Review of the Role of the Health Workforce in Reducing Inequalities in Cwm Taf through Social Prescribing initiative.

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Intended Audience: The Project Review Team, Cwm Taf University Health Board, Executive Director of Public Health Development and Director of Health and Healthcare Improvement Division, Public Health Wales.

Purpose of Document: To report on the first six months of the implementation of an initiative to encourage primary care social prescribing in Cwm Taf.

Publication/ Distribution:

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- Prescribing Team, Cwm Taf University Health Board
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- National Exercise Referral Scheme Lead and local co-ordinators
- Stop Smoking Wales Programme Lead
- Specialist Registrar in Sports Medicine
- Welsh Centre for Postgraduate Pharmacy Education.

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List of abbreviations

CAPSA	Comparative Analysis System for Prescribing Audit
CPSSS	Community Pharmacy Stop Smoking Service
NERS	National Exercise Referral Scheme
NECAF	National Electronic Claim and Audit Form
NRT	Nicotine Replacement Therapy
SSW	Stop Smoking Wales
UCL	University College London
ULHB	University Local Health Board
WCPPE	Welsh Centre for Postgraduate Pharmacy Education.

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Summary of key points

- The initiative was designed to encourage social prescribing by primary care clinicians. The intention was for social prescribing to become part of the wider prescribing advisory agenda and influence the number of brief interventions, referral and signposting to health improvement services.

- The project focused on the application of a model of educational outreach. Toolkits were developed to support the initiative.

- No protected time or additional resources were provided to implement the initiative. Support for planning the initiative, development of the toolkit and evaluation was provided by one of the Consultants in Pharmaceutical Public Health, Public Health Wales.

- This review studies the first six months of the implementation of the initiative. Early indications show that potentially a small number of improvements can be achieved with minimal input.

- In particular the review highlights:

    - A small increase in the number of people in Cwm Taf accessing NHS smoking cessation services. The number of contacts with Stop Smoking Wales (SSW) decreased over the study period whilst contacts with the Community Pharmacy Stop Smoking Service (CPSSS) reported an increase over the same period.

    - A small increase in the number of people referred and enrolling on the National Exercise Referral Scheme (NERS).

    - A decrease in the prescribing of drugs for the treatment of obesity.

- Whether the increase in patient numbers with the services is a result of the initiative alone is to be debated. Other locality efforts were being made to increase footfall with the health improvement services.

- It is too early to assess whether the trends observed continue or if the increases in patient numbers with the services have any long term population health benefits. For this reason the initiative will continue until December 2014, after which a further evaluation will be undertaken to determine the longevity of the project.

- It is recommended that the initiative continue using the current model and continue to make use of the GP Prescribing Performance Review Reports, the Annual GP Prescribing Visits, ScriptSwitch and support from the Consultant in Pharmaceutical Public Health.

1 Aim

The review studied the first six months of an initiative which has become known as *The role of the health workforce in reducing inequalities in Cwm Taf through a social prescribing initiative.* The aim of the review was to identify what is working well and make recommendations as to if and how the initiative should continue.

This project attempts to answer the following:

- What methods can be used to increase brief interventions and social prescribing to non-pharmacological public health interventions and health improvement programmes by the primary healthcare workforce?

- Do brief interventions and social prescribing of non-pharmacological public health interventions in primary care have an effect in reducing the GP prescribing budget?

2 Introduction

In 2012, the Institute of Health Equity, University College London, published a consultation report identifying the potential of the primary healthcare workforce in influencing the social determinants of health and thereby tackling inequalities.[1] The report described various examples and included signposting, referral systems and social prescribing initiatives.

The concept of social prescribing is not new. Across the UK, and Scotland in particular, there have been initiatives exploring ways to support the role of the primary healthcare workforce in improving signposting and social prescribing. [2,3,4] These initiatives have usually been carried out in populations of high deprivation.

Cwm Taf University Local Health Board (ULHB) serves one of the most deprived populations in Wales. People in Cwm Taf are reported to have the poorest health and lowest life expectancy in Wales. Lessons learned in the Scottish initiatives may be applicable to parts of Cwm Taf ULHB.

Social Prescribing has been defined as 'a method of impacting on the wider determinants of health such as the social, economic and environmental factors, through linking people with health problems to non-medical sources of help and support in the community, usually referral by primary care'.[2]

In the project under review, the Prescribing Advisory Team, delivered educational outreach messages to primary care healthcare professionals and staff, with an aim to influence and increase social prescribing interventions. The initiative focussed on interventions to increase physical

activity and interventions to encourage smoking cessation.

It was hoped that this initiative may contribute towards reaching the Welsh Government target of reducing smoking prevalence in Wales to 16 per cent by 2020. There is currently no Welsh Government target for increasing physical activity.

The prescribing advisors were supported in testing this model by being provided with:

- A series of training events,
- A toolkit of relevant and detailed material (one for physical activity and one for smoking cessation),
- Key slides to use in GP practices,
- Ongoing contact and support by the health board, service advisors and co-ordinators and a Consultant in Pharmaceutical Public Health, Public Health Wales.

The application of an educational outreach model by prescribing advisors to influence traditional GP prescribing has been tested, evaluated[5] and become everyday practice in all health boards in Wales. There is however, lack of evidence to support the application of a similar educational outreach model by prescribing advisors to influence and improve signposting, referral and social prescribing in primary care.

This report describes the first six months of the implementation of the initiative and studied the key activities and their impact during this period.

3 Background

3.1 Primary care in Cwm Taf

Cwm Taf ULHB has a population of approximately 290,000 (2007)[6] with around 302,500 patients registered with Cwm Taf ULHB general practices[6] (2009). Primary care services are commissioned from 48 GP practices and 77 community pharmacies across the borough. The health board area tends to be divided into four localities; Merthyr Tydfil, Cynon valley, Taf Ely and the Rhondda valley. Each locality is further divided into two cluster areas (north and south).

3.2 The Prescribing Advisory Team

The Primary Care Prescribing Advisory Team consists of pharmacists and pharmacy technicians working with and in GP practices across the health board. The focus of their work is to improve the quality and efficiency of prescribing and medicines management.

The prescribing advisory function is covered by two teams covering the four localities. One team provides support to GP practices in Merthyr Tydfil and the Cynon valley the other Taf Ely and the Rhondda valley. Each team has a team leader plus a small number of pharmacists and / or technicians who are either based completely in primary care or have joint posts between primary care and one of the hospitals in Cwm Taf.

Each locality has approximately one whole time equivalent pharmacist and one whole time equivalent technician providing prescribing advisory support. The time given to each GP practice varies and is dependent on the engagement and needs of the practice and the area of prescribing being addressed locally. Typically practices may have up to two days a week input from the Prescribing Advisory Team.

3.3 The social prescribing initiative

3.3.1 Preparation

The initiative was originally considered in May 2012 where the following background work was undertaken by the Consultant in Pharmaceutical Public Health:

- A literature review – which identified no published evidence describing the use of educational outreach models by pharmacists to primary care to influence signposting, referral and social prescribing,
- A survey of GP and GP practice staff (Appendix 1),
- A series of semi-structured interviews with GPs (Appendix 2),
- A survey of community pharmacists (Appendix 3),
- Preparation of training events (Appendix 4),
- Development of Smoking Toolkit and Physical Activity Toolkits (Appendix 5)

3.3.2 Training

Three training sessions were prepared and members of the prescribing advisory team were invited to attend (appendix 4). The training was aimed to explain and describe the following:

- The context of social prescribing in relation to the Inverse Care Law.
- The burden of unhealthy lifestyles to the population of Cwm Taf.
- The evidence base for physical activity and smoking cessation.
- The operation and local delivery of the various health improvement services (SSW, CPSSS and NERS).
- What referral data and information is available and how it may be utilised locally.
- Potential links with other health improvement programmes and prescribing initiatives such as Smoke Free Homes and Models for Access to Maternal Smoking Cessation Support.
- Theories of behaviour change, the key stages of change and Motivational Interviewing
- The development and use of the Toolkits.
- The importance of measuring and evaluating the work.

Training focussed on the following key areas:

- The **social prescribing initiative** – presentations and discussions led by the Consultant in Pharmaceutical Public Health.

- **Physical activity** – presentations and discussions led by a Consultant in Public Health (LPHT), the Specialist Registrar in Sports Medicine and the local NERS co-ordinators.

- **Smoking cessation** - presentations and discussions led by a Consultant in Public Health (LPHT) and other members of the LPHT, a SSW Health Promotion Practitioner and SSW Advisor and the Lead Pharmacist (Community Pharmacy & Primary Care).

- Core skills of **motivational interviewing and social influencing** – training was developed and delivered as a bespoke product by Welsh Centre for Postgraduate Pharmacy Education, Cardiff University to support the initiative.

The training was designed to provide transferable knowledge and skills that would be of benefit to the prescribing advisory team in their medicines management and social prescribing work. It was hoped that the training sessions would facilitate contact and build relationships with local champions including NERs co-ordinators, SSW advisors and members of the Local Public Health Team.

No budget was allocated to deliver the training.

3.3.3 Implementation

Implementation began in June 2013 and consisted mainly of 4 key elements:

- The Prescribing Advisory Team discussing smoking cessation and physical activity opportunistically with the GPs and practice staff during their day to day prescribing work whilst in practices. No formal protected time was allocated to the social prescribing work. The initiative was designed to encourage social prescribing to be embraced as part of the wider prescribing advisory agenda and to become part of everyday activity.

- The inclusion of social prescribing information about contacts with SSW and NERS in each individual GP Prescribing Performance Review Report. These reports is prepared and sent to every GP practice on an annual basis and historically provided information on the prescribing of medicines only.

- Social prescribing discussed for the first time during GP Prescribing Annual GP Prescribing Visits (June – September 2013). These are a routine annual commitment by the Prescribing Advisory Team and can be a tool to identify and agree further hands on prescribing work within the practice.

- The use of ScriptSwitch to prompt prescribers to signpost and refer to SSW, NERS and the CPSSS. ScriptSwitch is a computerised prescribing decision support tool compatible with all the major GP clinical systems. It is used in primary care to deliver guidelines, local initiatives and formulary choices instantly. It works at the point at which a drug is prescribed by the GP system and automatically displays a recommendation. It is installed in every GP practice in Cwm Taf. The addition of messages to key medicines to encourage social prescribing was included to support the initiative.

Implementation methods are described in further detail in Appendix 6.

A review was planned after a period of six months to inform the continuation of the initiative.

3.4 Stop Smoking Wales

Stop Smoking Wales is a national health improvement programme funded and delivered by Public Health Wales.

SSW has two main functions:

- Provision of specialist smoking cessation support to people wishing to quit.
- Provision of brief intervention training for individuals who regularly come into contact with people who smoke.

Adult smokers who are motivated to quit smoking can contact SSW directly using a freephone number. Clients are offered a seven week treatment programme based on a withdrawal oriented treatment model. The service offers information on pharmacological aids but does not prescribe or supply pharmacological treatments. There is no fee to the client for attending SSW services.

Sessions are held weekly, on weekdays and early evenings, across various community based locations. In Cwm Taf, sessions are held in local community centres, GP surgeries, community health clinics, community halls and workplaces.

Not every person enrolling with SSW will stop smoking. Research has shown that smokers are four times more likely to give up with a support programme. Quit rates are published is the Stop Smoking Wales Annual Reports.

3.5 Community Pharmacy Stop Smoking Service

The Community Pharmacy Stop Smoking Service is a local enhanced service available to any adult smoker wishing to quit providing they meet the eligibility criteria for the service. There is no fee to the client for using the CPSSS.

The CPSSS was established in 2006 to:

- Improve access to, and choice of, smoking cessation services, including access and supply of nicotine replacement therapy (NRT), bupropion or varenicline are not available via the CPSSS.
- Assist in the delivery of local smoking cessation strategies
- Offer referral to specialist services where appropriate.
- Optimise the cost effectiveness of NRT prescribing.

The service consists of three levels of support:

- *Level 1*: Promotion of healthy lifestyles where community pharmacists encourage smokers to quit, provide advice and signpost patients to smoking cessation services. This activity may be opportunistic or as part of a local/national health promotion campaign. The level 1 service should be provided by every community pharmacy under the NHS Community Pharmacy Contract.

- *Level 2:* Supply and support to clients who are receiving smoking cessation advice from SSW. This level enables the community pharmacist to supply NRT in response to a referral for supply by SSW.

- *Level 3:* Assessment, initiation, supply and monitoring of NRT.

The CPSSS report quit rates to be approximately equivalent to quit rates reported by Stop Smoking Wales.

3.6 National Exercise Referral Scheme

National Exercise Referral Scheme is a national scheme funded by Public Health Wales and provided by the Welsh Local Government Association. The scheme targets clients who have a chronic disease or are at risk of developing chronic disease.

The aims of NERS are:

- To offer a high quality scheme across Wales.
- To increase the long term adherence of physical activity for clients.
- To improve physical and mental health of clients.

Prior to the introduction of NERS, some health boards commissioned exercise referral schemes as local services. NERS was introduced in Cwm Taf in 2009 where it replaced existing exercise referral schemes.

The scheme is available to any client, meeting the eligibility criteria of the service. Access is by GP referral using a NERS referral form. Following referral the client's health and physical activity is assessed by an exercise coordinator.

The exercise programme lasts 16 consecutive weeks consisting of two hourly supervised group sessions each week. The intention of NERS is that once clients start suitable physical activity they will continue after the 16 week programme. The sessions are usually run in local leisure or community centres. Clients are charged £1.50 per exercise session.

