Health and Social Care Committee
Inquiry into the contribution of community pharmacy to health services in Wales

CP 37 – Welsh Food Alliance

What changes do citizens want to see that would improve service user / patient care?

Evidence submitted by the Welsh Food Alliance on behalf of a Community Pharmacy community consultation held on 19th September 2011 for presentation to the National Assembly for Wales, Health and Social Care Committee

Introduction

1. This process could have been assisted with a wider understanding of how to engage with service user and carer perspectives on this important issue. This could have been supported by factual information, for example, concerning government expectations about service model changes arising from the Wanless Report (2003); general financial pressures, including erosion of profitability in the sector and increased productivity pressure on pharmacists employed by multi unit operations. It is noted that we briefly discussed the role of salaried community pharmacists linked with Community Transport in rural and semi rural areas.

2. Since its inception the Welsh Food Alliance (WFA) has recognised that nutritious food and exercise have an important part to play alongside medication in bringing about health and wellbeing. We are also well aware of how drug companies support patient groups – or even set them up. Over the past ten years we have organised consultations and contributed to the Wales Wanless Review (2003), 'Beyond the Boundaries' (2006) and supported a public consultation and report on Medicines and Older People (2007). We welcome this long over due Inquiry and submit views.

Method of work in time available

3. Receiving the call of evidence, as some of us were departing on holiday, left a short space on return to pose four questions set out in the attached flyer to support your welcomed inquiry. This was not as straightforward as expected, although we are fairly experienced in seeking service user perspectives. Initially, WCVA assisted in an attempt to communicate with rural, Communities First and National Health, Social Care and Wellbeing Networks. This resulted in a limited response, except from previous contacts. Even then six people were unable to attend: awaiting treatment, without transport or due to work pressures. An e-mail sent by Dr. xxxxx, – National Service Framework for Older People, enabled contact with Frank Hogg, several LHBs and two local authorities. We attach a list of attendees and others who contributed by e-mail, or by phone. The two questions we posed were the same as posed in the above 2007 consultation: "What should be expected? What would make it better?"

4. Although most participants had a good understanding of the NHS in Wales, the questions posed assumed a fair degree of detailed prior knowledge and professional intimacy with the Community Pharmacy and NHS reform. This is why we invited Andrew Evans, the Welsh Assembly Government Community Pharmacy Manager to brief us on the contract (attached) and to join our event to answer factual questions on our first question, which we found most helpful. This lack of knowledge may explain a possible limited response from the public to your Inquiry. However, in a survey undertaken of older people attending an Older People's Information Day at Newport Centre two years ago WFA found that 90% of respondents listed 'medicines maladministration' in the top two of ten NHS type issues identified.

5. In the time available at our consultation we focused upon giving voice to public views and this we report as below. At the end we summarise issues. We attach a list of attendees, and publicly thank the Open University in Wales for the provision of free accommodation and Dr Paul Walker a former public health consultant with NPHS for chairing this event. The various contributions have been checked with the various individuals concerned. It is noted that some overlap with each other, but we wished individual contributions to speak for themselves.

Context

6. Fortunately on the day of our consultation a timely 'There is no age limit in the fight for health' letter appeared in the Guardian stating: "This week the United Nations is bringing together world leaders to discuss the global health crisis of non-communicable diseases (NCDs): strokes, cancer, heart attacks, lung disease and dementia (Report, 17 September). These diseases are on the rise like never before: by 2030, the World Health Organisation (WHO) predicts that the top four killers in the world will be NCDs. What is most striking is that their impact is felt most on those over the age of 60".
7. "An ageing population brings a new set of critical health challenges. Alzheimer's disease and other dementias, for example, affect 12% of those over 65 and more than 30% of those over 85. Over the next two decades, the number of people aged 65 and older suffering from diabetes is expected to increase by 134%. And then there's cancer, which, according to one British study, is six times more likely to affect women aged 60 to 64 than women aged 35 to 38.To win the fight against NCDs, governments and stakeholders must come together to create solutions that are appropriate for people of all ages, with no age limits being set for good health".

An effective community based approach

8. Dr Gwyneth Briwnant Jones, an experienced former Cardiff CHC chair writes: "Changes in the health system are necessary if we are to have an effective community based approach to fit the needs of today. The transfer of essential funds from secondary/tertiary to primary, tertiary and community services is necessary, in order to provide the infra-structure for

a good service, which focuses upon Patients and service users within the community. This is the context within which changes in Community Pharmacy will need to be considered".

