inquiry's final terms of reference on Thursday 20 October 2011, following a short public consultation on their content. The inquiry's final terms of reference are attached at Annex A to this paper.

3. The Committee's call for written evidence was issued on Monday 24 October 2011. The eight-week consultation period will close on Friday 16 December 2011. An eight-week consultation period was allocated to ensure sufficient time for a large number of stakeholders and the general public to make submissions to the inquiry.

4. Given the wide scope of the inquiry, the Committee agreed that it would be helpful to consider a work plan for its approach to the next stage of the inquiry, which will involve the gathering of oral evidence. A proposed approach is outlined in paragraphs 5 – 12 of this paper.

Proposed approach to oral evidence gathering

5. In order to ensure that the Committee addresses all the issues listed in the inquiry's terms of reference, it is proposed that the gathering of oral evidence is organised in accordance with two principles:
   (i) Oral evidence sessions to be arranged on the basis of interest groups (see paragraphs 6 – 8 below); and

(ii) Particular themes, as identified in the inquiry's terms of reference, to be allocated to specific Members to take forward for the duration of the inquiry (see paragraphs 9 –12 below)

(i) Oral evidence sessions based on interest groups

6. In order to ensure that the Committee considers a broad range of perspectives when undertaking this inquiry, it is proposed that witnesses are invited to attend Committee on the basis of the interest group to whom they belong.

7. Individual sessions would be arranged to concentrate on the perspectives of specific sectors / voices, for example:
   - service users, their families and carers;
   - public sector bodies;
   - private sector providers;
   - third sector organisations and providers;
   - professional and staff bodies;
   - regulators and inspectors; and
   - the Welsh Government.

8. Should the Committee wish to proceed on this basis, it is proposed that:
   - a list of suggested witnesses; and
   - an outline timetable for the oral evidence sessions,

   are compiled once the deadline for written evidence has passed (16 December). This paper could be considered by the Committee shortly after the Christmas recess with a view to beginning oral evidence sessions in early February 2012.[1]

(ii) Allocation of key themes to Members

9. In order to ensure that all aspects of the inquiry are addressed comprehensively, it is proposed that each of the bullet points listed in the terms of reference (that is, each key theme) is allocated to a member(s) of the Committee.

10. In practice, this would mean that the Committee would ask Member X and Member Y to concentrate, for the duration of the inquiry, on

[1] The Committee's meeting slots for January 2012 have already been allocated to other Committee business, including: completion of the inquiry into the contribution of community pharmacy to health services in Wales; an evidence session on the public health implications of inadequate provision of public toilets; and a general scrutiny session with the Minister for Health and Social Services.

gleaning information relating to the first bullet point in the terms of reference; Member Z, on the other hand, may be asked to take responsibility for matters covered by bullet point two, etc.

11. The purpose of this approach would be twofold:

    – firstly, to ensure that all aspects of the inquiry are considered in each meeting if the 'interest group' approach outlined in paragraphs 6 and 7 is adopted;

    – secondly, to provide the opportunity for Members to develop their expertise in relation to a particular aspect of the Committee's inquiry.

    Such an approach would not in any way prohibit Members from asking questions outside their allocated themes but would ensure protection for all themes to be covered, relative to one another.

12. Should Members wish to proceed on this basis, it is proposed that the Committee considers (and decides) who will lead on each aspect of the inquiry after the Christmas recess, when discussing possible witnesses and the timetable for the inquiry.

Other considerations

13. In order to inform the Committee's work on this inquiry, Members may also wish to consider employing the following tools:

(i) Expert advice

14. The Committee is permitted by Standing Orders to appoint an expert adviser(s) to assist the Committee in its work, should Members deem it appropriate to do so. The purpose of such advice is to:

    – complement, as opposed to duplicate, the in-house expertise contained within the Research Service; and

    – add value to the Committee's consideration of the subject matter in question.

15. Given the breadth of this inquiry, it is proposed that the Committee agree in principle to explore the options for appointing an expert adviser for this inquiry.

16. Should Members agree to the proposal in paragraph 15, possible candidates could be identified for consideration by the Committee shortly after the Christmas recess, when discussing possible witnesses and the timetable for the inquiry.

(ii) Public engagement

17. To ensure that the Committee hears the public's view on the provision of residential care for older people – including the views of current or possible future users of such services – the Committee may wish to undertake some public engagement activity beyond the standard calls for oral and written evidence.

18. Options could include:

   – *Establishing a reference group comprising members of the general public*

     Such a group could be used to feed into the Committee's consideration of key themes during the inquiry and to test the Committee's findings and recommendations;

   – *Undertaking informal visits*

     Time allocated to the Committee for its work could be set aside during the inquiry to allow Members to undertake informal visits in their own constituencies or regions. The purpose of such visits would be to allow Members to improve their understanding of relevant issues and inform their formal scrutiny of witnesses;

   – *Taking formal oral evidence outside the Senedd*

     The Committee may wish to take oral evidence outside Cardiff e.g. for the purpose of considering issues relating to deprivation or remoteness, the Committee may wish to travel outside the capital city. Similarly, should the Committee wish to consider the impact of an older, indigenous population coupled with a migrating older population on services, the Committee may wish to take evidence along the North Wales coast.

19. Working thematically (as proposed in paragraphs 9 – 12 of this paper) could mean that evidence taking outside the Senedd would not necessarily require the whole Committee to attend. Subject to quorum requirements[2], those Members leading on key themes would be able to lead the evidence gathering sessions taking place outside Cardiff Bay without the whole membership being present.

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[2] In accordance with Standing Order 17.31, four Members must be present to conduct a formal Committee meeting; in accordance with Standing Order 17.32, representatives of more than one political group must also be present.

20. Should the Committee wish to undertake activities as listed in paragraph 18, the Assembly's Outreach Team would be able to assist Members in this work.

Proposal

21. The Committee is invited to:

   - consider and agree, in principle, the approach to oral evidence gathering (paragraphs 5 – 12);

   - consider the options outlined in relation to:
     - expert advice (paragraphs 14 – 16); and
     - public engagement (paragraphs 17 – 20),

   and agree the Committee's approach to employing these tools.

ANNEX A

Terms of reference for the inquiry into residential care for older people

The terms of reference for the inquiry, as agreed by the Committee on 20 October 2011, are as follows:

To examine the provision of residential care in Wales and the ways in which it can meet the current and future needs of older people, including:

- the process by which older people enter residential care and the availability and accessibility of alternative community-based services, including reablement services and domiciliary care.

- the capacity of the residential care sector to meet the demand for services from older people in terms of staffing resources, including the skills mix of staff and their access to training, and the number of places and facilities, and resource levels.

- the quality of residential care services and the experiences of service users and their families; the effectiveness of services at meeting the diversity of need amongst older people; and the management of care home closures.

- the effectiveness of the regulation and inspection arrangements for residential care, including the scope for increased scrutiny of service providers' financial viability.

- new and emerging models of care provision.

- the balance of public and independent sector provision, and alternative funding, management, and ownership models, such as those offered by the cooperative, mutual sector and third sector, and Registered Social Landlords.

The Committee agreed to focus the inquiry on **residential care** only, although nursing care will inevitably be touched upon during discussions.

The Committee also decided to focus its attention on the provision of services for **older people** for the purpose of this inquiry, as opposed to adult care in its entirety.

Llywodraeth Cymru
Welsh Government

www.cymru.gov.uk

Welsh Government

Consultation Document

Proposals for Legislation on Organ and Tissue Donation:

A Welsh Government White Paper

Date of issue: **8 November 2011**
Responses by: **31 January 2012**

Overview

This consultation seeks responses on the Welsh Government's proposals for legislation on organ and tissue donation.

The objective of an Assembly Bill relating to organ and tissue donation is to introduce a system in Wales which aims to increase the number of organ and tissue donors in Wales, allowing more lives to be saved and to improve the quality of life of others.

Your responses will be considered in developing the Bill.

How to respond

The consultation responses form is available for completion at www.wales.gov.uk/consultations. Responses are welcome in either English or Welsh.

Responses to this consultation should be sent by e-mail or by post to the address below to arrive no later than 31 January 2012.

Further information and related documents

Large print, Braille and alternative language versions of this document are available on request.

An Easy-Read version of this document has been developed and is available from the address below.

Contact Details

Further information:

Organ Donation Bill Team
Welsh Government
Cathays Park
Cardiff
CF10 3NQ

Telephone: 029 2037 0011

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

Data Protection

How the views and information you give us will be used.

Any response you send us will be seen in full by Welsh Government staff dealing with the issues which this consultation is about. It may also be seen by other Welsh Government staff to help them plan future consultations.

The Welsh Government intends to publish a summary of the responses to this document. We may also publish responses in full. Normally, the name and address (or part of the address) of the person or organisation who sent the response are published with the response. This helps to show that the consultation was carried out properly. If you do not want your name or address published, please tell us this in writing when you send your response. We will then blank them out.