4 Methods

4.1 Period under study

This review covers the period 1 June 2013–31 December 2013. This covered the time of year when the Annual Prescribing Visits took place. Data was collected for the following periods:

- October 2012–December 2012 to use as a benchmark,
- 12-18 months prior to December 2013 to explore trends,
- 1 June –31 December 2013 with particular reference to 1 October– 31 December 2013 to identify any change resulting from the initiative.

4.2 GP practice activity

The initiative was designed to encourage social prescribing to be embraced as part of the wider prescribing advisory agenda and to become part of everyday activity. Prescribing advisors ceased opportunities to discuss social prescribing, smoking cessation and physical activity opportunities and services with GPs and practice staff whilst working in GP practices on their usual prescribing and medicines management priorities.

Prescribing advisors were asked to complete activity reports detailing the social prescribing activity and the time taken to do this for each GP practice visited. This enabled activity associated with the initiative to be identified and opportunity costs be calculated.

Activity was measured in half day sessions (3 hours). The reports recorded the planned actions, timescales agreed and methods proposed in supporting the actions. Activity reports were completed for 1 June-31 October 2013. The period 1 June-31 October 2013 covered the period when practices received their GP Prescribing Performance Review Report and Annual Prescribing Visit.

4.3 Service contacts

A 'contact' is defined as an individual who was scheduled to attend and attended at least one treatment/exercise session.

For the review data were collected on the initial 'contact' or enrolment with the service. This would measure the model being tested rather than the effectiveness of the service once the individual had enrolled. Data on the number of people attending and completing the programmes offered by the services were not collected nor analysed. Completion rates and success rates of the various services are however available.

Data were collected from the two NHS smoking cessation services provided in Cwm Taf, (SSW and CPSSS) and from NERS. Only SSW routinely report contact data.

Where appropriate data were converted to the same denominator, aggregated and standardised using GP practice list size.

4.3.1 Primary care stop smoking contacts

Data on the number of people enrolling with a smoking cessation service were collected from two main sources:

- Stop Smoking Wales
  - Quarterly Report (1 October - 31 December 2013)
  - Monthly Cwm Taf Health Board Reports (Oct 2012 – Dec 2013)
- CPSSS payment data-unpublished

Contact data from SSW were provided by WP practice code whilst CPSSS provide data by community pharmacy name and address. For SSW data was standardised by GP practice list size and presented as standardised by individual GP practices and GP cluster area. This enabled comparisons in SSW contact rates by GP practices and GP clusters.

Data from SSW and CPSSS was aggregated and standardised by GP practice list size and presented as standardised by individual GP practices and GP cluster area. This enabled comparisons in contact rates for combined smoking cessation services in Cwm Taf by GP practices and GP clusters.

4.3.2 National Exercise Referral Scheme contacts

Data on the number of people enrolling with NERS were collected from the NERS co-ordinators from two sources:

- The Rhondda Cynon database – unpublished
- The Merthyr Tydfil Scheme database - unpublished

Contact data from NERS were provided by GP practice name and locality which was converted to WP practice code. Data were aggregated to provide a Cwm Taf wide dataset. Contact data from NERS were standardised by GP practice list size and presented as standardised by individual GP practices and GP cluster area. This enabled comparisons in contact rates by GP practices and GP clusters.

4.4 Supply of pharmacotherapy

4.4.1 Primary care prescribing

Primary care prescribing data were retrieved from the Comparative Analysis System for Prescribing Audit (CAPSA) system. Data was collected and analysed for a basket of 31 different smoking cessation pharmacotherapies and one product used for the treatment of obesity. (Appendix 7)

4.4.2 Community pharmacy supply

Despite the establishment of a National Electronic Claim and Audit Form (NECAF) system to reimburse community pharmacy contractors who provide enhanced services, data regarding the supply of NRT via CPSSS,

is only available from January 2014. Data on NRT supplied via the CPSSS, to inform this review was therefore sourced locally from the health board.

4.4.3 Aggregated smoking cessation pharmacotherapy supply

Prescribing volume data and local supply data used for reimbursement of the community pharmacies providing the CPSSS is not collected in the same format and therefore datasets cannot be aggregated.

Data on the cost of smoking cessation pharmacotherapy was therefore used to examine the trends in supply of smoking cessation pharmacotherapy by the services in Cwm Taf.

4.5 ScriptSwitch data

Messages were added to the 31 smoking cessation pharmacotherapies and the one product used for the treatment of obesity.

- Stop smoking information messages stated '*Is the patient under a smoking cessation service (either via community pharmacy or Stop Smoking Wales)?'*

- The physical activity message stated '*Consider referral to National Exercise Referral Scheme using the appropriate form'*.

These formed part of wider clinical messages on the safety, use and guidelines for prescribing for these products already being given to prescribers via ScriptSwitch.

5 Results

5.1 GP practice activity

GP practices were visited by 8 different were members of the Prescribing Advisory Team during the study period.

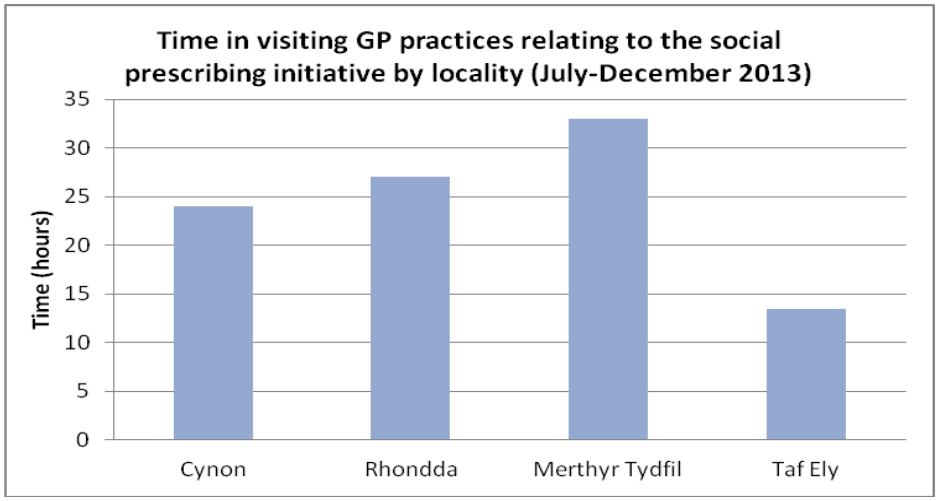
Activity reports were completed for 79% (n=38) of GP practices in Cwm Taf (Table 1). It is assumed that no activity took place in the 21% of GP practices with no activity record.

Table 1: Breakdown of activity reports completed for each locality

Area	No of practices with activity report	GP practices in locality
Cynon	5	12
Rhondda	15	15
Merthyr Tydfil	9	11
Taf Ely	9	10
Cwm Taf	38	48

The total time reported on the activity reports was 97.5 hours. This consisted of formal and informal visits and time working in the practices. The 97.5 hours were part of the prescribing advisors normal work allocation to the practice and was not additional to any time given to GP practices. Figure 1 illustrates the time reported for visiting GP practices by locality to discuss the social prescribing initiative**.**

Figure 1: Time reported for visiting GP practices by locality to discuss the social prescribing initiative (July–December 2013)



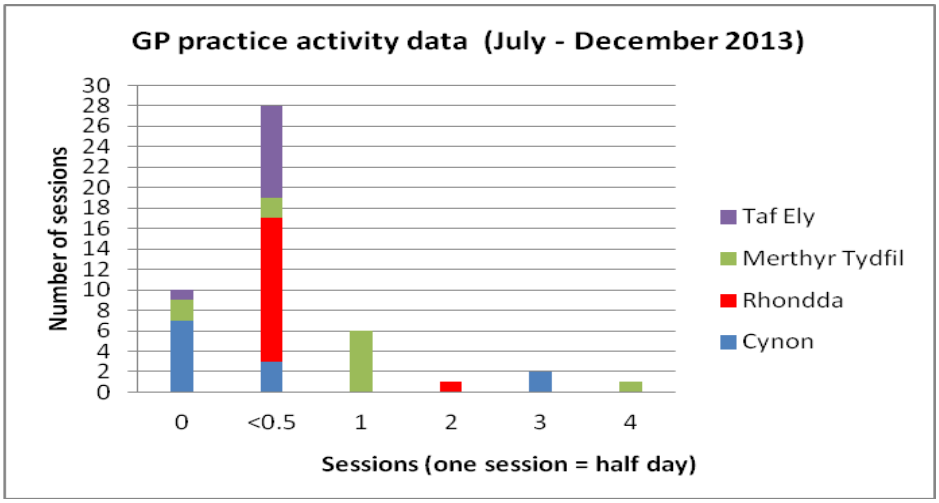
The activity reports indicate that there appeared to be variation in the time invested in visiting and discussing the social prescribing initiative across different localities and GP practices (Figure 1 and 2).

Ten GP practices were visited for one or more sessions (Table 2). Many GP practices were visited for less than one session i.e. less than a quarter of a working day (n=28) and 10 GP practices were not visited (Figure 2).

Table 2: GP practices visited for one session or more

Cynon	W95087, W95633
Rhondda	W95054
Merthyr Tydfil	W95290, W95028, W95005, W95647, W95032, W95086, W95023

Figure 2: Time spent visiting GP practices by locality (July – December 2013)



During the visits a number of key issues were commonly raised (Table 3). One GP practice may have discussed more than one topic during the visit.

Table 3: Commonly raised issues during visits to GP practices

Topic of discussion	No. of GP practices discussing each topic
READ codes	6
Material to give to patients	4
Tagging specific drugs	4
Key contacts (NERS)	3
Referral process (NERS)	3
Discuss with wider practice team	1
Waiting lists information (NERS)	1

The activity reports recorded the prescribing advisory work in GP practices in relation to the social prescribing initiative (Table 4). The most common form of work with the GP practices appeared to be practice meetings, many of which consisted of the Annual Prescribing Visit. Only once were the key slides that accompanied the toolkit used during a visit of the GP practices.

Table 4: Type of work carried out in practices by prescribing advisors

Type of practice work	No. of GP practices where work undertaken
Practice meeting	31
Individual GP meeting	8
Audit	4
ScriptSwitch	21
Patient clinic	1

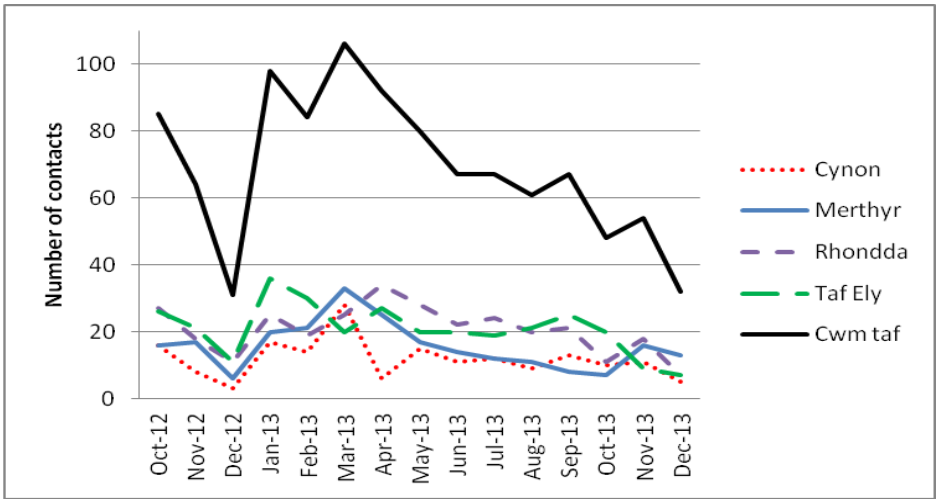
5.2 Service contacts

5.2.1 Primary care stop smoking activity data

5.2.1.1 Stop Smoking Wales

Figure 3 illustrates the trend in contacts with SSW over a 15 month period and in particular a downward trend reported since March 2013.

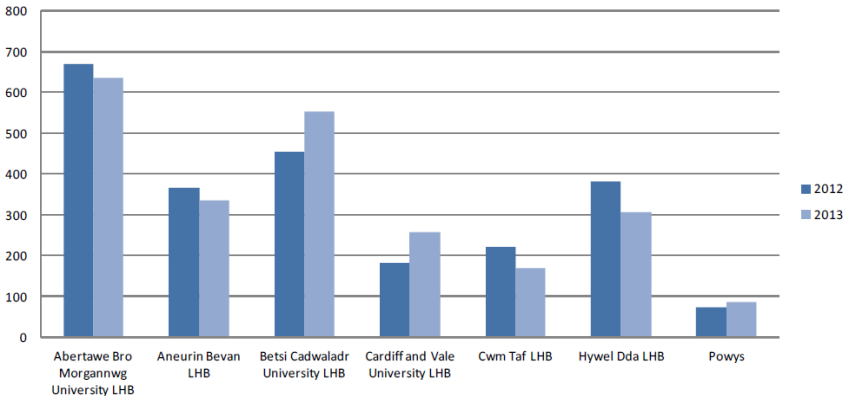
Figure 3: Contacts with Stop Smoking Wales by locality (October 2012–December 2013)



A similar downward trend in contacts with SSW has been reported for four of seven health boards in Wales over the same time period (Figure 4).

Figure 4: Contacts with Stop Smoking Wales by health board (1 October–31 December 2012 and 2013)

Source: Stop Smoking Wales Quarterly Report (1 October - 31 December 2013).



Note: Figure 4 illustrates all contacts made to SSW which includes those made from maternity and preoperative referral data whilst Figure 3 illustrates contacts made by GP practices only. Not all health boards illustrating a downward trend commission a CPSSS.