9. Hilda Smith who has served on three CHC's and District and Regional Health Authorities, writes: "An effective community based approach would require staff training, a change of use in premises and resources, including the use of medication to provide a more explicit and effective use of resources and possibly save money, but this should not be the primary motive for change. We will then have community pharmacy used effectively by patients and carers, with necessary support and advice available. A saving on wastage, a growth in health and wellbeing, less use of A&E Departments and admittance to hospital and making sure the out of hours service is effective and value for money. More information on drugs and usage should be available, how they work, appropriate use, and reporting of side effects and maladministration effectively carried out".

The Citizens voice or lack of it

10. Hilda Smith writes: "It is no use having comments on schemes agreed, but we need a way of looking ahead and not just basing change on the present formulae. We get very little information from patients that change the system. Lets now see if we can make a difference.

11. Have we accurately tested the use of drugs on older people? Are we more alert and careful with children? I ask because the number of older people using medication is growingly rapidly and in future will increasingly take place in a mainly unsupervised home environment with the emphasis upon community-based care. Could the increasing use of medication have any connection with the growth in Alzheimer's? To the lack of evidence from older people themselves to this inquiry and a growing inability to cope within their own homes?

12. Is there a connection between medication and lack of exercise, socialisation and stimulation, through to malnutrition due to loss of appetite? Is it due to medication taken at different times of the day and the dosage given? The incorrect, or lack of use of spacers (for lung conditions), which means that medication is not having the benefit intended? Do we assume and take for granted that as the body ages so does the mind and people treated accordingly, when they may be imprisoned by the side effects of medication? Is this the real lack of dignity and care? Do we need to increase the study of gerontology and make it an essential part of pre registration training for all health professionals? Having said that I am conscious that younger disabled people are living in the community, as well as older people.

13. How do we strengthen the service user and carers voice in the expenditure of large amounts of public money? Do we as a society repeatedly bury our mistakes when they constantly recur without giving voice to those that recover? It is significant that effective changes are only brought about when

a perceptive relative or carer, often a healthcare professional, challenges the system and brings about change.

14. In the pre-registration training of GPs is sufficient attention given pharmacology, especially as this relates to people with multiple conditions? How can this be addressed with the revalidation of GPs, alongside extended knowledge of gerontology? With GP referrals should diagnoses and treatment plans apply to referrals to specialised units, using cross border referrals as necessary. Otherwise effective use of this resource is only available to an administrative district and not a region. From a regional centre: effective training in use of new drugs and treatment could resonate and develop in primary care. Effective Community Pharmacy is a part of an overall system, as is research and development informed by the service users experience".

Reaching service users

15. Our experience at WFA is that the role of medication and its links with nutritious food and social wellbeing are well known. People are interested and wish to be involved. The survey we undertook with Mature Times in 2009 elicited 1200 replies with comments from respondents who provided a stamped addressed envelope. People do wish to be interested and involved, but our 'pill cure all' culture, with the rise of the advertising industry, becomes predominant and impacts on the attitude towards what is expected of community pharmacy

16. From this anonomised survey evidence we know how medication affects a persons ability to lucidly think, remember, write and record everyday events. A person states "I could do this quite well prior to taking a particular medication. After that it is if a fog descends, that immobilises thought and action processes and a loss of energy". Another good reason for Medicine Use Reviews!

17. Dr. xxxxx, – National Service Framework for Older People enabled us to reach Frank Hogg, from the Ceredigion Older Peoples Partnership (COPP). Frank writes, "You will need to bear in mind that many older people do not have computers. Other older people can only access electronic communication through the library. Often it is necessary to book the use of a computer the day prior to use, and use is often time limited to one hour or even half an hour. Reading information on screens takes time and is really inconvenient. Paper copies may be down loaded, if the printer works, and contains paper, but then costs 10p per page. Travelling, to and from the library by public transport, has to be considered. Wet, cold days, make all this even more problematical. Bus 'shelters' are often not very good shelters and often lack seats. Lack of adequate notice given in many documents, which seek a response, is therefore another problem, because paper copies may arrive with very short notice given for a reply, or even after the meeting concerned has taken place!

18. Therefore the involvement and dedication of professional staff is much appreciated. They have the resources (transport, technology, offices,

support, and funding etc). Elderly participants fund themselves, lack car transport, and lack communication equipment. Elderly people also have a more rapid attrition rate! However they really want to be involved and to play a part if only their difficulties are known, understood, and reduced or even eliminated. Older people have a wide range of experience and expertise, and could provide a useful and helpful contribution to 'Committees and Boards' that consider their needs and problems. A review of all such 'Committees and Boards' should be undertaken to try to eliminate overlapping and duplication|".