Names or addresses we blank out might still get published later, though we do not think this would happen very often. The Freedom of Information Act 2000 and the Environmental Information Regulations 2004 allow the public to ask to see information held by many public bodies, including the Welsh Government. This includes information which has not been published. However, the law also allows us to withhold information in some circumstances. If anyone asks to see information we have withheld, we will have to decide whether to release it or not. If someone has asked for their name and address not to be published, that is an important fact we would take into account. However, there might sometimes be important reasons why we would have to reveal someone's name and address, even though they have asked for them not to be published. We would get in touch with the person and ask their views before we finally decided to reveal the information.

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Contents

FOREWORD BY MINISTER FOR HEALTH AND SOCIAL SERVICES 1

EXECUTIVE SUMMARY 2

THE CASE FOR CHANGE 4

What is happening now 4

The legal framework 4
The NHS Organ Donor Register (ODR) 5

Moving to a soft opt-out system 5

THE PROPOSED SOFT OPT-OUT SYSTEM FOR WALES 7

Persons who will be included in the soft opt-out system 7

The opportunity to make an objection to donation 7
Living in Wales 8
Consent 9
Ability to understand 9
Adults aged 18 years and over 10
Persons that will not be covered by the new arrangements 10

The operation of the soft opt-out system for Wales 10

The retention of the existing Organ Donor Register (ODR) for the people of Wales 10
Maintaining records 11
How to make an objection to donation 12
Keeping the soft opt-out system up to date 12
The safeguard provided by the role of the family 13

What the soft opt-out system will not change 14

IMPLEMENTATION OF PROPOSED LEGISLATION 15

Impact assessment 15

Equality impact assessment 15
Privacy impact assessment 16
Regulatory Impact Assessment 16

Timetable 16

Welsh Language provision 17

Public awareness campaign 17

CONSULTATION QUESTIONS 18

FOREWORD BY MINISTER FOR HEALTH AND SOCIAL SERVICES

The shortage of human organs continues to cause unnecessary deaths and suffering, both to patients waiting for a transplant and their relatives. Around 300 people at any one time are on the active waiting list for a transplant and 51 people died in Wales in 2010/11 while waiting for an organ donation.

We are already implementing all the recommendations of a UK wide review and have made good progress. Last year 83 Welsh residents donated organs – a record number.

However, we are committed to taking things a stage further, as the number of organs available for transplantation is still insufficient to meet the need. The Welsh Government's aim is to increase the number of organs available for transplantation after death, in order to improve the health and quality of life for people who need a transplant. We will do this through implementing our manifesto commitment to bring forward an Assembly Bill to introduce an opt-out system of organ donation.

Our debates and consultations on this issue in recent years have convinced us that Wales is ready to take this step, as a nation known for altruism, generosity and thought for others. Wales has taken the lead on organ and tissue donation in the past, pioneering the concepts of a kidney donor card and a computerised Organ Donor Register. We believe we should continue to be progressive on this issue and follow the example of those European countries with excellent records in organ donation, introducing a soft opt-out system as one element of a package of measures to increase organ and tissue donor numbers. Please respond to this consultation and help us to get it right.

We propose that if you want to record your wishes to donate on the current Organ Donor Register, you will still be able to do so. You can actually do that right now. Details of how to get on the Organ Donor Register are in this White Paper.

Finally, please talk to those close to you about your belief in organ and tissue donation as this will make it much easier for them to understand your wish to donate in the event of your death.

Lesley Griffiths AM
Minister for Health and Social Services

EXECUTIVE SUMMARY

1. This White Paper sets out the Welsh Government's proposals for a soft opt-out system of posthumous organ and tissue donation in Wales.

2. The soft opt-out system that is being proposed for Wales is one in which the removal and use of organs and tissues is permissible unless the deceased objected during his or her lifetime. Individuals will have a formal mechanism for registering that objection. After death relatives will be involved in the decision making process around donation.

3. The Welsh Government is making this change to increase the number of organs available, because on average approximately one person in Wales dies each week as a donor cannot be found to enable transplantation to go ahead. Organ and tissue transplantation is one of the most effective forms of modern medical treatment that saves lives and improves quality of life for patients with organ failure. Transplants are the best possible treatment for most people with organ failure.

4. At the same time, other people die in circumstances where donation of their organs and tissues would be possible but does not happen. This is not because the deceased person objected to donation, but because they had not got round to signing the Organ Donor Register.

5. Evidence from other countries has shown that a system, such as the soft opt-out system being proposed for Wales, can increase the number of organs available for donation and therefore can save lives. Earlier consultations undertaken by the Welsh Government indicate public support for legislative change to a soft opt-out system.

6. This White Paper sets out the detail of the proposed soft opt-out system for Wales that covers the transplantation of organs and tissues from deceased persons. The key features of which are:

a) it will apply to people aged 18 or over who live and die in Wales;
b) those adults will have the opportunity to make an objection to donation of their organs and tissues;
c) there will be an effective and secure system for individuals to make an objection to donation should they wish to, and such a system will enable objection to donation of some or all organs and tissues;
d) any objection of an individual to donate organs and/or tissues will be upheld, after death;
e) the system will support the opportunity for individuals to change their minds, and to include people who move to Wales or who reach the age of 18;
f) after death families will be involved in the decision making process around donation.

7. The proposals will apply to the donation of organs and tissues for the purposes of transplantation only. It will not include the donation of organs and tissues for other purposes, such as research, display or commercial use.

8. There are often concerns that under a soft opt-out system individuals lose rights over their bodies and power to remove organs and tissues for transplantation is in the hands of the state. However, evidence shows that individuals are more likely to make decisions about donation during their lifetime under such a system. Individuals will also have their decision respected after death. Moreover, the burden of making a decision is removed from relatives in the most difficult of circumstances, when they often have no clear indication of what the deceased would have wanted.

9. The earliest that the soft opt-out system will be in operation in Wales is 2015. Prior to the new system coming into effect there will be a major public awareness campaign to ensure that all those people who wish to opt-out know how to do so.

10. The Welsh Government is undertaking a consultation on the proposals set out in this White Paper. Responses to the consultation should be submitted to the Welsh Government by **31 January 2012**, and guidance on how to do this is set out in Annex A.

THE CASE FOR CHANGE

1. In Wales, in 2010/11, 51 people died whilst on the waiting list or following removal from the list due to deterioration in their health. Across the United Kingdom more than 1,000 people die each year while waiting for an organ transplant.

2. At the same time, other people die in circumstances where donation of their organs and tissues would be possible, but does not happen. Not because the deceased objected to donation, but because they never got round to signing the NHS Organ Donor Register (ODR) or informing their relatives of their wishes.

3. Organ and tissue transplantation is one of the most effective forms of modern medical treatment that saves lives and improves quality of life for patients with organ failure. Transplants are the best possible treatment for most people with organ failure.

4. Donation covers organs and tissues including kidneys, heart, liver, lungs, pancreas, the small bowel, corneas and sclera (from the eyes), valves and pericardium (from the heart), skin, bone, tendons and cartilage.

5. While almost all of us would be willing to accept an organ or tissue transplant, only 31 per cent of the population in Wales are currently on the ODR. Research suggests that many more people would like to join the register but have not yet done so. Creating an environment in which donation is the normal choice will enable more organs and tissues to be available when they are needed the most.

6. International comparisons illustrate there are a range of factors which influence organ donation rates and the introduction of an opt-out system is one of those factors. Research suggests that organ donation rates from deceased persons increase by approximately 25 to 30 per cent in countries where an opt-out system applies.

7. The Welsh Government believes that a move to a soft opt-out system for donation will normalise donation, encourage and enable discussion about these issues, and increase the number of organs and tissues available for those in most need.

What is happening now

The legal framework

8. The Human Tissue Act 2004 is the legislative framework for organ and tissue donation in Wales, England and Northern Ireland. Similar provisions apply in Scotland under the Human Tissue (Scotland) Act 2006.

9. Both legal frameworks provide an opt-in system. An opt-in system is based on explicit consent where individuals volunteer to become organ and tissue donors.

Consent does not have to be in writing, but in practice most decisions to donate involve carrying a signed donor card, or actively joining the ODR.

10. Individuals have to take positive steps to record their wishes to donate.

11. However, where a person has not made a known decision for or against donation, the family may still consent to donation on behalf of the deceased. During 2010/11 just over 67 per cent of donors in the UK were not on the ODR.

The NHS Organ Donor Register (ODR)

12. The ODR is a confidential, computerised database which holds details of people who have signed up to become organ and tissue donors in the event of their death. The Register is used after a person has died to establish whether they wanted to donate and if so, which organs and tissues.