Table 5 illustrates contacts with SSW by locality and by health board.

Table 5: Contacts with Stop Smoking Wales by locality (1 October–31 December 2012 and 2013).

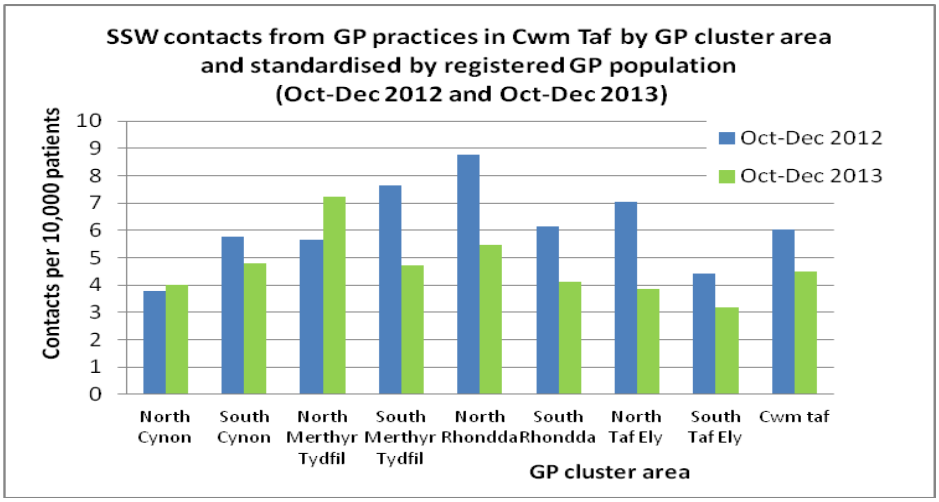
Area	No of GP practices in locality	Contacts with SSW		Change	No. of practices where contacts registered	
		Oct – Dec 2012	Oct – Dec 2013		Oct – Dec 2012	Oct – Dec 2013
Cynon	12	27	26	-1	7	10
Rhondda	15	56	36	-20	7	8
Merthyr Tydfil	11	39	36	-3	11	11
Taf Ely	10	58	36	-22	9	10
Cwm Taf	48	180	134	-46	36	39

Between 1 October 2013 and 31 December 2013 there were 134 contacts with SSW made from GP practices compared with 180 for the same quarter the previous year (Oct-Dec 2012). This represents a reduction in contacts by 25%. There appears to be an overall decrease in the number of contacts with SSW for all localities across Cwm Taf when comparing quarters 1 October–31 December 2012 and 2013.

Data reported by SSW indicate that contacts with the service for 1 October–31 December 2013 were drawn from all GP practices in Merthyr Tydfil and Taf Ely and only a proportion of GP practices in the Cynon and Rhondda localities (Table 5).

Figure 5 illustrates contacts with SSW by GP cluster area, standardised by registered GP population.

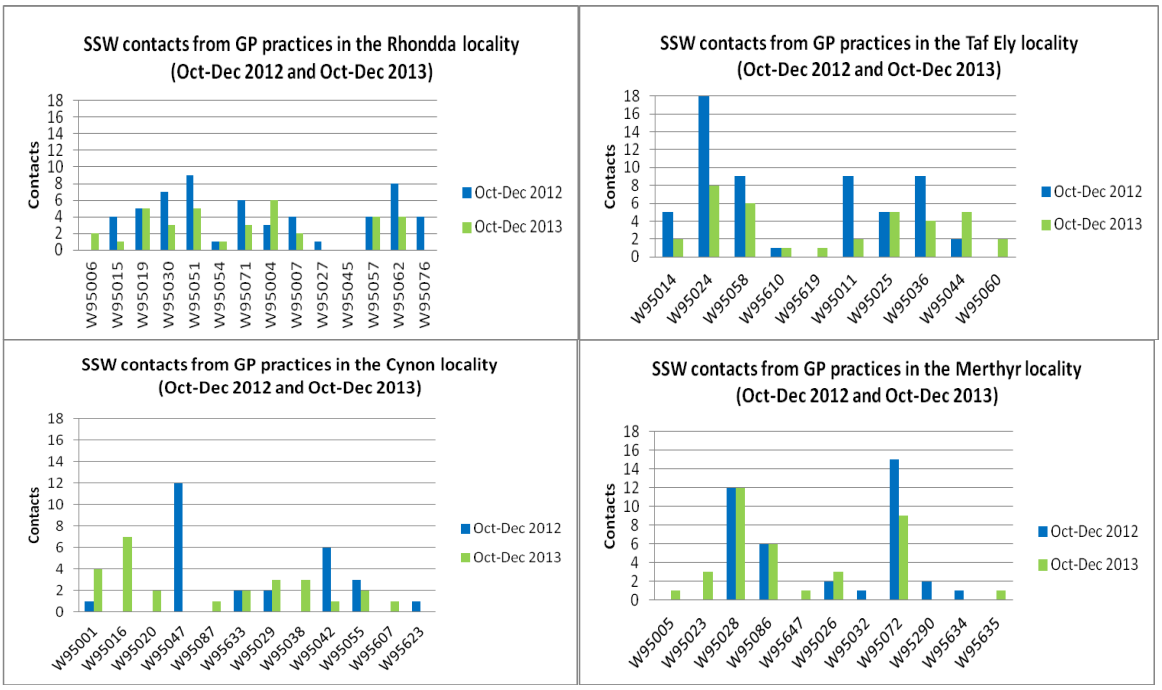
Figure 5: Contacts with Stop Smoking Wales by GP cluster area (1 October–31 December 2012 and 2013)(standardised by registered GP population)



The standardised data indicates an increase in GP practice rate of referal to SSW for the north Merthyr Tydfil locaility only for 1 October–31 December 2012, compared with the same quarter for 2013 (Figure 5).

Figure 6 illustrates contacts with SSW by individual GP practice within each locality and the variation in contact rate between practices and localities.

Figure 6: Contacts with Stop Smoking Wales by GP practice by locality (1 October–31 December 2012 and 2013)

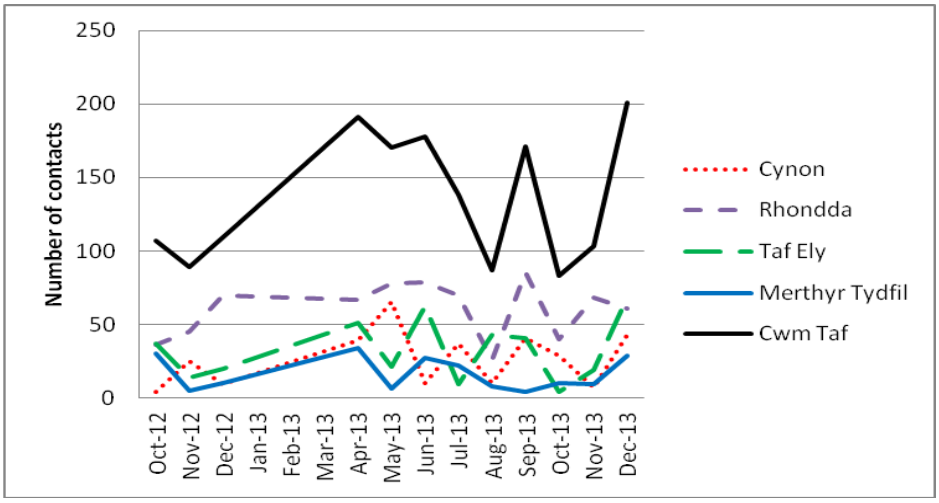


SSW report an increase the number of contacts for some practices compared with the same quarter the previous year and a reduction in others. There does not appear to be an association between the GP practices having additional support from the prescribing advisors and an increase in reported contacts with SSW registered at those practices.

5.2.1.2 Community Pharmacy Stop Smoking Service

Figure 7 illustrates the trend in contacts with the CPSSS over a 15 month period.

Figure 7: Contacts with the Community Pharmacy Stop Smoking Service by locality (October 2012–December 2013)



The CPSSS is provided by 40% (n=31) community pharmacies in Cwm Taf. The availability of the service is presented in Table 6.

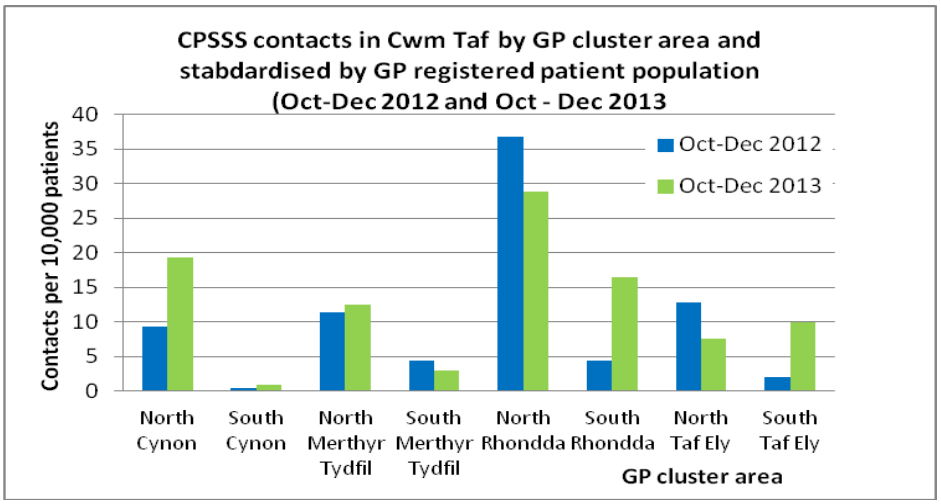
Table 6: Contacts with the Community Pharmacy Stop Smoking Service by GP cluster area (1 October–31 December 2012 and 2013).

Area	Pharmacies providing CPSSS	CPSSS contacts		Change
		Oct – Dec 2012	Oct – Dec 2013	
Cynon North	3	37	77	+40
Cynon South	1	1	2	+1
Cynon TOTAL	**4**	**38**	**79**	**+41**
Rhondda North	7	134	105	-29
Rhondda South	2	17	64	+47
Rhondda TOTAL	**9**	**151**	**169**	**+18**
Taff North	6	60	35	-25
Taff South	4	11	56	+45
Taff TOTAL	**10**	**71**	**91**	**+20**
Merthyr North	5	36	40	+4
Merthyr South	3	12	8	-4
Merthyr TOTAL	**8**	**48**	**48**	**0**
Cwm Taf TOTAL	**31**	**308**	**387**	**+79**

Between 1 October 2013 and 31 December 2013 there were 387 contacts reported with the CPSSS compared with 308 for the same quarter the previous year. This represents an increase in contacts by 21%. With the exception of Merthyr south, all clusters in Cwm Taf reported an increase in the number of contacts with the CPSSS over the study period.

Figure 8 illustrates contacts with the CPSSS by GP cluster area, standardised by registered GP population.

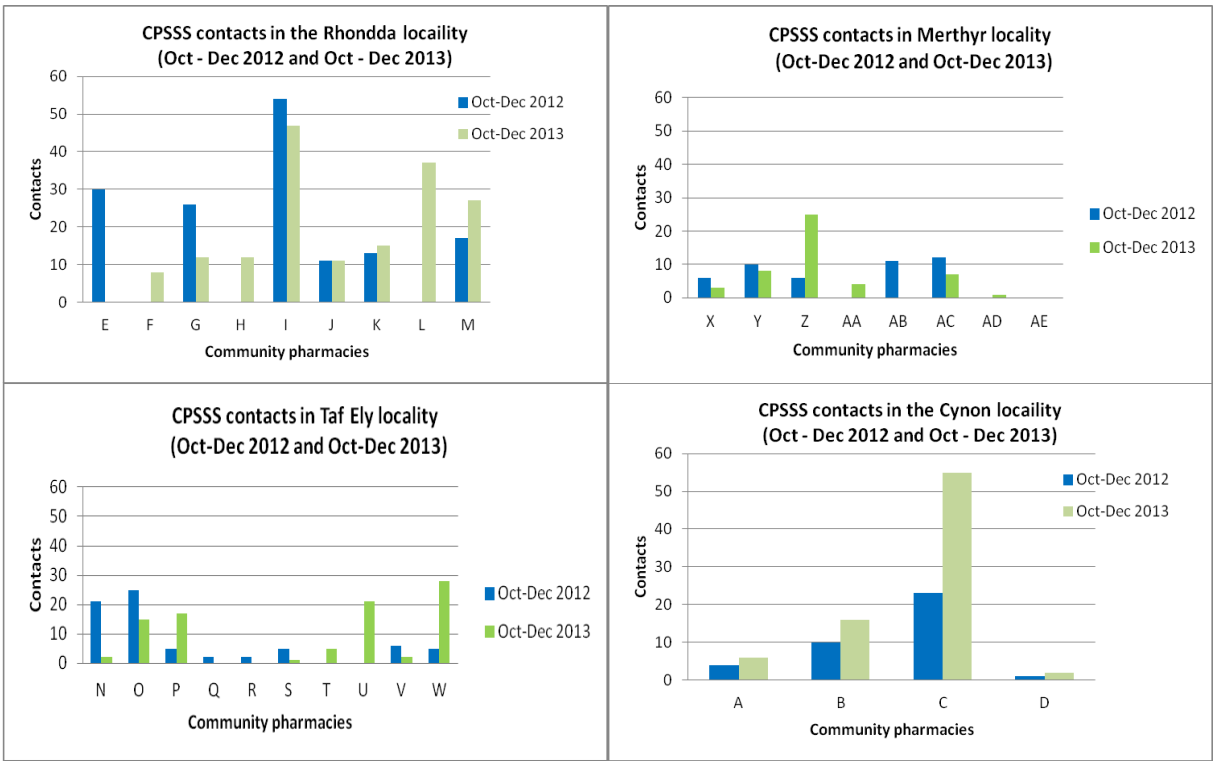
Figure 8: Contacts with the Community Pharmacy Stop Smoking Service by GP cluster area (1 October–31 December 2012 and 2013)(standardised by registered GP population)



The standardised data for 1 October–31 December 2012 and the same quarter for 2013, indicates an increase in the rate of contacts with CPSSS for 5 of the 8 cluster areas (Figure 8).