A Public Health Practitioner and now service user view

18. The key insights for Dr Paul Walker were: "GPs and Community Pharmacists (CPs) to work together to improve medicines use and reduce wastage and dangerous polypharmacy. Having GPs and CPs based in the same building as envisaged by Lord Dawson when he invented Health Centres in 1920 is the key here. Because of the concentration of services that this would entail however such a system would need to be supported by an outreach pharmacy service particularly in rural areas. Better community transport particularly in rural areas would also support such a system".

19. "Medical training is too much focused on diagnosis and not enough on pharmacology and, very important, other non-pharmacological methods of treatment".

20. "Standardisation of the shape, size and colour of specific medicines is crucial in my view to avoid confusion".

21. "A record of present and past medication to be held by each patient in the form of a booklet or smart card would be a great benefit".

Communication Between Pharmacists and GPs

22. Ron Walton, a former CHC member and former University Social Administration lecturer writes, "The Medicine Use Review (MUR) is a valuable innovation to help patients obtain maximum benefit from prescribed medicines and also cope with side effects or complications of taking a number of medications. Good communication between GPs and Pharmacists is essential for the system to work well. Many patients will return to their GP if they experience distressing side effects from medicine and their GP is de facto reviewing both the clinical decision and the use of the medicine. But GPs are not pharmacy specialists and prescribing patterns are partially determined by experience and habit rather than a detailed knowledge of the medicine or alternatives.

23. Patients' awareness of MURs is at a low level at present although some will have noticed adaptations at their local pharmacy to create a consulting room. Therefore GPs need to be pro-active in encouraging and referring patients to their pharmacist for a regular MUR (particularly for older people

and those with multiple medications). Where a patient independently requests an MUR at the pharmacy there needs to be clear communication from the pharmacist to the GP. (Hilda comments: should we have a requirement for MURs whenever a certain number of prescriptions are dispensed?)

24. The borderline between an MUR (pharmacist) and a clinical review (GP) can be a very grey area. It would be very useful for Local Committees of GPs to have meetings with Community Pharmacists in their locality to develop understandings and clear working arrangements for referral to MUR and communicating the outcomes. This would aid the formation of trust between the professions and, more importantly, reduce medicine problems for patients and reduce medicines waste.

25. Older people and those with multiple medications are at greater risk of unanticipated side effects and have medicines changed more frequently. It may be that the suggestion of 12 months as the interval for an MUR is too long for many of these patients and that a shorter interval would benefit them (eg, six months, although some present felt this could be shorter depending on a persons circumstances).

26. Anecdotally, we observe variability in the quality of MURs: one involving the pharmacist completing a questionnaire when interviewing the patient, whereas another involved a 15 minute conversation, following a 30 minute delay, of what was thought to be a MUR, with no notes taken. How will evaluation or professional revalidation support consistent quality?

27. At present the GP is an important gateway to MURs. GPs should be encouraged to use this service for the benefit of their patients. At a more general level better communication between Community Pharmacists and GPs could result in discussions about good standard prescribing practice and contribute to enhanced and standardised prescribing in local areas".

Community Pharmacy - market structure; MURs; Patient voice

28. David Smith, a former Wales lay member of the Council for Professional Regulatory Excellence writes: "When considering community pharmacy we need to recognise the role of exercise and nutritious food and how this relates to medication; the need to move from dispensing to diagnosis and treatment; and the potential conflict between ethics and business.

29. Large retail chains have transformed the traditional perception of local independent pharmacists. Changing industry structure means although the number of pharmacies remains approximately the same, a good proportion of pharmacists are employees of large companies. They also will have company policies relating to the employment of locums, which has been a point of concern.

30. With government clawing back anticipated profits companies are having to ensure employees dispense an increasing volume of prescriptions in a

limited amount of time, and the issue of constant repeat prescriptions for people with whom they have no face to face contact.

31. Across the UK large chains are reported to employ in excess of 55% of all Community Pharmacists. Corporations, such as Boots, Lloyds, Asda and Sainsburys have obligations to shareholders that could conflict with public health priorities.