13. Members of the public can sign up to the register in a variety of ways, including:

- registering online (www.organdonation.nhs.uk);
- by contacting the NHS Donor Line (0300 123 23 23);
- when registering for a driving licence with the Driver and Vehicle Licensing Authority (DVLA);
- when registering with a GP;
- when requesting a European Health Insurance Card;
- applying for a Boots Advantage Card.

14. Donated organs are allocated for transplantation according to need and the matching of blood and tissue type, on a UK basis. They are matched by blood group and in the case of kidneys, for tissue type. The best matched transplants have the best outcome.

Moving to a soft opt-out system

15. The Welsh Government sought views in 2008/09 on how to increase the number of organ donors. This included a series of public meetings across Wales, including an inter-faith meeting, and took account of written views and a telephone survey.

16. This generated public debate which confirmed significant support for increasing organ donation rates. A wide range of suggestions were put forward on how this might be achieved, including possible changes to the system of consent for donation.

17. The debate confirmed people in Wales were keen for a change to the organ donation consent system, with a number preferring a soft opt-out system.

18. On the back of the public discussion and debate, the Welsh Government published a consultation paper, *Options for changes to the organ donation system in Wales.* The result of consultation showed strong public support for the Welsh Government to pursue legislative change and introduce a soft opt-out system of organ donation in Wales.

19. In the First Minister's legislative statement of 12 July 2011, he set out that the Welsh Government will *"…launch a white paper consultation on an Organ Donation (Wales) Bill before the end of this year. The Bill will provide for an opt-out system of organ donation, backed by a comprehensive communication programme."*

20. This White Paper sets out the Welsh Government's proposals for a soft opt-out system of posthumous organ and tissue donation for the people of Wales.

THE PROPOSED SOFT OPT-OUT SYSTEM FOR WALES

21. Opt-out systems are characterised as hard or soft:

a) in a hard opt-out system the removal and use of organs and tissues is permissible unless the deceased objected during his or her lifetime;

b) in a soft opt-out system the removal and use of organs and tissues is also permissible unless the deceased objected during his or her lifetime, but after death relatives are involved in the decision making process around donation.

The Welsh Government is proposing a soft opt-out system for Wales.

22. The key features of the soft opt-out system of posthumous organ and tissue donation that the Welsh Government intends to introduce for Wales are:

a) it will apply to people aged 18 or over who live and die in Wales;

b) people will have the opportunity to make an objection to donation of their organs and tissues;

c) there will be an effective and secure system for individuals to make an objection to donation should they wish to, and such a system will enable objection to donation of some or all organs and tissues;

d) any objection of an individual to donate organs and/or tissues will be upheld, after death;

e) the system will support the opportunity for individuals to change their minds, and to include people who move to Wales or who reach the age of 18;

f) after death families will be involved in the decision making process around donation.

Persons who will be included in the soft opt-out system

23. The soft opt-out system for Wales will apply to people aged 18 or over who live in Wales, and who have had the opportunity to make an objection to donation of their organs and tissues in the event of their death.

The opportunity to make an objection to donation

24. The Welsh Government believes everyone has the right to object to donate their organs and tissues in the event of their death, and to have that right respected. In order to ensure an objection can be made, the opportunity to object must exist and be given.

25. In order to ensure an individual has the opportunity to make an objection, there must be:

a) access and availability of information about the soft opt-out donation system in Wales;

b) an ability on the part of the individual to understand the information available and reach a decision; and

c) a system by which objection can be made.

26. The Welsh Government's proposals for the process for making and recording the objection are set out later in this White Paper.

Living in Wales

27. The Welsh Government is not proposing that the new legislation will cover all people who die within Wales, only those who both live and die in Wales.

28. Further, the Welsh Government proposes the new arrangements will apply to people who have lived in Wales for a sufficient time in order to gain knowledge and understanding of the system.

29. The reason for applying the arrangements to people who both live in Wales and have lived here for a sufficient period of time is to seek to ensure that such people will be aware of the system and know of the mechanisms to object; it cannot be expected that people who visit Wales will know of the arrangements, and have had the opportunity to object.

30. It is recognised that the legislation will need to provide certainty as to the meaning of living in Wales.

31. Whether a person is considered to be usually living in Wales or not, will need to reflect their usual daily lives, and not be swayed by temporary absences (such as holidays, recreation and business). The mechanism devised will need to be clear to the clinicians and to the public.

32. As set out above, a person must have lived in Wales for a period of time to enable them to have gathered sufficient knowledge and understanding of the soft opt-out system of organ and tissue donation. Views on the period of time are sought as part of this White Paper.

33. There will be an extensive and wide-ranging programme of awareness raising in the lead-up to the introduction of the new system. This will seek to ensure those people living in Wales will be aware of the new arrangements and the choices available to them.

34. When the new arrangements are operational, we will ensure people moving to Wales have sufficient time to gain the knowledge and understanding of the system so they may object to donation if they wish. These safeguards will establish the period of time required prior to being included within the soft opt-out system.

Consent

35. Opt-out systems, such as the soft opt-out system being proposed for Wales, are sometimes referred to as a *"presumed consent"* system of organ and tissue donation.

36. Consent is central to most organ and tissue donation systems. This is because consent is generally seen as the ethical and legal justification for the removal and use of organs and tissues.

37. Under the current opt-in system in place in Wales, consent for donation is given when individuals volunteer to become organ and tissue donors by actively joining the NHS Organ Donor Register (ODR). Additionally, in the absence of consent from the individual, the family may also consent to donation on behalf of the deceased where that person has not made a known decision for or against donation.

38. Under the proposed soft opt-out system for Wales, unless an individual makes an objection their organs and tissues will be available for donation after their death. Therefore consent for donation, in the absence of objection, is presumed. As a safeguard, after death families will be involved in the decision making process around donation.

Ability to understand

39. The Mental Capacity Act 2005 confirms that a person must be assumed to have capacity to make decisions unless it is established otherwise. This principle will not be altered by the proposed soft opt-out system for organ and tissue donation in Wales.

40. We recognise that under the current organ donation arrangements the mental capacity of an individual to understand the nature of the decision to join the Organ Donor Register (ODR) is not tested.

41. People may have the mental capacity to make decisions about some aspects of their life, but not others. It is recognised that some people may never have the mental capacity to make a particular decision, some may lose the mental capacity to make that decision, and for others their mental capacity may fluctuate.

42. The consequence of this is that no organ and tissue donation system which relies on an individual's opportunity and ability to opt-out can make a simplistic division between those with, and those without, sufficient mental capacity to decide.

43. The Welsh Government proposes that clinicians will, in the event of the death of an adult and in discussion with their family, identify those people who lacked capacity to make a decision about organ and tissue donation.

Adults aged 18 years and over

44. The Welsh Government recognises there are difficulties inherent in assuming children will understand the nature and purpose of donation of their organs and tissues, in order that they may object to such an action.

45. Section 2 of the Human Tissue Act 2004 sets out the current meaning of 'appropriate consent' in relation to activities regarding the body of a deceased child. For the purposes of that section, children are people under the age of 18.

46. We therefore propose children and young people who have not attained the age of 18 years will not be included under the move to a soft opt-out system; the system will incorporate young people when they reach their eighteenth birthday.

Persons that will not be covered by the new arrangements

47. The following will not be included within the soft opt-out system of organ and tissue donation for Wales:

a) persons who die in Wales but who do not normally live in Wales (for example visitors);
b) persons who die in Wales and normally live in Wales, but have not lived in Wales for the required length of time;
c) persons who usually live in Wales, but who die outside Wales;
d) persons who cannot be identified at their death;
e) adults (those aged 18 or over) who do not have the capacity to understand and make a decision about objecting to donation;
f) children and young people aged under 18 years of age.

The operation of the soft opt-out system for Wales

48. The Welsh Government will ensure there will be a robust and secure system for individuals to make an objection to donation of some or all of an individual's organs and tissues. The system will also ensure any objection of an individual to donate their organs and/or tissues is upheld, after death.

49. The soft opt-out system will enable individuals to change their minds, for example withdraw an objection, and to include people who move to Wales or who reach the age of 18.

The retention of the existing Organ Donor Register (ODR) for the people of Wales

50. The ODR is a confidential, computerised database which holds details of people who have signed up to become organ and tissue donors in the event of their death. The register is used after a person has died to establish whether they wanted to donate and if so, which organs and tissues.

51. The Welsh Government has considered carefully whether the existing ODR will continue to apply in Wales after the new legislation comes into effect. The value and importance of the existing ODR, and the commitment that individuals make by joining the register is recognised. For these reasons the Welsh Government will ensure the ODR continues to be available to individuals living in Wales.