Figure 9 illustrates contacts with individual pharmacies of the CPSSS within each locality and indicates the variation in contact rates between pharmacies and localities.

Figure 9: Contacts with the Community Pharmacy Stop Smoking Service by locality (1 October–31 December 2012 and 2013)



Some community pharmacies increased the number of contacts compared with the same quarter the previous year and others reported a reduction for the same period.

There does not appear to be an association between the GP practices with additional support from the prescribing advisors and the increase in reported contacts with the CPSSS in the same cluster areas.

5.2.1.3 All contacts with smoking cessation services

Figure 10 illustrates the trend in contacts with the Cwm Taf smoking cessation services over a 15 month period.

Figure 10: Trend in contacts with NHS smoking cessation services in Cwm Taf (October 2012–December 2013)

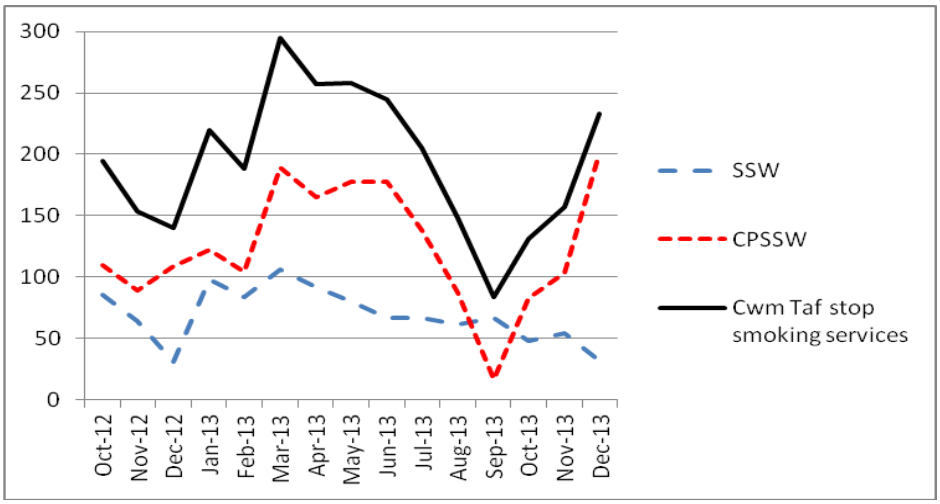


Table 7 illustrates aggregated data by cluster.

Table 7: Contacts with NHS smoking cessation services in Cwm Taf by GP cluster area (1 October–31 December 2012 and 2013)

Area	No of contacts with SSW		No. Of contacts with CPSSS		Total number of contacts	
	Oct – Dec 2012	Oct – Dec 2013	Oct – Dec 2012	Oct – Dec 2013	Oct – Dec 2012	Oct – Dec 2013
Cynon North	15	16	37	77	52	93
Cynon South	12	10	1	2	13	12
Cynon TOTAL	**27**	**26**	**38**	**79**	**65**	**105**
Rhondda North	32	20	134	105	166	125
Rhondda South	24	16	17	64	41	80
Rhondda TOTAL	**56**	**36**	**151**	**169**	**207**	**205**
Taff North	33	18	60	35	93	53
Taff South	25	18	11	56	36	74
Taff TOTAL	**58**	**36**	**71**	**91**	**129**	**127**
Merthyr North	18	23	36	40	54	63
Merthyr South	21	13	12	8	33	21
Merthyr TOTAL	**39**	**36**	**48**	**48**	**89**	**84**
Cwm Taf	**180**	**134**	**308**	**387**	**488**	**521**

An increase of 6.7% (n=33) in the number of contacts accessing Cwm Taf smoking cessation is observed for 1 October – 31 December 2013 compared to the same period the previous year.

Figure 11 illustrates the change in contacts with NHS smoking cessation services in Cwm Taf for 1 October – 31 December 2013 compared to the same period the previous year.

Figure 11: Contacts with NHS smoking cessation services in Cwm Taf (1 October–31 December 2012 and 2013)

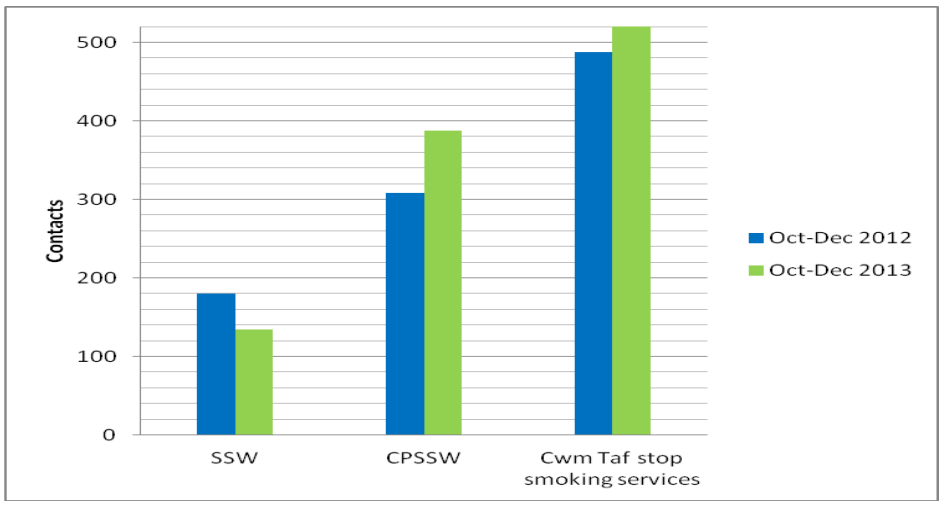
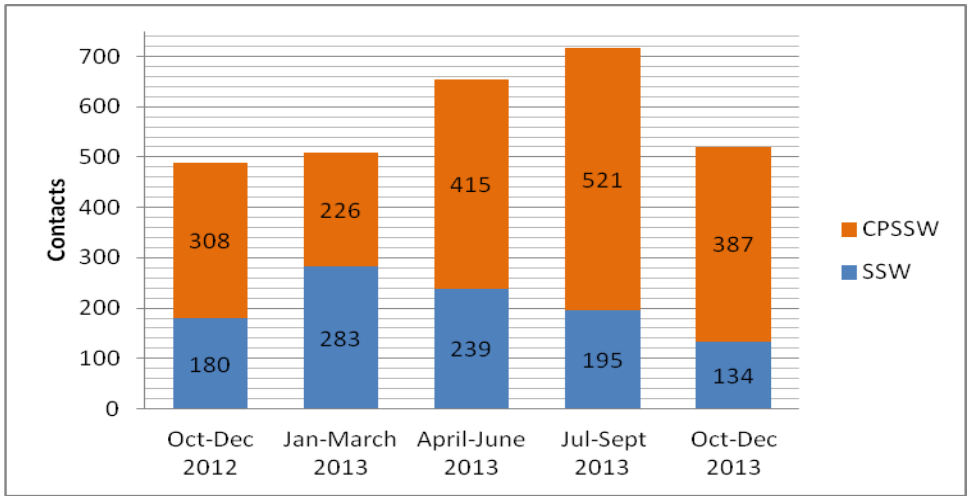


Figure 12 illustrates the reduction in contacts with SSW and the increase in contacts by CPSSS since 1 October 2012.

Figure 12: Trend in contacts with NHS smoking cessation services in Cwm Taf by quarter (1 October 2012-31 December 2013)

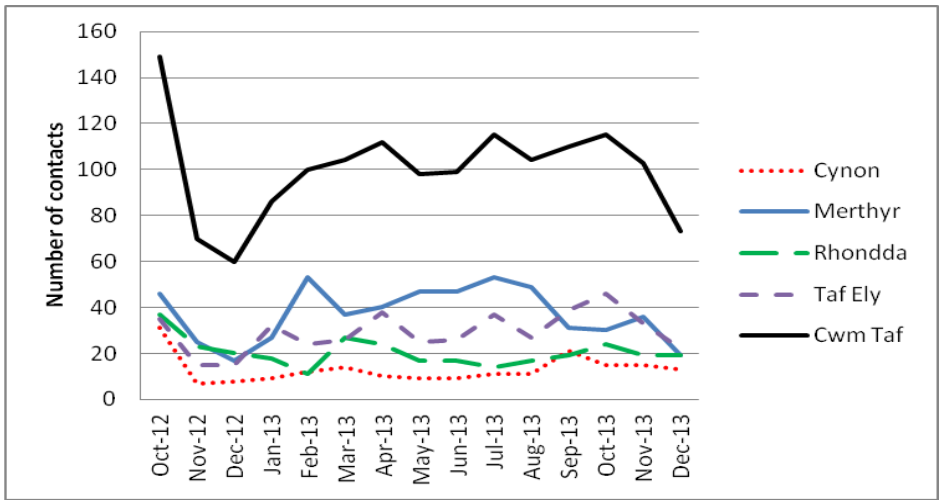


Where SSW appear to have reported a reduction in the number of contacts accessing the service for quarter 1 October -31 December 2013, compared with the same quarter the previous year (n=-46), the CPSSS has reported an increase in the number of smokers accessing this service for the same period (n=79) (Table 7 and Figure 11). The net result being a slight increase in contacts accessing smoking cessation services in Cwm Taf (n=33) for the study period (Figure 11 and 12).

5.2.2 National Exercise Referral Scheme contact data

Figure 13 illustrates the trend in contacts with NERS over a 15 month period.

Figure 13: Trend in contacts with the National Exercise Referral Scheme by locality (1 October 2012–31 December 2013)



Between, 1 October–31 December 2013 there was an increase in contacts with NERS compared with the same quarter the previous year (Figure 13).

Data is not routinely available or published across Wales it is therefore not possible to compare NERS contacts across health boards.

Table 8 illustrates contacts with NERS by locality.

Table 8: Contacts with the National Exercise Referral Scheme by locality (1 October-31 December 2012 and 2013)

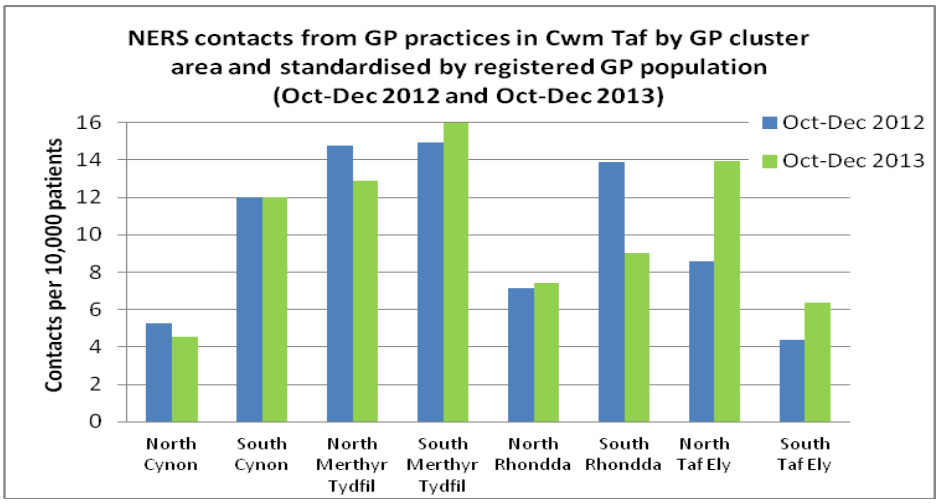
Area	No of GP practices in locality	Contacts with NERS		Change
		Oct – Dec 2012	Oct – Dec 2013	
Cynon	12	46	43	-3
Rhondda	15	80	62	-18
Merthyr Tydfil	11	88	85	-3
Taf Ely	10	65	101	+36
Cwm Taf	48	279	291	+12

Between, 1 October–31 December 2013 there were 291 contacts with NERS compared with 279 for the same quarter the previous year. This represents a slight increase in the number of contacts by 4.3% (n=12)

During the study period, only the Taf Ely locality reported an increase in the number of contacts with NERS. A reduction in NERS contacts was reported for the other 3 localities (Table 8).

Figure 14 illustrates contacts with NERS by GP cluster area, standardised by registered GP population.