32. In 2008 a review of Medicine Use Reviews (MURs) found that chains had implemented the service more rapidly, but also noted a weak negative association between the levels of provision and levels of deprivation and long term illness. Hence, our consultation was partly aimed at Communities First areas, where examples of really effective Health partnerships in shaping service provision are relatively rare (see para 22.5 of a recent Government Communities First evaluation 16/2011).

33. Evidence suggests that asthma targeted MURs are beneficial; eg, see Portlock, Holden, and Patel 'A community pharmacy asthma MUR project in Hampshire and the Isle of Wight'. Pharm J 2009; 282:109-120.

34. If 53% of unused MUR funds allocated by the Welsh Assembly Government are being used by LHBs for other purposes, will greater ministerial direction be given to target specific population groups, in areas, for example, with high concentrations of frail older people?

35. CHC's should be alert to public safety issues and the contribution of community pharmacists as part of a system with necessary checks and balances. I am unclear how establishing protocols to visit individual pharmacies might be a good use of time, where the HQ's of multi unit operations drive internal consistency to protect their brand, combined with the statutory professional inspection arrangements.

36. In the context of our newly emerging NHS driven 'Neighbourhood Care Networks' a far more significant development in one part of Wales could be the establishment of Patient Participation Groups to help provide meaningful citizen engagement in the context of planning, delivery and evaluation of services.

37. To inform the future of Community Pharmacy it would be useful for (a) the Inquiry to publish information about the structure of the pharmacy market in Wales so that we are all clear where and how public money is being used; and (b) for an appropriate representative and accountable citizens body to advise the Minister and National Assembly members on key issues relating to the equity, efficiency, effectiveness and value for money and the implications for access, safety and quality of patient care with the multiple chains operating in Wales.

38. The NAfW has an all party Community Pharmacy Group. This appears to be a private conversation between trade interests and elected representatives. Where is the patients voice and how could this be

supportive of public health objectives? More widely, in terms of health professional regulation and public protection / patient safety issues, the then CHC Board made recommendations to the Minister in 2009 about how this issue could be addressed".

Young Carers

39. Lindsay Haveland, Senior Health and Social Care Facilitator, who WFA have worked with previously on rural older peoples food issues commented by email: "Young carers often complain that pharmacists will not allow them to collect their parents' medicines unless a "responsible" adult accompanies them. This has led to all sorts of problems. Perhaps there should be a universal system for identifying young carers, similar to that used for adult carers. Also, there is the aspect of, if a young carer has an accident or is involved in a medical emergency, what happens to the cared for, if services are not aware of the caring responsibility?

Communication issues

40. Lindsay also writes: "Locality working - I know some work is being done in the Abergele area around making the taking of medication easier for people to understand. This should be universal. There should be better sign posting to support organisations, and this would also work within the locality setting. Other issues include:

41. Those with a chronic condition (such as coeliac syndrome) are given medicines containing the ingredient, which exacerbates the condition.

42. Pharmacists not being informed when a patient on repeat prescriptions is 1) admitted to hospital, 2) discharged from hospital, 3) left the area, or 4) died. This does not include those whose medication is changed by the hospital, but no note has come from the GP so that the repeat prescription can be changed. This leads to waste.

43. The fact that pharmacists are not supposed to fill drugs dispensers for patients, on the grounds that they can no longer ensure the efficacy of the medication.

44. The fact that some patients have very low literacy and numeracy levels, and this is particularly the case of those on long term Incapacity Benefit (in Rhyl a few years ago out of 450 + patients seen by a health advisor, 75% had literacy and numeracy levels of Entry Level 1 – 3, chronological age between 5 and 9 years). (David Smith comments: Health Literacy issues needs to extend beyond "time to provide proper counsel" - see RPS Journal 20 August 2011).

Information made available to service users.

45. Frank Hogg writes about the "specific problem of unreadable expiry dates. Boxes often do have expiry dates, but all too frequently the dates are 'blind stamped' into the 'shiny white' paper end flap of the container opening.

46. Following conversations with other older people, I have found that many boxes stored in older peoples homes had passed the appropriate date. The medicines have more than one name, which adds to confusion, eg the proprietary name, the medical name, and sometimes a generic or even a Latin name. E.g. 'Cardicor' is also 'Bisoprolol' very confusing when both names are used almost interchangeably. Older people usually have several medicines taken in differing quantities at differing times of the day and night. Dosset boxes help but do not eliminate the problems. Some experience the onset of other problems such as memory loss, isolation, and lack of sympathetic neighbours, or visitors. Relatives, including children, may have moved away to find employment, and may only return very occasionally.