52. The retention of the ODR for those individuals living in Wales who wish to use it, together with the new soft opt-out system, will provide benefits to individuals –

a) the ability to record wishes in case an individual dies outside Wales, where the soft opt-out system will not apply;
b) the ability to record an individual's wishes if they are not yet included within the soft opt-out system in Wales, for example they have only recently moved to Wales or they are under the age of 18;
c) because organs and tissues are given to recipients across the United Kingdom, regardless of where they are donated, retention of the ODR in conjunction with the soft opt-out system will mean more organs and tissues available to those people who need them. This will improve the health and quality of life for people who need a transplant.

Maintaining records

53. NHS Blood and Transplant (an England and Wales Special Health Authority) hold and maintain the current ODR. Although the Welsh Government is committed to retaining the ODR (as set out above), we recognise it is not, currently, a record of all people who would be willing for their organs to be donated - in the last year alone, just over 67 per cent of donors in the UK were not on the ODR.

54. It is also not a record of people who do not wish their organs to be donated – indeed there is currently no formal mechanism for people who feel strongly against organ donation to register their objection. In the absence of such a mechanism it is impossible to be sure whether an individual's autonomy is being respected after death.

55. For these reasons the Welsh Government cannot use the existing ODR, as it is currently set up, to provide a safe and effective soft opt-out system.

56. The Welsh Government has therefore considered a number of record keeping options, to run alongside the existing ODR, which will ensure that an individual's autonomy is respected after death. These include:

a) Option A – a register for Wales of persons who have not objected, and a register of persons who have objected;
b) Option B – a register for Wales of only those persons who have not objected;
c) Option C – a register for Wales of only those persons who have objected;
d) Option D – no register(s) but a record of objection given to and held by a person's general practitioner.

57. Apart from option D, which relies on the GP record, there is a requirement for a register to be held. This indicates the need for a secure and confidential central register, which is accessible to clinicians after an individual's death.

58. The Welsh Government recognises that the record system put in place to support the operation of the soft opt-out system for Wales must be integrated into, and work cohesively with, the operation of the organ and tissue donation arrangements for the UK. Such arrangements could include adaption of the current ODR to accommodate the soft opt-out system in Wales.

59. The practical considerations for holding and maintaining any central register will be considered in light of the consultation responses to this White Paper.

How to make an objection to donation

60. The actual method(s) of making an objection will be influenced by whether a register is held, and if so the type of register (or registers). In any case, the Welsh Government will ensure any and all methods put in place enable an individual to make a confidential objection to donation in any easy and accessible manner.

61. Under the current arrangements an individual can register their intentions to donate all organs and tissues or to select specific organs or tissues. The Welsh Government recognises that individuals may be content to donate some of their organs and tissues, but not all.

62. The arrangements to be put in place for the soft opt-out system for Wales will enable an individual to opt-out of donating all organs and tissues, or to opt-out of donating some organs or tissues.

Keeping the soft opt-out system up to date

63. The soft opt-out system will need to be sufficiently flexible to accommodate changes after the main introduction of the new arrangements. Such changes will include:

a) an individual changing their mind, for example previously objecting but now wishing to donate;
b) people who move to or from Wales;
c) young people reaching the age of 18.

64. The Welsh Government recognises the soft opt-out system which it introduces must acknowledge and enable these changes, so as to ensure that an individual's choices are respected and followed in the event of death.

65. These important operational considerations will be influenced by whether a register is held, and if so the type of register (or registers).

The safeguard provided by the role of the family

66. Currently where organ donation is being considered, a clinician will firstly check the ODR to ascertain whether an individual has indicated they would wish to be an organ donor. Regardless of whether an individual is on the register or not, clinicians will approach family members to ascertain the wishes and views of the deceased person about donation. This allows any evidence from the family of the individual's recent wishes to be understood.

67. Under the Human Tissue Act 2004 (the Act), and the associated Codes of Practice, clinicians approach relatives in the order that they are listed:

- spouse or partner;
- parent or child;
- brother or sister;
- grandparent or grand child;
- niece or nephew;
- stepfather or stepmother;
- half-brother or half-sister;
- friend of long standing.

68. The wishes of the deceased are given primacy under the Act, and the Welsh Government will not deviate from this important principle under the new legislation. Indeed the soft opt-out system will provide additional clarity on the individual's views, because objection cannot be recorded within the current system.

69. The Codes of Practice currently advise health professionals to sensitively encourage relatives to accept the deceased's wishes, whilst making it clear that the relatives do not have the right to override those wishes.

70. The Welsh Government is committed to a soft opt-out system of organ and tissue donation in which the views of relatives will be taken into account. Retaining the role of relatives in this way serves a number of purposes –

a) it acts as an important safeguard: families may be aware of an unregistered objection;

b) it recognises the doctor's duty of care towards relatives to relieve and not add to their distress and bereavement; and

c) details obtained from relatives about the patient's medical and behavioural history can play an important part in the success of a transplant.

71. Under a soft opt-out system of organ and tissue donation, in conjunction with an extensive public awareness programme, individuals are far more likely to have discussed their views with their families and to have made their views clear prior to death.

72. The Welsh Government recognises the importance of the role of the family in a soft opt-out system. The wishes of the deceased will be respected and in order to safeguard these wishes family involvement is essential. We are seeking your views on the role of the family as part of this White Paper.

73. Whilst relatives will still be consulted, the burden of making the decision in the absence of any indication of the deceased person's wishes at such a difficult time will be reduced.

What the soft opt-out system will not change

74. The Welsh Government may only make legislation in relation to Wales. Therefore the soft opt-out system will apply in relation to Wales only.

75. The Welsh Government's policy intention is that the proposals:

a) will not change the way patients are cared for (including the medical treatment they will receive) up to and including the time of death;

b) will not change the way in which death is confirmed – there are very clear and strict standards and procedures for confirming death;

c) will not include living donation of organs and tissues (namely, the transplantation of an organ or tissue from a living donor to a transplant recipient - often a friend or family member);

d) will not change the way that organs and tissues are allocated by NHS Blood and Transplant;

e) will not alter the clinical decision making for, and processes associated with, transplant;

f) will not allow donated organs and tissues to be available for any purpose other than transplantation. The new system will not mean that donated organs and tissues may be used for purposes such as research, display or commercial use;

g) will not remove an individual's opportunity to join the current Organ Donor Register.

76. The soft opt-out system that is being proposed for Wales is one in which the removal and use of organs and tissues is permissible unless the deceased objected during his or her lifetime. Individuals will have a formal mechanism for registering that objection. After death relatives will be involved in the decision making process around donation.

77. Such a system will improve the way individuals in Wales are able to set out their wishes for donation, and strengthen the position for those who do not wish to donate, whilst still ensuring that more organs and tissues are available for those who need them.

IMPLEMENTATION OF PROPOSED LEGISLATION

Impact assessment

Equality impact assessment

78. The Welsh Government is committed to making sure that as policies, strategies, action plans and legislation are developed, every effort is made to actively contribute to an environment that is free from discrimination. Part of this is about assessing the impact that policies and actions may have on the people of Wales, to make sure that the Welsh Government does not discriminate but takes every opportunity to promote equality and good relations.

79. The policy contained within this White Paper has had an initial equality screening assessment in line with the Welsh Government's Inclusive Policy Making practice. This initial assessment has found –

a) high relevance of the policy in respect of race, faith, and human rights;

b) medium relevance in respect of disability and age;

c) no evidence of a specific impact of the policy with regards to sexual orientation, marriage and civil partnership, or gender and gender re assignment.

80. During the process of initial assessment it has been noted that patients from the same ethnic group are more likely to be a close match within the context of organ donation.

81. People of Asian or African-Caribbean descent are three to four times more likely than white people to develop end-stage renal failure and need a kidney transplant. Data from NHS Blood and Transplant identifies that in the UK people from Asian or African-Caribbean ethnic groups make up 23 per cent of the waiting list for kidney donation although they account for 8 per cent of the population (based on 2001 Census figures). Only 3 per cent of deceased donors are of Asian or African-Caribbean descent.

82. The Welsh Government will seek, through the consultation process on this White Paper, to have specific discussions with black and minority ethnic (BME) communities and faith groups.

83. A detailed Equality Impact Assessment will be developed and published by the Welsh Government as part of the introduction of future legislation. Consultees are invited to comment on the impact of the policy on the equality strands of:

a) d isability;

b) r ace;

c) gender and gender reassignment;

d) ag e;

e) religion and belief and non-belief;

f) sexual orientation; and

g) hum an rights.

Privacy impact assessment

84. A privacy impact assessment will assess the privacy implications of activities which involve the use of (or changes to the use of) personal data as defined by the Data Protection Act 1998.

85. Following consultation on this White Paper an initial screening under the privacy impact assessment will take place, so as to consider the privacy implications associated with making and recording any objection under the soft opt-out system.

Regulatory Impact Assessment

86. W hen the proposed legislation is laid before the National Assembly for Wales, the Welsh Government will provide an Explanatory Memorandum including a Regulatory Impact Assessment (RIA).