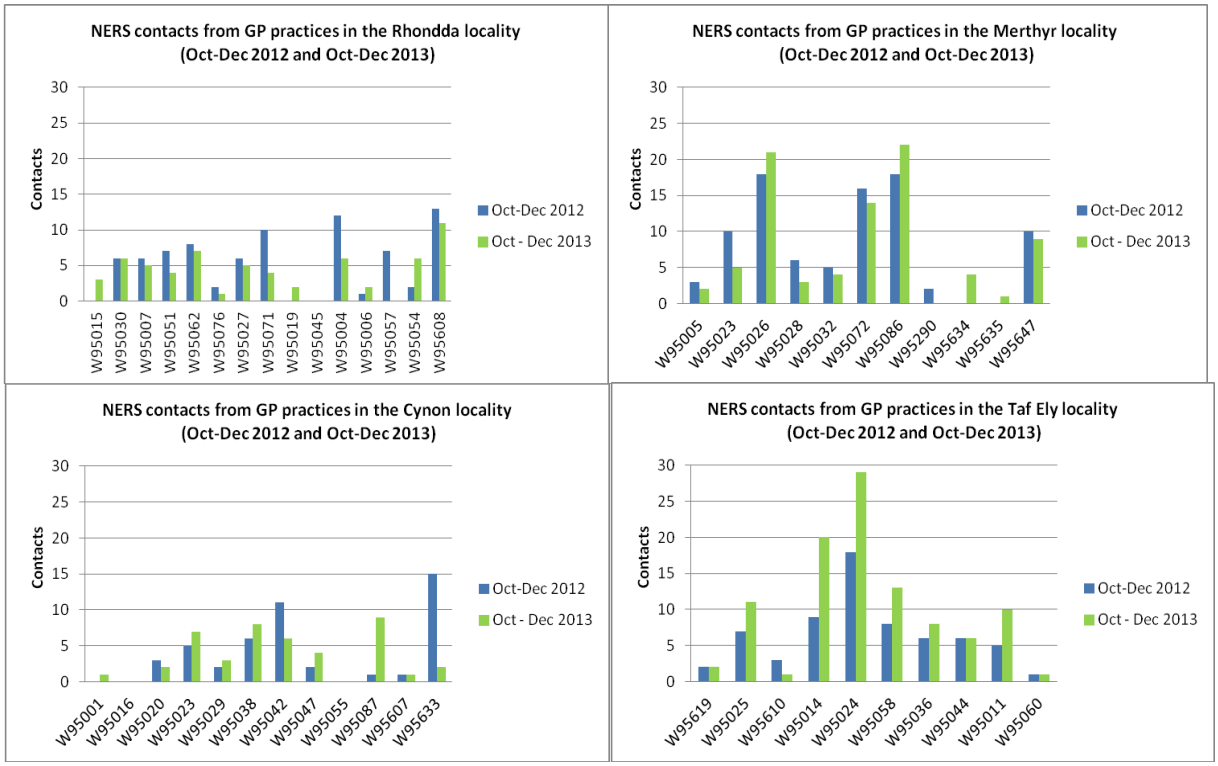
Figure 14: Contacts with the National Exercise Referral Scheme by GP cluster area (1 October–31 December 2012 and 2013)(standardised by registered GP population)



The standardised data for 1 October–31 December 2012 and the same quarter for 2013, indicates an increase in GP practice rate of referal to NERS for the south Merthyr, north Rhondda and north and south Taf Ely locailities (Figure 14).

Figure 15 illustrates contacts with NERS within each locality and indicates the variation in contact rates between GP practices and localities.

Figure 15: Contacts with the National Exercise Referral Scheme by locality (1 October–31 December 2012 and 2013)



Contacts with NERS arose from all GP practices in Taf Ely and only a proportion of GP practices in Merthyr Tydfil, Cynon and Rhondda localities for 1 October–31 December 2013. Within each locality, some GP practices reported an increase in referrals whilst others a reduction over the study period (Figure 15). There does not appear to be an association between the GP practices with additional support from the prescribing advisors and an increase in contacts reported with NERS.

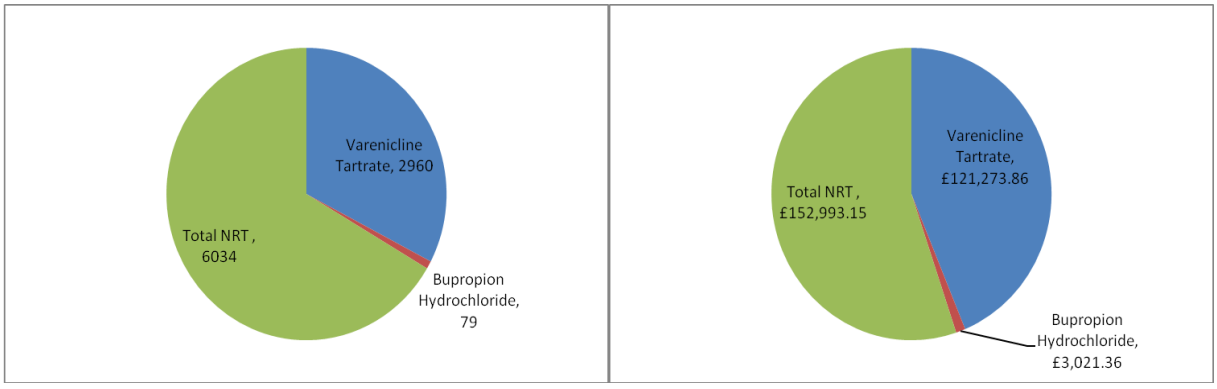
5.3 Supply of pharmacotherapy

5.3.1 Smoking cessation pharmacotherapy

5.3.1.1 Prescription volume and cost

Figure 16 illustrates the prescribing of smoking cessation pharmacotherapy by product group and presented as items and cost.

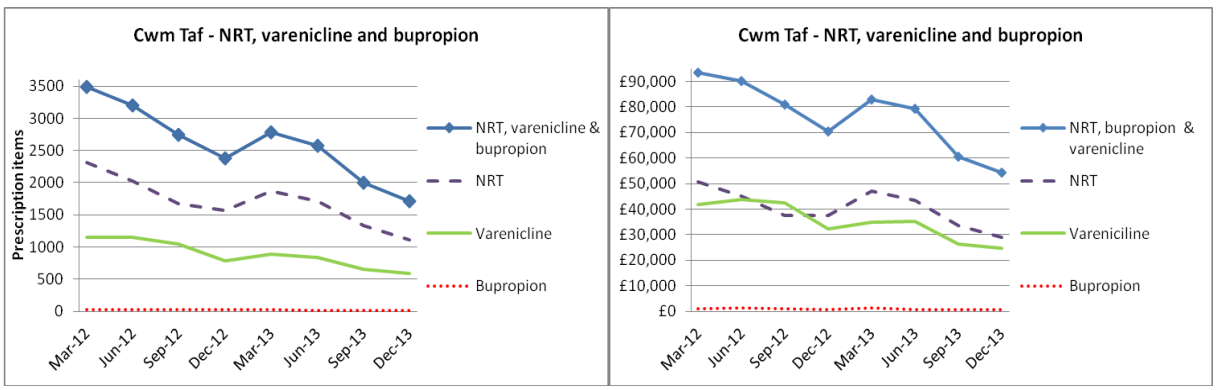
Figure 16: Breakdown of items and cost of smoking cessation pharmacotherapy supplied by NHS prescription in Cwm Taf (1 January–31 December 2013)



Between, 1 January 2013 to 31 December 2013, primary care prescribers supplied 9073 prescriptions for smoking cessation pharmacotherapy (66% for NRT products, 32% for vareniciline and 1% for bupropion) at a total cost of £347,869 (Figure 16).

Figure 17 illustrates the trend in the number of prescription items and associated cost for NRT products, bupropion and varenicline.

Figure 17: Trend in prescription items and cost of smoking cessation pharmacotherapy by quarter (1 March 2012–31 December 2013)



A general downward trend in the number of prescription items and associated cost for NRT products, bupropion and varenicline was observed since March 2012.

Table 9 presents prescription items for quarter 1 October – 31 December 2013 and the same quarter the previous year.

Table 9: Prescription items for smoking cessation pharmacotherapy by locality (1 October–31 December 2012 and 2013)

Area	Prescription items for smoking cessation pharmacotherapy		Change
	Oct – Dec 2012	Oct – Dec 2013	
Cynon	637	440	197 (-31%)
Rhondda	694	458	236 (-34%)
Merthyr Tydfil	446	281	165 (-37%)
Taf Ely	601	531	70 (-12%)
Cwm Taf	2378	1710	668 (-28%)

Comparing the quarter data for 1 October–31 December 2013 with the same period the previous year, there appears to be a reduction in the number of prescription items for smoking cessation pharmacotherapy by 668 items (28%) (Table 9).

The reduction in prescribing of smoking cessation pharmacotherapy was observed in all localities in Cwm Taf with the greatest reduction reported for Merthyr Tydfil (Table 9, Figure 18).

Figure 18: Prescription items for cost of smoking cessation pharmacotherapy by locality for (1 October–31 December 2012 and 2013)

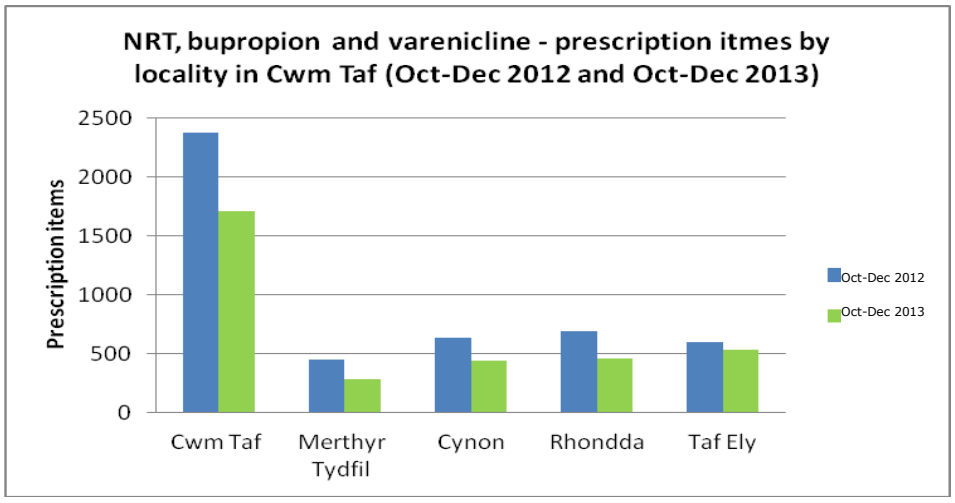
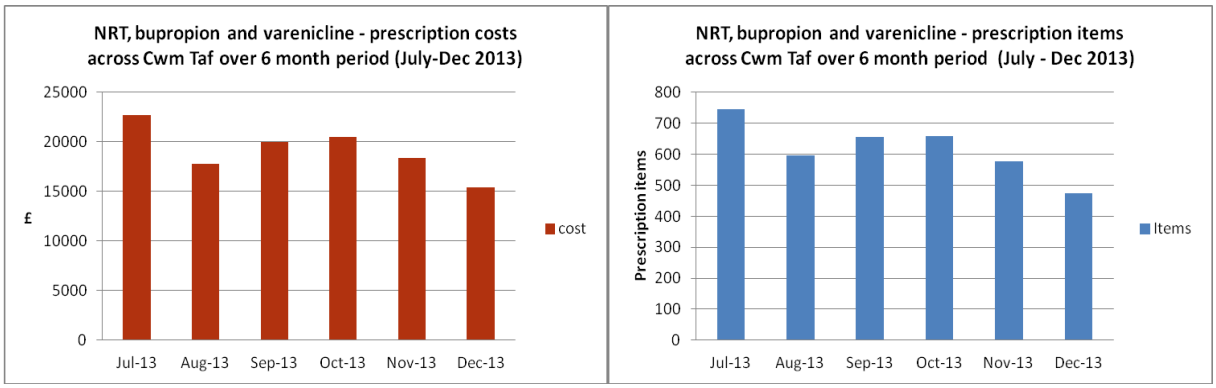


Figure 19 illustrates the trend in prescription items and cost of smoking cessation pharmacotherapy over the study period.

Figure 19: Prescription items and cost of smoking cessation pharmacotherapy (1 July–31 December 2013)



Note: When presented as items per 1000 PUs the graphs are identical

The downward trend in prescribing of smoking cessation pharmacotherapy is consistent with the timescales of the project, 1 October–31 December 2013 (Figure 19).

A similar downward trend was observed for the cost of the prescription items indicating a reduction in prescribing cost of £16,327 per quarter over the study period.

5.3.1.2 Community Pharmacy Stop Smoking service supply of NRT

Using cost as a denominator to measure of supply, Figure 20 illustrates the trend in cost of NRT supplied via the CPSSS since April 2012.

Figure 20: Trend in cost of NRT supplied through the Community Pharmacy Stop Smoking Service (1 April 2012–31 December 2013)

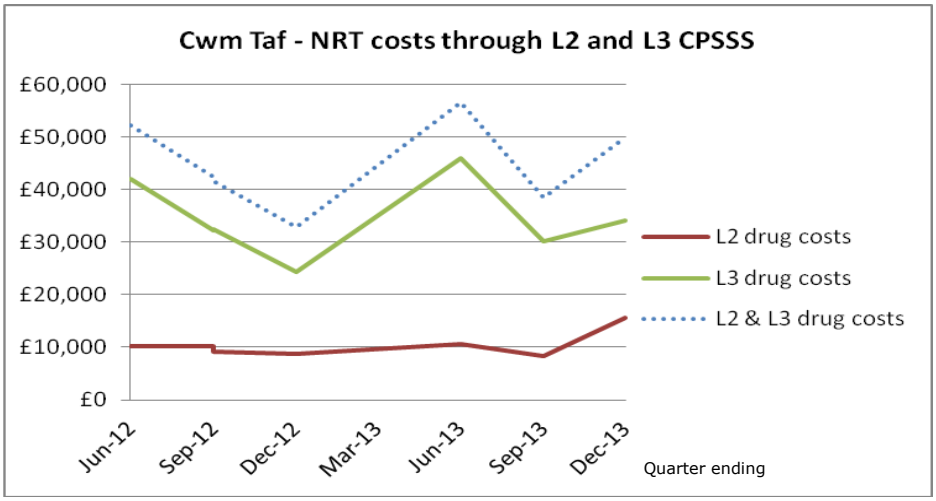


Table 10 presents the cost of NRT supplied by the Community Pharmacy Stop Smoking Service by locality.