47. The 'Discharge notes' in some hospitals are written quickly and sometimes under busy pressure by medical staff. Sometimes those notes are duplicated or even quadruplicated, and sometimes as 'carbon copies'. The 'patients copy' may be the 4th, virtually unreadable copy. These notes are sometimes illogical, in a haphazard order and seem not to be produced to be easily interpreted or understood.
48. These issues require serious consideration and I will ensure that this matter is raised with our Local Health Board so that a proper formal investigation can take place, perhaps jointly with Public Health Wales.

Rural communities

49. Trish Buchan, Health & Social Care Facilitator, PAVO writes: "For many years community high street pharmacies have provided valued source of independent advice and support to people in rural communities not least in delivering prescriptions. At best they have been part of the extended informal local primary care team; easily accessible on local high street and open at times when the surgery is not. Many pharmacists lived in or near communities in which they worked. This is probably still the case in most areas but during the last two years I have become increasingly aware of problems - some through personal experience and others raised by Third sector groups. Issues that have come to my attention are:

- Not having sufficient stock to dispense full prescriptions. This means people have to return to top up prescriptions and on at least one occasion Tramadol was not available in the local pharmacy I am aware that in one area the community have organised themselves to take prescriptions to a neighbouring pharmacy six miles away as they perceive this to be a long term problem.
- Using different sources of generic drugs. This confuses people because of variable colours, size, shape, etc.
- Very limited other stock in pharmacies –the best pharmacies provide a valuable sources of commodities not available in other shops.
- Use of locums.
- Bad weather has prevented pharmacist from traveling to work. This is problematic when there is only one pharmacist working. It impacts on

people e.g. such as those using methadone (business continuity and winter contingency plans could be tightened up).

- There have been issues about volunteers, carers including young carers picking up prescriptions –a code of practice would be good
- There have been really positive developments by Community Pharmacies including delivering prescriptions to peoples' homes, health promotion initiatives and blood pressure checks.

50. Basically, Communities Pharmacies are and have been a fantastic resource for rural people. There are opportunities for extending roles, e.g. supporting self-care but it is important to ensure that the core pharmacy service is maintained at a high quality".

Carers and community pharmacies

51. Lindsay Haveland, Senior Health and Social Care Facilitator: "re: carers and community pharmacies. …There are a few carers centres in mid and South Wales that have pharmacy projects working to help champion carers in much the same way that is being done in GP surgeries but it is very patchy. Anything we can do to plug the gap and make it easier for carers both in identifying them and ensuring pharmacists are more carers aware has to be explored. Have attached some background research into why strengthening this link is so important. http://professionals.carers.org/health/articles/identifying-carers-through-pharmacies,860,PR.html

BME communities

52. Anna Ros-Woudstra, *Development Officer - Swyddog Datblygu,* Ethnic Minority Communities First Team, Cardiff, writes: Effective Community Pharmacy could be a good thing for BME communities. Especially with the following:

- Bridge the gap accessing health services
- Medicine Use Reviews that are appropriate to different cultural and related health needs, which engage with local community organisations
- Improve trust and information with regards health issues/ health professionals. Eg, ensure pharmacy staff can reflect the make up of the locality in terms of ethnicity and languages.
- Make sure people know that information and services are available and how they can use them – do not assume people know how to use the services or what to do with the information
- Address communication issues re the colour, size, shape, etc of medication and varied cultural needs of different communities
- Prevent auto-medication and passing on medicines – inform about side effects
- Health checks and signposting to other health providers
- Links with grassroots BME community organisations to inform, promote new models of health service planning and delivery

- Participate in community health events.

53. It is important though, that in order to engage with the BME communities that the Community Pharmacists are prepared to go to the communities, have information chats within their community venues and help bridge the gap that way. As an example: BME communities in Butetown were not using the blood pressure services within their local pharmacy, but when somebody from the local pharmacy attended an event providing health checks they had big queues – many BME community members where not aware they could go to the pharmacy to take the test.

54. They are several health projects/reports that has very explicit recommendations around local and culturally appropriate health services, such us:

- The Inverse Care Law in Action? A primary and community Health Care Needs Assessment For Butetown and Grangetown wards in Cardiff- 2006
- Nicola Hughes – (2008) Inequalities in Health Fund – HeartLink Project- Hearth diseases and diabetes action in BME in South West Cardiff- Final Report 2008
- Welsh Assembly Government (2005) Health ASERT Programme Wales. Enhancing the Health Promotion Evidence base on Minority Ethnic Groups, Refugees/ Asylum Seekers and Gypsy Travellers.
- Butetown Speak Out Be Heard – Community Consultation Report 2010, Butetown Communities First.
- "Barefoot" Health workers project – Final Report 2002-2007 – Inequalities in Health Fund. Sue Torner – Sept 2007."