87. The RIA will set out the costs and benefits associated with achieving the proposed Bill's strategic objective of maximising the number of organs and tissues donated by patients in Wales.

88. When quantifying costs, the Regulatory Impact Assessment will seek to establish:

a) who will bear any costs;

b) any one-off costs (for example, setting up a register or initial public awareness campaigns);

c) any recurrent costs (for example, costs associated with operating a register, or ongoing communication programmes); and

d) any other costs.

89. An initial estimate of costs has been developed as part of the preparation for this White Paper. This initial estimate indicates that prior to implementation up to £2.85m will be required for training and communications.

90. Further work will be required to refine the recurrent operational costs in relation to the soft opt-out system, including any registers and record keeping systems.

Timetable

91. This White Paper is a consultation document and the Welsh Government is inviting views on the proposals by **31 January 2012.**

92. Following consideration of the consultation responses, a Bill will be brought forward by the Welsh Government and introduced into the National Assembly for Wales during 2012/13.

93. It is currently expected that there would be a lead-in period between the making of the legislation and the new soft opt-out system coming into force. Such a time period will enable the appropriate mechanisms and systems of operation to be established, and for the major public awareness campaign to be rolled out.

94. The lead-in period is likely to be two years, and therefore the earliest that the soft opt-out system will be in operation in Wales is 2015. Further details on the implementation programme will be set out in Explanatory Memorandum and RIA for the Bill when it is introduced.

Welsh Language provision

95. The soft opt-out system will comply with the requirements set out in the Welsh Language Act 1993, and any relevant provisions of the Welsh Language (Wales) Measure 2011 in force at the time.

Public awareness campaign

96. This White Paper has set out the need for, and importance of, a major public awareness campaign prior to the new soft opt-out system coming into effect. Fuller details of the proposals for such a campaign will be set out in the Explanatory Memorandum and RIA, however the early proposals include –

- out of home activity (e.g. billboards);
- extensive television, radio, press and online activity;
- community activity;
- stakeholder engagement; and
- printing and distribution of bi-lingual leaflet to all Welsh households (with additional copies for outlets such as GP surgeries).

97. The public awareness campaign will be extensive both in its use of different forms of media and in its duration (prior to and after enactment of legislation) to ensure that all those people who wish to opt - out know how to do so.

CONSULTATION QUESTIONS

As part of the consultation process the Welsh Government is seeking responses on particular aspects of the policy proposals, however respondents are invited to provide additional comments and evidence on the proposal as a whole.

Persons who will be included in the soft opt-out system

1. The White Paper sets out individuals must have lived in Wales for a sufficient period of time before being included within the soft opt-out system.

   a) What factors should be taken into account when determining whether an individual 'lives in Wales'?

   b) What should that period of time be?

2. Do you agree discussions between clinicians and family in the event of an individual's death, will identify and safeguard those who lack capacity?

3. Do you agree that the soft opt-out system for Wales should only apply to persons aged 18 years and over? If not, why?

The operation of the soft opt-out system for Wales

4. Do you agree with the retention of the existing Organ Donor Register to be operated in conjunction with the soft opt-out system?

5. In relation to the record keeping options for the soft opt-out system –

   a) Which of the suggested options do you prefer? (See paragraph 56 of the White Paper.)

   b) Are there other options you feel would provide an effective and secure system?

6. What is the role of the family in safeguarding the wishes of the deceased?

Implementation

7. How can the Welsh Government ensure that the public awareness campaign is effective?

8. The Welsh Government would welcome your views on the potential impact of the proposed soft opt-out system for the Welsh Language, race, faith, disability, age, sexual orientation, gender, gender reassignment, marriage or civil partnership.

9. The Welsh Government has asked a number of specific questions; if you have any related issues which have not been specifically addressed, please record them here.

Agenda Item 5

Health and Social Care Committee

Meeting Venue:	**Committee Room 1 - Senedd**
Meeting date:	**Wednesday, 16 November 2011**
Meeting time:	**09:30 - 11:45**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

This meeting can be viewed on Senedd TV at:
http://www.senedd.tv/archiveplayer.jsf?v=en_200000_16_11_2011&t=0&l=en

Concise Minutes:

Assembly Members:	**Mark Drakeford (Chair)** **Mick Antoniw** **Rebecca Evans** **Vaughan Gething** **William Graham** **Elin Jones** **Lindsay Whittle** **Kirsty Williams**
Witnesses:	**Lisa Turnbull, Royal College of Nursing** **Melanie Gadd, Family Planning Association** **Jason Harding, Diabetes UK** **Sue Thomas, Royal College of Nursing**
Committee Staff:	**Llinos Dafydd (Clerk)** **Naomi Stocks (Clerk)** **Mike Lewis (Deputy Clerk)** **Stephen Boyce (Researcher)** **Victoria Paris (Researcher)**

1. Introductions, apologies and substitutions

1.1 Apologies were received from Darren Millar and Lynne Neagle. There were no substitutions.

2. Inquiry into the contribution of community pharmacy to health services in Wales - Evidence from the Royal College of Nursing Wales

2.1 The witnesses responded to questions from members of the Committee on the contribution of community pharmacy to health services in Wales.

2.2 The witnesses agreed to provide additional information on models used in England to provide primary health care.

3. Inquiry into the contribution of community pharmacy to health services in Wales - Evidence from Diabetes UK Cymru and the Family Planning Association

3.1 The witnesses responded to questions from members of the Committee on the contribution of community pharmacy to health services in Wales.

3.2 The Family Planning Association (FPA) agreed to provide:

- figures on the number of pharmacies across Wales that are participating in the Emergency Hormonal Contraception (EHC) scheme; and
- further detail on whether there is variability across Wales in the capability of the community pharmacy network to deliver EHC services.

3.3 The Committee requested a note from its secretariat exploring the extent to which arrangements are in place for pharmacists to port their training and qualifications across local health board boundaries and across the Welsh-English border.

4. Papers to note

4.1 The Committee noted the letter from the Minister for Health and Social Services and the Deputy Minister for Children and Social Service on the additional information on the draft budget 2012-13. The Committee agreed to write to the Minister to seek further clarification of the precise figure used by the Government, when calculating its budget, to reflect health inflation.

5. Motion under Standing Order 17.42(vi) to resolve to exclude the public from the meeting for item 6

5.1 The Committee agreed the motion under Standing Order 17.42(vi) to resolve to exclude the public from the meeting for item 5.

6. Inquiry into Stroke Risk Reduction - Private discussion on key issues

6.1 The Committee discussed the key messages and recommendations on the inquiry into stroke risk reduction.

TRANSCRIPT

View the meeting transcript.

Health and Social Care Committee

Meeting Venue:	**Committee Room 3 - Senedd**
Meeting date:	**Thursday, 24 November 2011**
Meeting time:	**09:30 - 11:15**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

This meeting can be viewed on Senedd TV at:
http://www.senedd.tv/archiveplayer.jsf?v=en_400000_24_11_2011&t=0&l=en

Concise Minutes:

Assembly Members:

Mark Drakeford (Chair)
Mick Antoniw
Rebecca Evans
Vaughan Gething
William Graham
Elin Jones
Lynne Neagle
Lindsay Whittle
Kirsty Williams

Witnesses:

Elspeth Weir, Community Pharmacy Scotland
Malcolm Clubb, Community Pharmacy Scotland
Alex MacKinnon, Royal Pharmaceutical Society

Committee Staff:

Llinos Dafydd (Clerk)
Catherine Hunt (Deputy Clerk)
Stephen Boyce (Researcher)

1. Introductions, apologies and substitutions

1.1 Apologies were received from Darren Millar. There were no substitutions.

2. Inquiry into the contribution of community pharmacy to health services in Wales - Evidence from Community Pharmacy Scotland and the Royal Pharmaceutical Society Scotland

2.1 The witnesses responded to questions from members of the Committee on the contribution of community pharmacy to health services.

2.2 Witnesses from Community Pharmacy Scotland agreed to provide:

- a copy of a report by the Scottish Government on its Review of the Community Pharmacy Public Health Service for Smoking Cessation and Emergency Hormonal Contraception;
- a link to a report by the University of Manchester on the change in patient consultation patterns in primary care which investigated the uptake of the Minor Ailments Service in Scotland.

3. Petition on Public Toilet Provision in Wales - Consideration of the Health and Social Care Committee's approach

3.1 The Committee considered the paper on the approach to its work on public toilet provision in Wales. The Committee agreed that its work should focus on the public health implications of inadequate public toilet provision and that the public consultation should close on 23 December 2011.