Table 10: Cost of NRT supplied by the Community Pharmacy Stop Smoking Service by locality (1 October–31 December 2012 and 2013)

Area	Cost of NRT supply £		Change
	Oct – Dec 2012	Oct – Dec 2013	
Level 2	8,649	15,687	+7,038 (81%)
Level 3	24,224	34,172	+9,948 (41%)
Cwm Taf total	32,873	49,859	+16,986 (52%)

Comparing the quarter data for 1 October–31 December 2013 with the same period the previous year, there appears to be an overall increase in the cost of supply of NRT through the CPSSS by 52% (Table 10).

The cost of NRT increased for both the L2 and L3 CPSSS but was greater for the level 2 service (81%) compared with the level 3 service (41%). Overall costs of NRT via the L3 service was twice that for the L2 service (L3 =£34,172 and L2=£15,687).

Cost of supply of NRT through the CPSSS was not available by locality.

5.3.1.3 Combined supply of smoking cessation pharmacotherapy

Using cost of smoking cessation pharmacotherapy as a marker of supply, there appears to be a downward trend observed since April 2012 (Figure 21).

Figure 21: Trend in cost of smoking cessation pharmacotherapy (1 April 2012–31 Dec 2013)

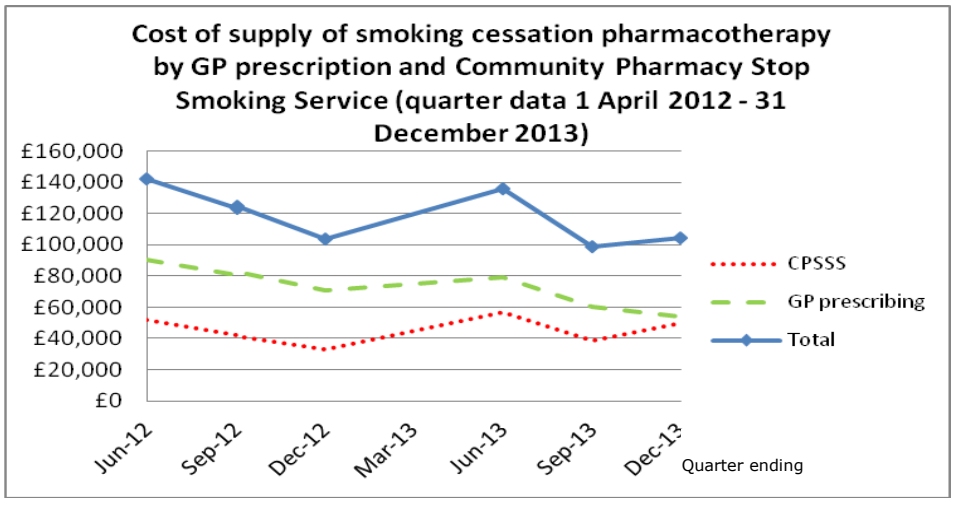


Table 11 illustrates data for 1 October–31 December 2013 with the same period the previous year.

Table 11: Cost of smoking cessation pharmacotherapy by service (1 October–31 December 2012 and 2013)

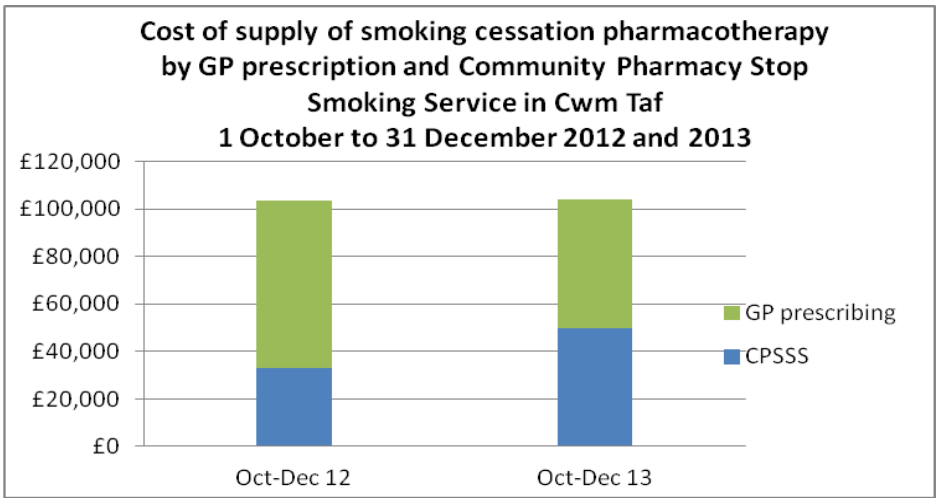
Area	Cost of smoking cessation pharmacotherapy £		Change
	Oct – Dec 2012	Oct – Dec 2013	
CPSSS	32872	49859	+16,987 (+52%)
GP prescribing	70581	54253	-16,328 (-23%)
Cwm Taf Total	103453	104111	+658 (+0.6%)

There appears to be a small increase in cost of 0.6% (£658)(Table 11). Data indicates an increase in the cost of NRT supplied through the CPSSS by 52% and a 23% decrease in cost via GP prescribing.

No significant changes in product costs have been identified over the study period, but caution is needed in interpreting the results due to the possibility of small fluctuations in product costs.

Figure 22 illustrates the breakdown of cost of supply of smoking cessation pharmacotherapy by GP prescribing and the supply by the CPSSS

Figure 22: Trend in cost of smoking cessation pharmacotherapy by service (1 October–31 December 2012 and 2013)



The overall cost of smoking cessation pharmacotherapy by appears to have increased marginally. The supply of smoking cessation products via the CPSSS appears to have increased to the same extent that GP prescribing has decreased.

5.3.2 Drugs for the treatment of obesity

5.3.2.1 Prescription volume and cost

Between, 1 January 2013 to 31 December 2013, primary care prescribers supplied 3417 prescriptions for orlistat at a cost of £113,200.

Figure 23, 24 and table 12 illustrate a reduction in the trend in the number of prescription items and associated cost for orlistat since January 2012 and over the study period.

Figure 23: Trend in prescription items and cost of orlistat (1 March 2012–31 December 2013)

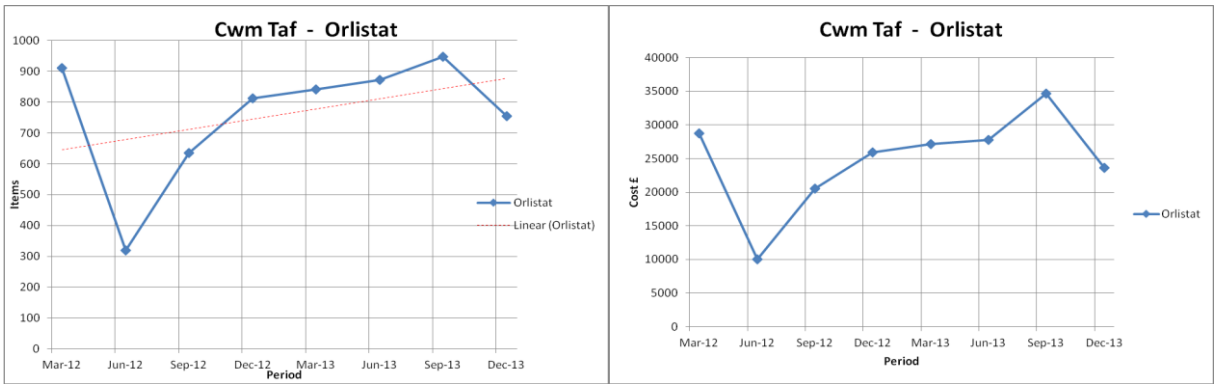


Figure 24: Trend in prescription items and cost of orlistat (1 July–31 December 2013)

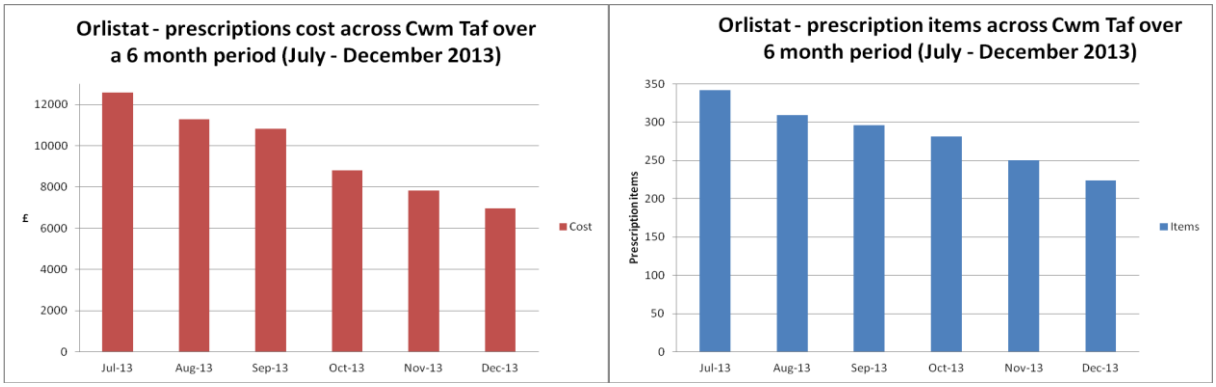


Table 12: Prescription items for orlistat by locality (1 October–31 December 2012 and 2013).

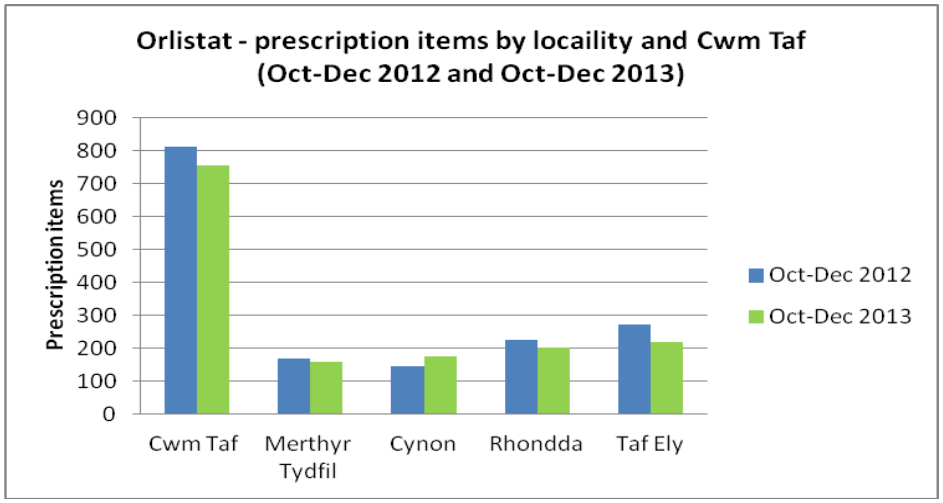
Area	Prescription items for orlistat		Change
	Oct – Dec 2012	Oct – Dec 2013	
Cynon	145	175	+30
Rhondda	226	202	-24
Merthyr Tydfil	168	159	-9
Taf Ely	273	219	-54
Cwm Taf	812	755	-57

There appears to be a reduction in the number of prescription items for orlistat by 57 items for 1 October–31 December 2013, compared with the same period the previous year (Table 12).

Prescribing costs reduced by £2357 between 1 October–31 December 2013 (Figure 24). Projected savings if this trend continued could be approximately £10,000 for a 12 month period.

The reduction in prescribing of orlistat was observed in the Rhondda, Merthyr Tydfil and Taf Ely localities (Table 12, Figure 25).

Figure 25: Prescription items for orlistat by locality (1 October–31 December 2012 and 2013)



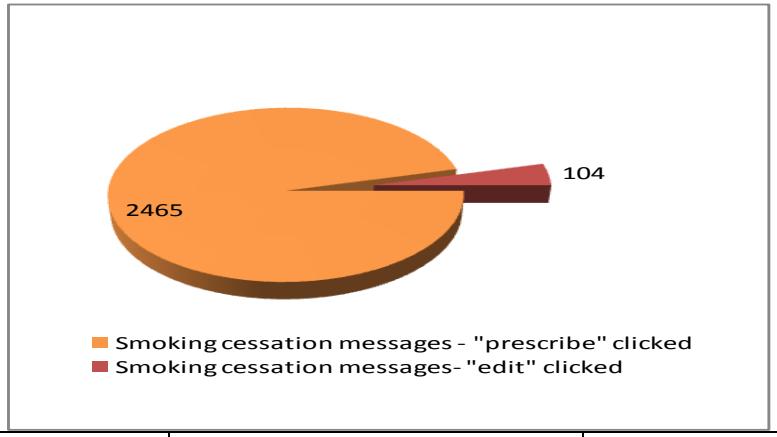
5.4 ScriptSwitch

5.4.1 Nicotine replacement therapy, bupropion and varenicline

The stop smoking information message was added to 31 Nicotine Replacement Therapies in August 2013. (Appendix 7)

Figure 26 presents the number of ScriptSwitch smoking cessation messages over the study period.