Supply and delivery of medication

55. Linda Rollings RMN, Service Manager, St Luke's Healthcare, Hillside, Ebbw Vale, writes: "At this Hospital we use a local pharmacy for the supply and delivery of medication. We have a service level agreement that states that the pharmacist completes an audit on a monthly basis on each of our three units. We are about to open another hospital that will, in time, have four units. When reviewing the summary of structure and enhanced services I wondered how do you ensure the value and standard of all the services that a pharmacy may offers, within his/her pharmacy, whilst having commitments to independent hospitals".

Care Pathway

56. Sue Dryburgh, Planning & Commissioning Assistant (Older People), Monmouthshire County Council writes: " Our comments on Monday were based around the service user's/carer's knowledge about the medications being administered, their side effects and the implications of not taking as directed. In addition the problem of hospital discharges (Andrew Evans did

say that this was being addressed this year but it still doesn't take away the problem of the first couple of days at home without input from the GP surgery or pharmacy and with a bag full of medication – particularly a problem if the service user is elderly and confused). We would also like to highlight the level of responsibility expected from poorly paid and not always sufficiently trained care workers and the importance of involving the care agency responsible for administration in the MUR?"

Communities First perspective

57. David Napier writes: I speak on behalf of *some* of the communities within Caerphilly County Borough as a Communities First Health and Wellbeing Officer. Of course do not speak on behalf of all Communities First staff. The main grudge has been the lack of pharmacies in the north of the borough in particular, but also including Trinant in the east. Although it is recognised that the infirm/house-bound etc can have a delivery service there are many others who may not have the transport to be able to get to a pharmacy, as the transport system is not the best in the area.
58. There is also an issue regarding the timing of satellite doctor's surgeries and although a separate issue it does have an affect on the issue at hand, in that if it is difficult to see a GP then they are more inclined not to bother going and even if they then do get a prescription that lethargy and the bad transport system fuels their lack of attendance at future GP appointments and thus the picking up of any prescription.
59. Whilst the feasibility of a peripatetic pharmacist may not be to the benefit of what is after all a business concern *something* should be possible to alleviate the issues in these areas.
60. The other issue I raised was regarding the prescription waste audit. One of the issues was that I wanted to know if they asked the rational for any wastage i.e. did they forget to take medicine, take the wrong medicine (due to possible change in shape/name) or took medicine but 'felt better' after only taking half of the prescription and so on. Without this knowledge government cannot surely make informed judgement of what is actual 'waste', and thus begin to know how to prevent such waste in future. Whatever the outcome, the recent meeting has prompted some ideas for a few projects

61. **Summary**: `these observations are a summary of detailed discussion in a wide-ranging conversation and email contributions, which have been listed in no particular order. It would have been interesting if organisations representing the views of the public we seek to serve and using public resources had been able to research and publish patient views on a very important issue.

62. As stated by Dr Gwyneth Briwnant Jones "Changes in the health system are necessary if we are to have an effective community based approach to fit the needs of today. The transfer of essential funds from secondary / tertiary to primary and community services is necessary, in order to provide the infra-structure for a good service, which focuses upon Patients and service users within the community. This is the context within which changes in Community Pharmacy will need to be considered".

Conclusions

63. We need to review medical services to ensure that the focus is upon the patient and the community. This includes:
    - Improved communication between GPs and Community Pharmacists.
    - Ensuring that consistent MURs are undertaken to ascertain the effectiveness of the treatment, especially in the case of older people and disabled service users who may have a combination of medications.
    - Medicine Use Reviews that are appropriate to different cultural and related health needs, which engage with local community organizations.
    - Provision of clear pathways for the acquisition, receipt and safe use of medicines, particularly for older and disabled service users.
    - Assurance that health professional revalidation supports the above.
    - The role of salaried community pharmacists, linked with Community Transport in rural and semi rural areas.
    - Neighbourhood Care Networks across Wales embed Public and Patient Engagment at an early phase when considering ‘promoting more cost-effective prescribing in selected groups of medicines’.

Hilda Smith and David Smith

23 September 2011