3.2 The Committee agreed to add additional organisations to the proposed consultation list.

4. Papers to note

4.1 The Committee noted the minutes of the meeting held on 10 November.

4.1 Inquiry into the contribution of community pharmacy to health services in Wales - Additional evidence from Community Pharmacy Wales

4.2 The Committee noted the additional evidence from Community Pharmacy Wales.

5. Motion under Standing Order 17.42(vi) to resolve to exclude the public from the meeting for item 6

5.1 The Committee agreed the motion under Standing Order 17.42(vi) to resolve to exclude the public from the meeting for item 6.

6. Inquiry into the contribution of community pharmacy to health services in Wales - Private discussion on emerging issues

6.1 The Committee considered the issues emerging from its inquiry into the contribution of community pharmacy to health services in Wales.

TRANSCRIPT

View the meeting transcript.

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 Medic:ines 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 effectively direct and target MUR's to patients with complex medicines management needs. There was an expected commitment to 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 Interventions by pharmacist – cost 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 the overall take up of the scheme, especially concerning readmission rates and improvement in prescribing indicator/AOF targets, however there were effective interventions which, if actioned, could effectively contribute to better patient care.

Assessment
Overall, the results are illustrated below. Obviously 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 adherence 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 patients with chronic conditions. The following comments were annotated 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.

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

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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.

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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

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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-

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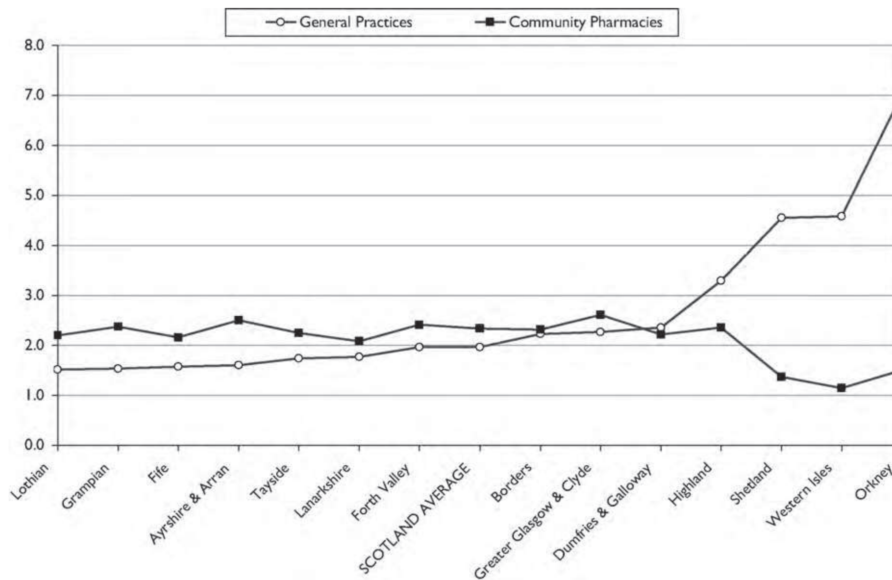

Fig. 1. Numbers of community pharmacies and general practices per 10,000 Health Board population (2009).

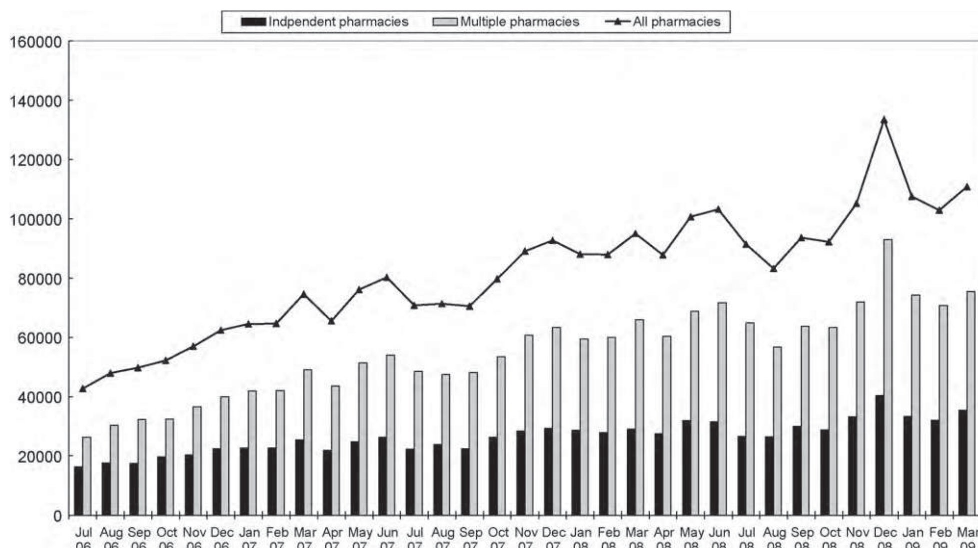

Fig. 2. Minor Ailments Service items supplied per month in Scotland between July 2006 and March 2009.

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

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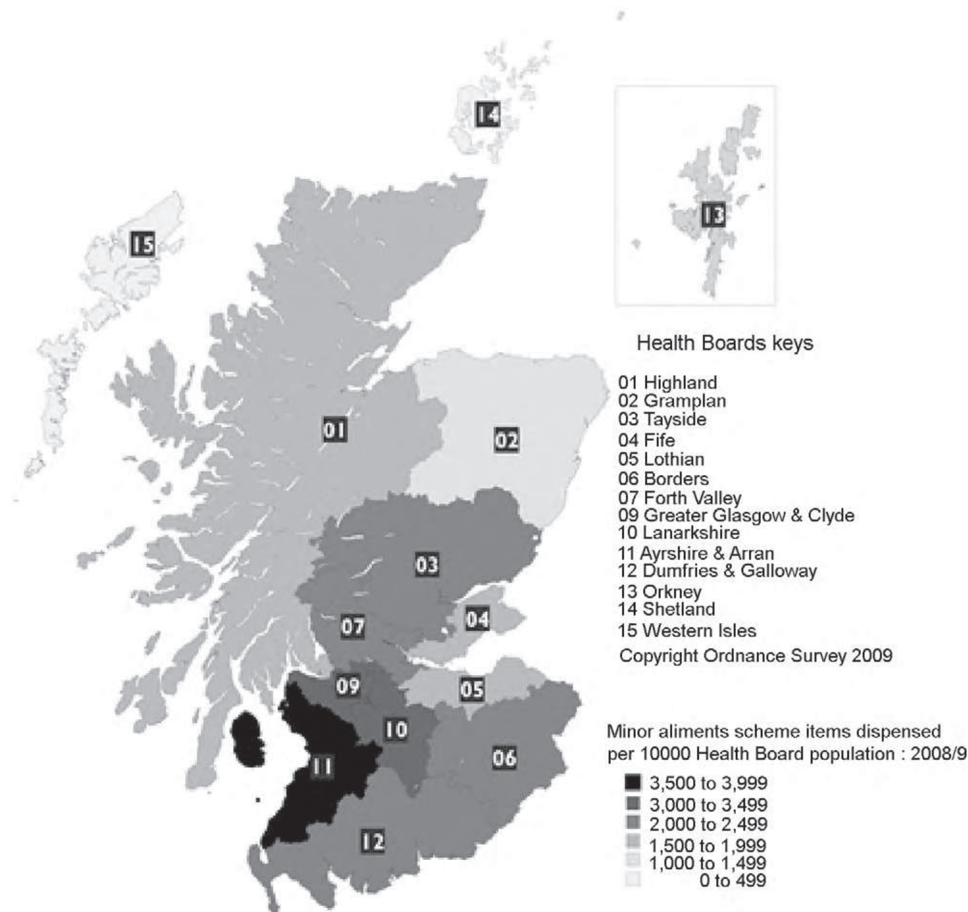

Fig. 3. Minor Ailments Service items supplied per 10,000 Scottish Health Board population 2008/09.

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

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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).