Figure 26: ScriptSwitch smoking cessation messages to prescribers (1 August 2013-31 January 2014)



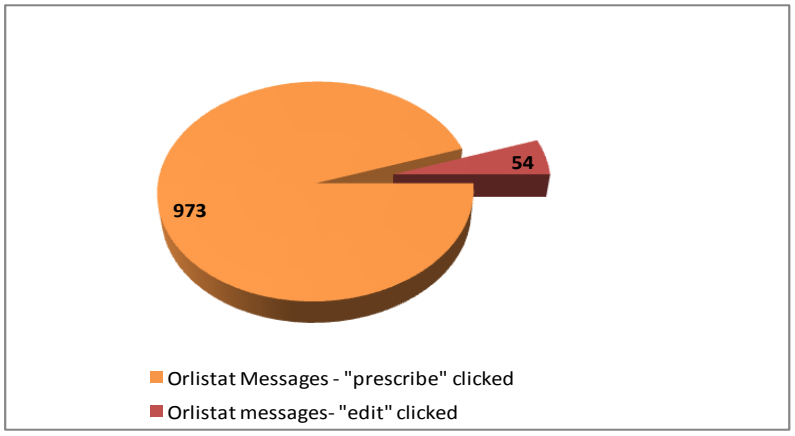
ScriptSwitch software reminded prescribers on 2569 occasions over a 6 month period (1 August 2013 and 31 January 2014), to check that the patient being prescribed the NRT was enrolled with a smoking cessation service (Figure 26). For 95% of the time the prescriber continued to write a prescription but on 104 occasions another action may have been taken.

5.4.2 Orlistat

The physical activity information message was added to orlistat (Xenical); the only medicine recommended for the treatment of obesity.[7]

Figure 27 presents the number of ScriptSwitch orlistat messages over the study period.

Figure 27: ScriptSwitch orlistat messages to prescribers (1 August 2013-31 January 2014)



ScriptSwitch software reminded prescribers on 1027 occasions, over a 6 month period (1 August 2013 and 31 January 2014), to check that the patient being prescribed the NRT was enrolled with a smoking cessation service (Figure 27). For 95% of the time the prescriber continued to write a prescription but on 54 occasions another action may have been taken.

6 Limitations

- Implementation of the initiative began in June 2013. This review has identified that the first three months of the work consisted mainly of practices visits. The majority of the practice work occurred at the end of 2013, providing only 3 months of activity to review. It is possible that this review has been conducted too early to identify changes arising from the initiative and any longer term impact of this work.

- The routes of entry to the health improvement services under study vary. Access to SSW is by self referral via a freephone number, the CPSSS is dependent on patients approaching the community pharmacy themselves whilst access to NERS requires a signed referral form by the GP. Contact data of the various services under study therefore should be used only as a crude measure of the number of people enrolling with a service and does not always reflect GP practice referral, signposting or brief intervention behaviour.

- Care needs to be taken when studying contacts by GP practice as this does not always arise from either GP referrals or signposting. Conversely every referral or signpost to a service may not convert to a patient enrolling on a programme despite GPs best efforts.

- The review used data from a range of sources, some of which are either published and / or available from national databases or routinely reported. It was necessary for some data to be collected locally. Although believed to be correct, the quality and quality assurance of the locally collected data cannot be verified.

- Data is not always a format that can easily be aggregated. This is particularly relevant when analysing GP prescribing data and supplies of smoking cessation products from pharmacies.

- The data used to analyse activity of each health improvement service included only those contacts identified by GP practice. Data did not include contacts arising from secondary care signposting or referral such as maternity and pre-operative services to referral to SSW and cardiac rehabilitation services referral to NERS. This report focussed on primary care (GP) referrals and signposting and has not attempted to describe the full extent of contacts with the various services and from where the contacts have arisen.

- The focus of the usual work of the Prescribing Advisory Team is on prescribing and management of traditional medicines. Although the headcount of the prescribing team appear to be large in numbers, care should be taken in interpreting the capacity and structure of the Prescribing Advisory Team and the existing prescribing priorities and cost pressures the team are being asked to deliver. Many members of the team provide sessional and part time work.

- The initiative was developed with support mainly from a Consultant in Pharmaceutical Public Health. Occasional support was also provided by the Local Public Health Team, SSW and NERS advisors and co-ordinators. No budget or resources were identified to implement the project.

7 Discussion

This review used a number of data sources to assess the first six months of a social prescribing initiative designed to test the following:

- How best to increase appropriate brief interventions and social prescribing to non-pharmacological public health interventions and health improvement programmes in primary care?

- If brief interventions and social prescribing of non-pharmacological public health interventions in primary care have an effect in reducing the GP prescribing budget?

7.1 GP practice activity and referrals

Activity reports provided information about the time ascribed to this initiative over the study period. The initiative was designed to encourage social prescribing to be embedded as part of the wider prescribing advisory agenda and to become part of everyday activity. This may be the reason that only limited activity was reported on the activity reports.

It appears that the GP Prescribing Performance Review Report and Annual GP Prescribing Visit was the main method used to discuss smoking cessation and physical activity with the GP practices. Only a small number of practices were reported to have had additional input (n=10) over and above the Annual GP Prescribing Visit. Practices in Merthyr Tydfil locality appear to have been given approximately twice the amount of time of those in Taf Ely.

Detailed analysis of the activity reports and contact data from the health improvement services under study, does not suggest a strong link between the time spend in practice and the increase in contacts with any of the services.

Findings indicate:

- Additional prescribing support given to three GP practices in Merthyr Tydfil may account for the increase in contact with the CPSSS in that locality and increase in contact with SSW reported in the north Merthyr Tydfil cluster. However this would not explain the decrease in contacts with NERS reported for the same practices.

- Additional prescribing support given to two GP practices in the north Cynon cluster may account for an increase in contacts with the NHS smoking cessation services and NERS for those practices.

- Some practices with no activity reported or limited support had the greatest increases in reported contacts by SSW and NERS.

7.2 Contact with services

7.2.1 Smoking cessation services

The number of contacts with SSW across Cwm Taf appears to have decreased by approximately 25% when comparing the study period with the same period the previous year. A gradual decline has been observed since March 2013 across all localities. The general downward trend in the number of contacts with SSW was also reported for a number of other health boards in Wales; in particular those without a complimentary CPSSS. When data is standardised to take into account populations, an increase in the number of contacts with SSW is reported for practices in the Merthyr Tydfil (north) cluster area only. The reason for the overall decline in contacts with SSW cannot be easily explained. Neither can the reason that for some practices in Merthyr Tydfil there appears to have been an increase in contacts with SSW. These require further investigation. Consideration also should be given to the impact the CPSSS has on contacts with SSW.

Converse to the downward trend in contacts accessing SSW, the CPSSS appears to have increased the number of contacts using the service. The increase in contacts has not been consistent with large fluctuations reported over the last 2 years. The increasing trend in contacts with the CPSSS is observed across all localities in Cwm Taf irrespective of the number of pharmacies providing the service.

Aggregated data indicates that the total number of contacts with NHS smoking cessation services (SSW and CPSSS) in Cwm Taf has increased by 6.7% (n=33) over the study period, compared with the same period the previous year. This suggests that the model under study may in some part increase appropriate brief interventions and social prescribing to non-pharmacological public health interventions and health improvement programmes in primary care. Whether this increase is a result of the initiative is to be debated. Other efforts are also being made locally to increase footfall with all NHS smoking cessation services in order to achieve the Welsh Government target.

As the initiative is in its earliest stage and minimal formalised effort has been attributed to the initiative, a further increase in contacts may be observed as the project progresses. It is likely however the small increase in contacts to date will have little large scale impact on a population basis.

7.2.3 National Exercise Referral Scheme

There appears to be a general downward trend in contacts with NERS since September 2013. This may be explained by seasonal variation as a similar downward trend was observed October–December 2012.

The number of contacts with NERS over the study period indicates a slight overall increase by 4.3% (n=12) compared to the same period the previous year. Taf Ely was the only locality however reporting an increase in the number of contacts with NERS over the study period. This can be attributed to the large increase in contacts with NERS by one practice in Taf Ely in particular. This suggests that the model under study may in some part increase appropriate brief interventions and social prescribing to non-pharmacological public health interventions and health improvement programmes in primary care, even if this is isolated to one locality.

7.3 Supply of pharmacotherapy

7.3.1 Smoking cessation pharmacotherapy

A general downward trend is reported in prescription items and cost for smoking cessation pharmacotherapy (NRT, bupropion and varenicline) since January 2012. The study period in particular observed a reduction in prescription items by 28% (668 items). The downward trend was reported for all product groups. This reflects the downward trend in contacts with SSW.

The downward trend in prescription items in parallel with the reduction in contacts with SSW indicates that GPs are not prescribing NRT, bupropion and varenicline without behavioural support provision by a smoking cessation service. This supports national guidance on the prescribing of smoking cessation pharmacotherapy.

The CPSSS reported an increase in cost of NRT by 52% (£16,986) across level 2 and 3 services over the study period. This reflects the increase in contacts with the service. Although the cost of level 3 service exceeded level 2 service costs, the greatest increase was reported for the level 2 service. The level 2 service, where the community pharmacist supplies NRT for patients supported by SSW, may be substituting GP supply of NRT via a prescription.

Aggregated costs of smoking cessation pharmacotherapy from both SSW and the CPSSS, as a marker of activity, indicates that there has been a gradual reduction in supply of smoking cessation pharmacotherapy since April 2012. During the study period however there appears to have been a slight increase in cost of £658, which could be attributed to the overall increase in activity of the CPSSS. Although the unit cost of NRT, bupropion and varenicline has remained relatively stable over the last couple of years, care needs to be taken when studying costs as changes

in product formulations may have also influenced the increase in costs observed.

The initiative studied whether brief interventions and social prescribing of non-pharmacological public health interventions in primary care had an effect in reducing the GP prescribing budget. An increase in the number of people accessing SSW would in fact result in an increase in costs arising from GP prescriptions for smoking cessation pharmacotherapy.

Findings suggest an increase in spend in the GP prescribing budget of £658. An increase in supply of smoking cessation pharmacotherapy would suggest more people are using pharmacotherapy to aid their quit attempts. To achieve the best outcomes this should be combined with behavioural support and be consistent with an increase in contacts with SSW. This would inevitably result in an increase in the GP prescribing budget.

7.3.2 Anti-obesity drugs

Prescribing data for the anti-obesity drug orlistat, indicates a reduction in the number of prescription items (n=57) and associated cost (£2357) for the study period. If this trend continues significant savings (approximately £10,000 over 12 months) could be yielded against an annual spend of over £110,000.

The initiative studied whether brief interventions and social prescribing of non-pharmacological public health interventions in primary care have an effect in reducing the GP prescribing budget. Findings would suggest that for orlistat this was the case.

7.4 ScriptSwitch

ScriptSwitch triggered a message on over 3500 prescriptions (smoking cessation or physical activity) over a 6 month period. Of these over 150 resulted in an action other than a prescription being written. ScriptSwitch does not record what this action was. This may have been referral or signposting to SSW, CPSSS and NERS. The number of messages reported over the study period reinforces the potential of ScriptSwitch as a tool to remind prescribers to refer or signpost patients to the relevant services.

8 Conclusion and recommendations

8.1 Conclusion

This review studied the first six months of the implementation of the initiative. Early indications suggest that a number of potential improvements can be achieved with minimal input. In particular this review highlights the following:

- An increase in the number of people in Cwm Taf accessing specific NHS smoking cessation services

- An increase in the number of people in Cwm Taf enrolling on the NERS programme.

- A decrease in the prescribing of drugs for the treatment of obesity.

It is too early to assess whether this trend continues with time or the small increases in patent numbers with the services have any long term population health benefits.

The review concludes that some success, although small in numbers, has been achieved using the model proposed in the initiative. The toolkit, training and material has been prepared and made available to the Prescribing Advisory Team for future use.

Whether the initiative continues using the same model needs to be considered in light of the recommendations of this review.

8.2 Future work and recommendations

- To continue the initiative for a further 12 months (until end of December 2015) using the current model and continue to make use of:
    - The training and toolkits provided,
    - The GP Prescribing Performance Review Report and Annual GP Prescribing Visits for 2014,
    - ScriptSwitch,
    - Ongoing support from the Consultant in Pharmaceutical Public Health. Consideration needs to be given to the method and timescales of further evaluation in light of the limited support that can be offered by the Pharmaceutical Public Health Team.
- To consider additional resources and protected formalised time to the Prescribing Advisory Team to apply the model proposed.
- To establish a local mechanism to collect and collate data and to provide regular feedback to GP practices and community pharmacies on contacts and referrals to SSW, the CPSSS and NERS.
- To identify a local lead from within the prescribing team and the Local Public Health Team to provide a shared role in leading and continuing the momentum of this initiative locally. This will ensure sustainability of the project and any improvements achieved.

9 References

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Appendix1

Summary of survey of GPs and practice staff

A number of GP practices, identified from referral data as either having high or low referral rates to SSW and / or NERS, from each of the 4 localities in Cwm Taf were contacted by telephone and invited to participate in a semi-structured interview.

A series of face to face semi-structured interviews (n=6) were conducted in the interviewees place of work. Prepared questions were used to guide the interview. As a result, the views of five GPs and two Practice Managers drawn from the four GP practices were collected. Two GP practices were located in Merthyr, one in Taf Ely and one in the Rhondda valley.

The interviews were transcribed from hand written notes and thematically analysed according to the following themes:

- Targeting patients for lifestyle advice, brief interventions or referral
- General information about health improvement services and initiatives
- Feedback and communication from the health improvement services
- General issues about the health improvement service design and delivery
- Electronic support systems
- The acceptance of a prescribing advisor discussing public health issues

Summary of key points

- There were different levels of relationships between the GP practices and the service providers. This varied according to GP practice and service. As a result:

  - Communication between service provider and GP practices differed. Where services were delivered from within the GP practice premises communication was good. Where services were delivered elsewhere communication varied, was described as needing improvement and to be more frequent.

  - Access to information about local health improvement programmes and activities was inconsistent. GP practices tended to rely on face to face contact of the service provider and a range of web based and electronic resources. There was little consistency between GP practices as to resources being utilised.

  - There was variation in the information available to the GP practice to pass on to their patients. Replenishment of material and paperwork was identified as a problem.

Appendix 1 *continued*

- There was confusion over the different ways the various health improvement programmes and services were being accessed and delivered. Some required referral by a GP or nurse whilst others were via patient self referral. There was a suggestion made to simplify the point of access. This could be based on one service delivery model, for example, cards with one telephone number to be given to patients or one contact named individual at health board to signpost to information resources.

- Where information was made available, some GP practices were not confident that this was up to date.

- The referral of patients to SSW and the NERS tended to be adhoc. There appeared to be no systematic approach described by any respondent regarding what informs the decision to refer patients.

- Where patients were being referred, no standard READ codes for advice or referral to a health improvement programme were routinely being used by the GP practice.

- A number of barriers to referral were noted, in particular the paperwork and mechanism for referrals by GP only to some services was reported to be an issue.

- There was little feedback to GP practices on contacts with the services and trends in referrals. Feedback on individual patient's details was also variable.

- In practice resources such as TVs in waiting room, poster displays and GP practice websites could provide a resource to patient educational and signposting of information. These appear to be underutilised in displaying information on health improvement resources.

- The model of using the prescribing advisor as the messenger was acceptable.

This piece of qualitative work has provided an insight into some of the attitudes and beliefs of GPs and their practice team in recommending and referring patients to health improvement initiatives. It allowed good practice to be identified and also provided some examples of barriers and enablers that potentially affect brief intervention advice on health improvement and referral to some health improvement services.

The findings of this exercise in conjunction with the findings of the GP practice Survey (Appendix 2) and provides an understanding of the issues of GP practices in encouraging their patients to access health improvement initiatives and programmes.

The initiative *The role of the health workforce in tackling health inequalities in Cwm Taf* can attempt to address a number of the issues identified. Some issues raised are directly related to the design and delivery of the service which is outside of the scope of the initiative. Considerations are needed on how to take issues related to the design and delivery of service forward.

Appendix 2

Summary of semi-structured interviews with GPs

A questionnaire of 9 questions was developed and trialled in 3 GP practices in one locality. Following feedback, the questionnaire was amended for use in the survey.

The Prescribing Advisory Team invited GP practices to undertake the survey during their routine practice visits. This was done opportunistically. In addition an email was sent to all primary care nursing staff by the Nurse Manager, Primary Care Nursing Service inviting participation.

A total of 84 questionnaires were completed from 31 practices across Cwm Taf representing 65% of the total practices in the health board area.

Sixty five percent of questionnaires were completed by clinical staff (n=31 GPs, n=20 nurses, n=4 healthcare assistants) with the remaining completed by non clinical staff (receptionists and practice managers).

Summary of key points

- GP practices in general were happy to participate in the survey.
- The GP practices surveyed were all referring and signposting patients to health improvement programmes but the extent varied, referral was adhoc and tended to be low in patient numbers.
- There was willingness by primary care staff to improve efforts to signpost, refer and socially prescribe when appropriate.
- Generally the healthy lifestyle advice and referral / signposting to health improvement services was considered to be the role of the GP and nurse rather than practice support staff and reception staff.
- The more clinical the member of staff, the greater expectation that this was their responsibility to signpost and refer patients to health improvement services. There is potential to explore and enhance the contribution of non-clinical staff.
- Participants had a greater knowledge and increased confidence in the more established services in the locality and as a result referred more commonly to these services than others.
- Knowledge, confidence and attitude towards services were more positive for those services with a history of delivery on site (i.e.in GP practices).
- Preferred methods of communication and information provision were identified as email, websites and practice and professional meetings.
- Barriers and enablers were identified. These fell broadly into 4 categories of: information / communication, service issues, GP practice issues and patient issues. Some may be addressed through the initiative; others such as national design for service delivery are for wider debate at national level.
- Using the Prescribing Advisory Team to facilitate discussions and provide information about public health interventions was found to be acceptable.

Appendix 2 *continued*

- The survey provided an insight into the attitudes and beliefs of various members of the GP practice team.

- It has also provided examples of barriers and enablers that potentially affect brief intervention advice on health improvement and referral to some health improvement services (see table below).

- Some barriers are related to the design and delivery of the service which is outside of the scope of the initiative Considerations are needed on how to best to overcome these barriers**.**

BARRIERS	ENABLERS
Information / communication issues.	
• Insufficient information for practice • Lack of training for practice staff • Difficulty (for the practice) in communicating with the service provider	• More information for practice • Better quality information for practice • Material for patients • Face to face contact with health improvement service providers • Education for practice and staff and feedback on referral rates to practices from health improvement service providers.
Service issues about the design and delivery of the programme	
• Perceived long waiting times • Insufficient or unacceptable service provision • Disagreement over patient criteria for the service • Inadequate duration of a programme • Lack of in-practice services • Lack of electronic referral options	• Location and ease of access of service • Methods for referral • Clear referral criteria and re-referral options.
Practice issues	
• Lack of incentives for the practice to advise and refer • Differing priorities of the practice which is often driven by the GP contract (where healthy lifestyle topics are limited)	• Incentives for the practice to advise and refer as there is limited incentive through by the GP contract • Who assess a patient's eligibility to access the service.
Patient issues	
• Patient choice to not be healthy • Lack of patient motivation to take up health lifestyles • Difficulty for patient in accessing services in particular those with lack of transport.	• Increasing the public awareness through media and targeted campaigns • Availability of accessible transport for patients to access the service

Appendix 3

Summary of survey of community pharmacists

A questionnaire consisting of 8 questions was developed. The questionnaire was based on one that had been developed and used in General Practices across Cwm Taf and tailored for the community pharmacy workforce. The questionnaire was completed opportunistically and pharmacy staff invited to participate in the survey during visits to the pharmacy by the health board employed Community Pharmacy Facilitator and health board run training events.

A total of 35 questionnaires were completed, 63% (n=22) by pharmacists and 37% (n= 13) by support staff. This represented 45% of the 77 community pharmacies across the borough.

A number of respondents worked across the localities in community pharmacy chains and provided responses according to their experiences across the health board area. The actual representation cannot be quantified but would be greater than the 45% reported.

Summary of key points

- Community pharmacists and their staff in general were happy to participate in a survey to establish their knowledge of services available, attitude towards service provision and enablers and barriers to referral for a range of lifestyle interventions.

- The more established services for smoking cessation where pharmacy has historically had a role in providing the supply of treatment were the services that respondents had greater knowledge and confidence in and as a result report to refer to more commonly.

- The survey indicated that all members of the community pharmacy team currently advising patients on healthy lifestyles and refer / signpost to associated services with the community pharmacist being most commonly asked. Enhancements to this role need to involve all members of the community pharmacy team staff.

- Barriers and enablers were identified some of which can be addressed by local initiatives and provision of information; others are for wider debate about service design and delivery which needs to be at a national level.

- Generally the majority of respondents agreed that the Prescribing Advisory Team could support community pharmacies in this area of work.

Appendix 4

Training

Three training events for the Prescribing Advisory Team were provided. There was no budget identified for training so speakers were sourced from local and national services sessions with no remuneration. Venues were provided free of charge.

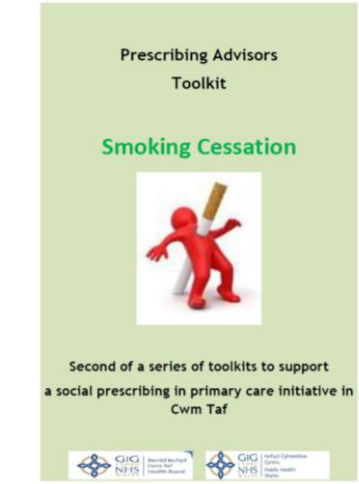
Exercise – an update
December 2012. Cwm Taf Health Board. Abercynon 9.30am -2.00pm
• Introduction to social prescribing and the initiative • The Inverse Care Law and its relevance to Cwm Taf • National Exercise Referral Scheme (NERS) • Referral rates • Other linked public health programmes • Support pack – toolkit development
Speakers
Angela Jones, Rhodri Martin, Sally Hudd, Kevin Russell, Carla Jackson, Sian Evans. [Local Public Health Team, Specialist Registrar in Sports Medicine, National Exercise Referral Scheme co-ordinators, Pharmaceutical Public Health].
Smoking– an update
February 2013. Cwm Taf Health Board. Abercynon 9.30am -12.30pm
• The burden of smoking in Cwm Taf • Cwm Taf Strategic Action Plan • The evidence base for stopping smoking • Smoking cessation services in Cwm Taf • Community Pharmacy Stop Smoking Service • Stop Smoking Wales, National overview & local issues • Smoke free homes
Speakers
Angela Jones, Margaret Munkley, Joanne Sullivan, Elaine Seldon, Dan Clayton, Emma Hinks, Sian Evans. [Local Public Health Team, Stop Smoking Wales Advisors, Cwm Taf Community Pharmacy Lead, Pharmaceutical Public Health].
Brief introduction to motivational interviewing and social influencing
June 2013. Welsh School of Pharmacy, Cardiff. 9.30am - 4.30pm
• The project • Behaviour change and motivational interviewing • Social Influencing • Objective setting • What next?
Speakers
Mair Davies, Debra Roberts, Sian Evans. [Welsh Centre for Postgraduate Pharmacy Education, Pharmaceutical Public Health].

The purpose of the training programme was to ensure the prescribing advisers were informed about the key public health topic areas and associated programmes in order influence primary care professionals to encourage their patients to choose healthier lifestyles. Generally feedback was positive with the majority of participants indicating the training increased their knowledge and confidence.

Appendix 5

Toolkits (Smoking and Physical Activity)

Smoking

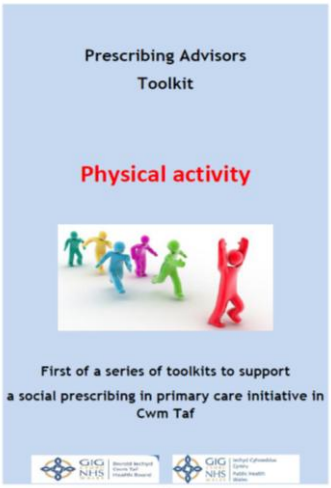


Contents

Appendix 5 *continued*

Toolkits (Smoking and Physical Activity

Physical Activity



Contents

Appendix 6

Breakdown of key stages of implementation

	2013								2014
	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan
Annual reports									
Annual visits									
Practice visits									
Practice work									
Project review									

Timescales of the project implementation

GP Prescribing Performance Review & Annual Visit report

Data on referrals to health improvement programmes (Stop Smoking Wales and the National Exercise Referral Scheme) presented in each individual GP Prescribing Performance Review and Annual Visit report. This report is provided to the practice for consideration in advance of the annual visit.

N.B: *data described as referrals are patient contacts made with the service.*

Data presented:

- as 12 month activity
- by GP practice as rate per 1000 PU
- as a bar chart
- compared with the average rate for the locality and health board

Data was presented in a format consistent to that being provided for prescribing indicators. Data on contacts made with the Cwm Taf Community Pharmacy Stop Smoking Service was not available for discussion during the annual visit.

GP Practice Annual visit

GP Practices in Cwm Taf usually have annual visit by the Prescribing Advisory Team. The purpose of the visit is to discuss and agree priority prescribing and medicines management areas for change. Visits are usually undertaken in May and June each year.

At every GP Practice Annual Prescribing Visit (2013) where appropriate:

- brief interventions and referral / signposting to smoking cessation and physical activity programmes were discussed
- actions agreed regarding GP practice activities to encourage an increase in referrals to such programmes
- support required by GP practice to identified and agreed.

Appendix 6 *continued*

Prescribing Advisor GP practice based work

The principle of the project is to capitalise on the existing arrangements in primary care where Prescribing Advisory Team are working with GP practices to influence and achieve improvements in prescribing and medicines management. The activities in each GP practice therefore varied according to the relationship with the GP practice and the existing arrangements of working. An activity worksheet was provided to capture the work different types of interventions and work being carried out within each GP practice. This was used as a tool to inform the review and the final evaluation.

It was suggested the following activities should be attempted:

- A multi/ uni disciplinary practice meeting
- Liaison with different healthcare professions within the GP practice (e.g. GP, nurse, healthcare assistant, pharmacist prescriber)
- Liaison with non-clinical staff to encourage their role in providing information and signposting patients
- Identification of smoking cessation and physical activity opportunities local to the GP practice that have not been provided in the toolkit –to encourage the development of a GP practice based directory.

Enhanced practice based work may consider the following activities:

- Computer searches to identify patients for practice to target
- Audits
- Manipulation of GP computer system to trigger messages
- Training / CPD sessions
- Patient clinics
- Liaison with local health improvement programmes leads to visit GP practice

The member of the Prescribing Advisory Team working in each GP practice was provided with:

- face to face training
- toolkit – reference guide
- key slides

Appendix 7

CAPSA Drugs baskets

Smoking cessation products	
Nicotine bitartrate	CAPSA BNF code 0410000AA
Varenicline	CAPSA BNF code 0410000AB
Nicotine	CAPSA BNF code 0410000PO
Bupropion	CAPSA BNF code 0410000QO
Nicotine dependence	CAPSA BNF code 0410020

Drugs to treat obesity	
Orlistat	CAPSA BNF code: 0405010P0