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(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

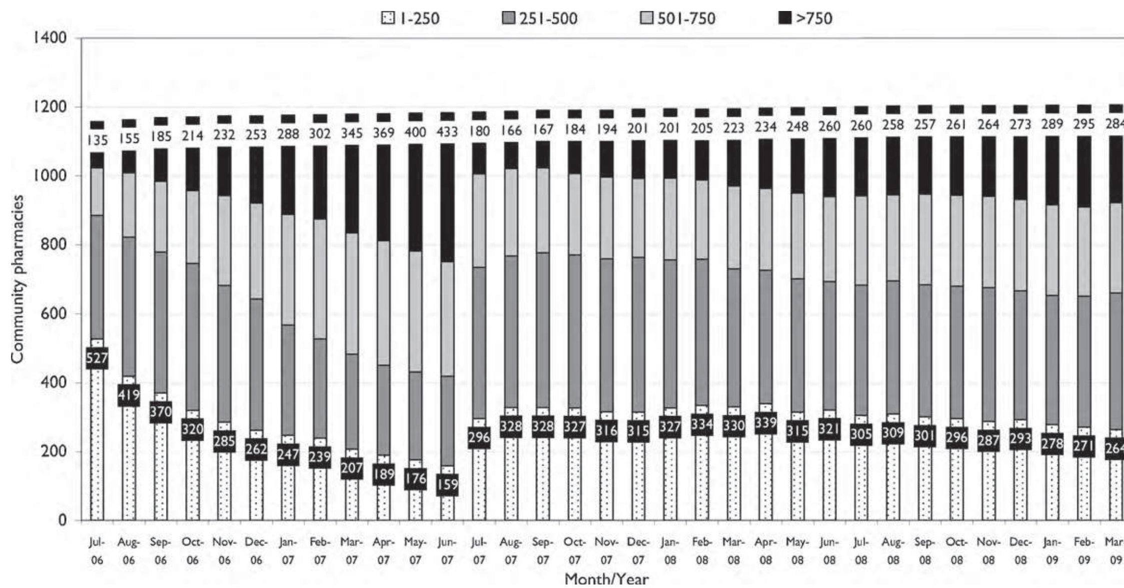

Fig. 4. Number of community pharmacies by Minor Ailments Service remuneration bands in Scotland, between July 2006 and March 2009.

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.

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[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.

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Agenda Item 5e

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

Health and Community Care

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

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Scottish Government Social Research
2011

This report is available on the Scottish Government Social Research website (www.scotland.gov.uk/socialresearch) only.

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Table of Contents

1 EXECUTIVE SUMMARY 1

2 INTRODUCTION 9

Aims and Objectives of Evidence Gathering Exercise 9
Background 9
PHS Smoking Cessation Service 11
PHS Emergency Hormonal Contraceptive Service (EHC) 13

3 METHOD 14

Review of Literature 14
Analysis of Routine Data 14
On-line Survey of Community Pharmacists and NHS Boards 15
Interviews with Smoking Cessation Service Users 18

4 FINDINGS - PHS SMOKING CESSATION SERVICE: RESULTS FROM ANALYSIS OF ROUTINE DATA 20

Introduction 20
Smoking Rates and Services in Scotland 20
Characteristics of Users of the PHS Smoking Cessation Service 20
Claims for Smoking Related Items 21
Self Reported Quit Outcomes 24

5 FINDINGS - THE VIEWS OF COMMUNITY PHARMACISTS AND NHS BOARD STAFF ON THE PHS SMOKING CESSATION SERVICE 27

Introduction 27
The Smoking Cessation Service 27
Effectiveness of the PHS Smoking Cessation Service 30
Strengths of the PHS Smoking Cessation Service 33
Areas where service works better 34
Continuing to offer the service 34
Links with other Local Smoking Cessation Services 35
Data Collection 37
The Scottish Government PHS Smoking Cessation Specification 37
Training and Support 40
Governance and Quality Assurance Arrangements 42
Improving the PHS Smoking Cessation Service 44
Summary 47

6 FINDINGS: USERS' VIEWS OF SMOKING CESSATION SERVICES PROVIDED IN COMMUNITY PHARMACIES 48

Introduction 48
Accessibility of the Service 48
Satisfaction with the Service 48
Effectiveness of the Service 49
Recommendations for Service Development 49
Summary 50

7 FINDINGS - PHS EMERGENCY HORMONAL CONTRACEPTIVE SERVICE (EHC): RESULTS FROM ANALYSIS OF ROUTINE DATA 51

Introduction 51
Number of EHC Items Dispensed 51
Number of EHC Claims 51
Patient characteristics 54
Evidence on service users' experiences of community pharmacy EHC services 54

8	THE VIEWS OF NHS BOARD AND COMMUNITY PHARMACY STAFF ON THE PHS EMERGENCY HORMONAL CONTRACEPTION (EHC) SERVICE	55
	Introduction	55
	The EHC Service	55
	Effectiveness of the PHS EHC Service	57
	Support and training	58
	The Scottish Government PHS EHC Service Specification	60
	Integration and Links with Other Services	61
	EHC Data Collection	62
	Governance and Quality Assurance Arrangements	63
	Improving the EHC Service	64
	Summary	65
9	DISCUSSION AND CONCLUSIONS	66
	Introduction	66
	Limitations of data	66
	Smoking Cessation	66
	Emergency Hormonal Contraception (EHC)	72
	Conclusions	76
APPENDIX A	SURVEY QUESTIONS	79

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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.

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[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.

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[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.

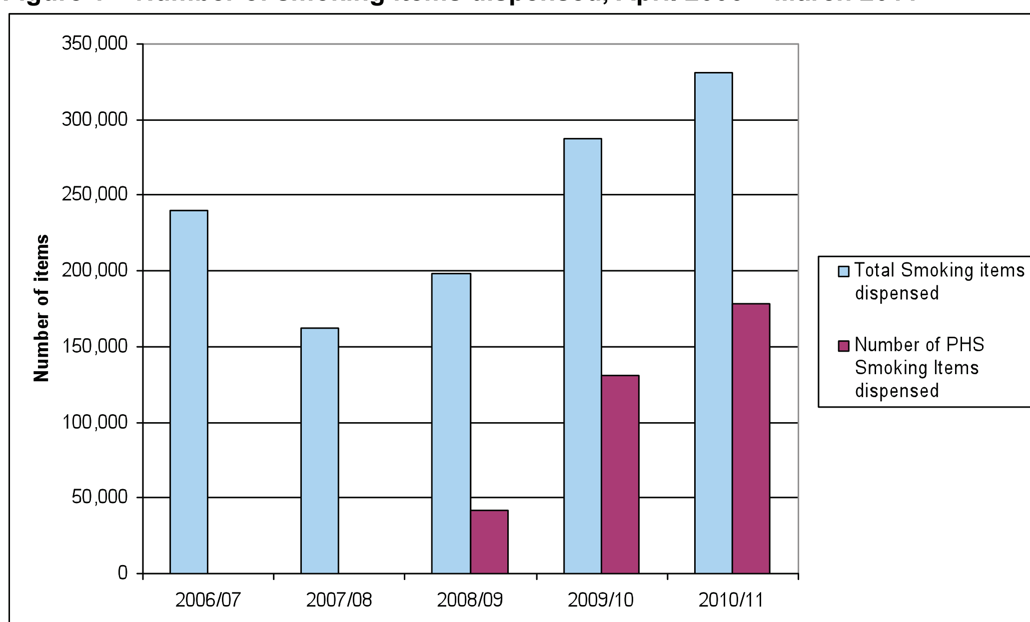
Claims for Smoking Related Items

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

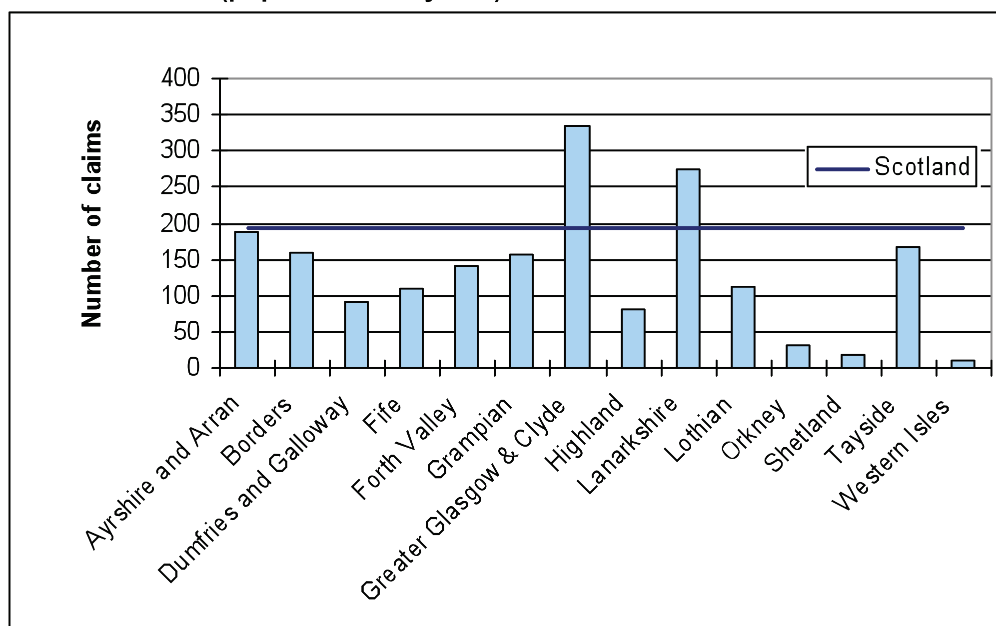


Note: Data is based on Nicotine only.
Excludes items not dispensed using a prescription e.g. in hospital.
Source: Prescribing information system, ISD Scotland.

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)

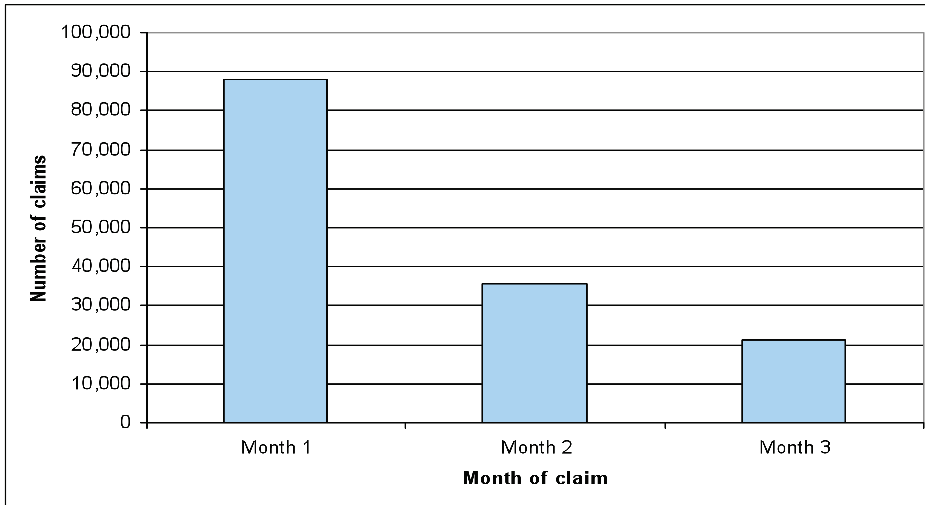


Source: Based on data from Prescribing Information System, ISD Scotland.

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

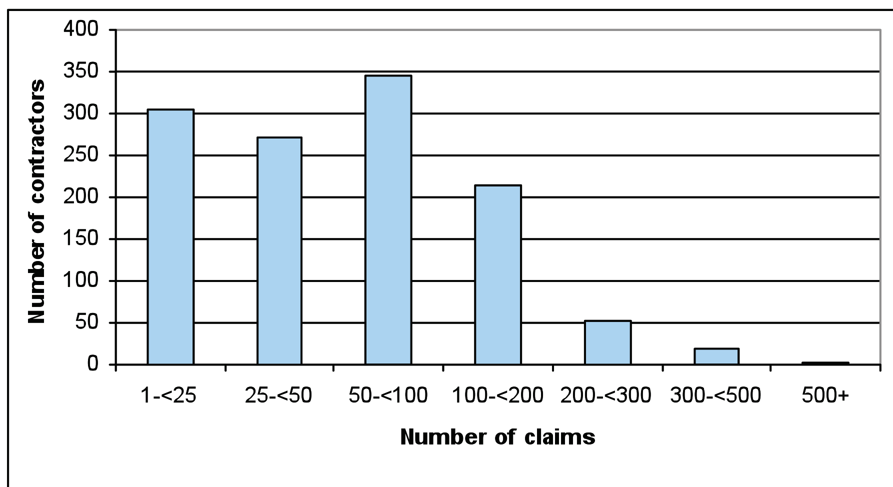


Source: Prescribing Information System, ISD, Scotland

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

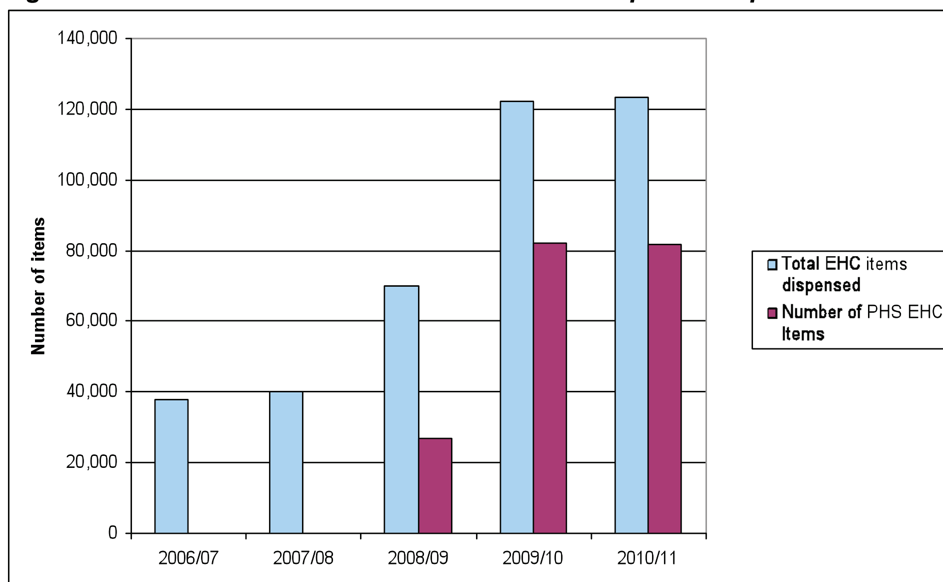
Introduction

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.

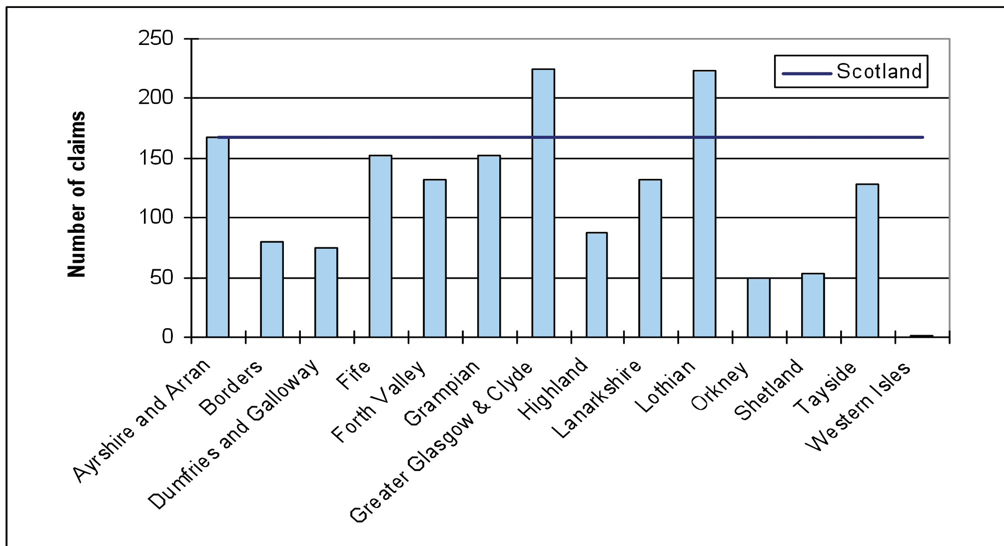
Other potential reasons, for the discrepancy, might be:

- 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.

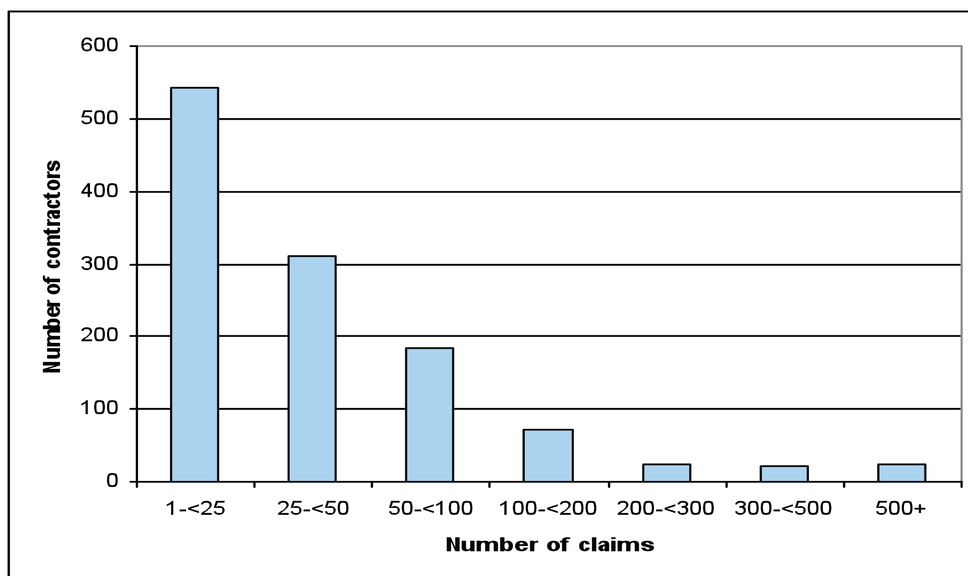
Figure 6 – Rate of EHC patient claims per 10,000 population by NHS Board July 2010 – June 2011



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

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[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.

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[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?

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