EAHP statements survey 2016: sections 1, 3 and 4 of the European Statements of Hospital Pharmacy

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EAHP Statement 1: Introductory statements and governance.

EAHP Statement 3: Production and compounding. EAHP Statement 4: Clinical pharmacy services.

ABSTRACT

Background The 2016 European Association of Hospital Pharmacists (EAHP) Statements survey builds on previous surveys and focuses on sections 1, 3 and 4.

Objective To collect statistical data about the level of implementation of the Statements, and identify important barriers to their implementation.

Methods An online questionnaire was sent to all hospital pharmacies in EAHP member countries. Data were analysed by researchers from Keele University School of Pharmacy, UK and the EAHP Survey Group. If an incomplete survey was submitted, the quantitative data were not used, although any free-text responses were incorporated.

Results The overall response rate was 16% (904 out of 5711 requests) with 730 complete responses. In the first part of the survey, data were collected on the hospital pharmacy setting. While almost half (n=335) of hospital pharmacies served over 500 beds, 77% (n=564) of hospital pharmacies had ≤10 pharmacists. In section B, evidence was gathered about the degree of implementation of sections 1, 3 and 4 of the Statements and the main barriers to, and drivers of, implementation. The questions related to production and compounding (section 3) received very positive responses (all questions from this section received at least a 70% positive response rate), indicating that responders are having less difficulty implementing these statements compared with others. The introductory statements and governance questions (section 1) received a more mixed response. Only 343 (47%) responses indicated that the pharmacists worked routinely as part of multidisciplinary team. Many of the questions relating to clinical pharmacy services (section 4) received a more negative response overall, with six questions receiving <50% positive responses.

Conclusions This iteration of the survey provides the EAHP with further insight into the implementation of the Statements across the member countries as well as the barriers to, and drivers of, implementation in sections 1, 3 and 4. This is essential to inform the plans for EAHP to best support their implementation.

INTRODUCTION

The European Association of Hospital Pharmacists (EAHP) Statements survey 2016 represented the final step in the first cycle of the revised format of the EAHP annual survey. After the EAHP General Assembly 2014 decision, the EAHP survey changed the tool for measuring the level and progress of implementation of the Statements which were adopted in 2014.^{1,2} In this model, the baseline survey was to be followed by two alternating annual surveys covering three of six sections of the

Statements. The results of the baseline and 2015 survey, describing the status for sections 2, 5 and 6, has already been published,^{3,4} and here we report the results of the 2016 survey aimed at sections 1, 3 and 4. Repeating the surveys in future will allow the EAHP to measure progress in implementation and identify the main barriers. This will inform the implementation project, currently one of the most important EAHP activities, and the need for any potential update of the European Statements.

METHODS

The survey was drafted following a meeting of the EAHP Survey Group and was conducted between October and November 2016, spanning 35 EAHP member countries. The sections of the Statements covered in the 2016 survey were:

- ▶ Section 1: Introductory statements and governance;
- ▶ Section 3: Production and compounding;
- ▶ Section 4: Clinical pharmacy service.

As with previous surveys, the 2016 EAHP Statements survey consisted of three sections:

- ▶ Section A: general questions about the participant's hospital pharmacy, such as workforce skill-mix and number of beds served;
- ▶ Section B: questions about the current activity of pharmacists associated with each statement;
- ▶ Section C: questions about the hospital's readiness and ability to implement the statements.

Questions in section A were designed to allow further analysis of dependencies between main implementation barriers and hospital type, level of staffing, etc. In section B, a value was allocated to each response to rate the degree to which respondents were able to comply with each statement (where 1=cannot comply, 5=always comply).

In section C, respondents were asked to what degree they agreed with the question, and the same Likert scale was used (1=strongly disagree, 5=strongly agree). For the purposes of identifying those Statements where the barriers to implementation were greatest, a response of 3, 4 or 5 was deemed to indicate less difficulty in complying with that statement—a 'positive response'. A response of 1 or 2 was deemed to indicate some difficulty in complying with that statement—a 'negative response'. Where this was the case, the participant was asked a follow-up question to identify the barriers to implementing the Statement.

Five standard preselected options were used for every question, with some questions having additional specific options. The five main options were:

1. We are prevented by national policy and/or legislation;

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2. Not considered to be a priority by my managers;
3. Not considered to be a priority by me;
4. We would like to do this but we have limited capacity;
5. We would like to do this but we have limited capability.

There was also an 'other' option field, where the respondent could give a free-text response if they had a different answer. Respondents were allowed to select multiple options. Having identified the level of implementation of the Statements, and any barriers to implementation, participants were also asked for specific information to deepen the understanding of the topic.

SurveyMonkey was used as the software tool for the survey. The EAHP General Assembly used English as the only language for the survey to facilitate data assessment and to avoid additional costs and possible errors resulting from translation of questions and answers. The survey was conducted from October 2016 to November 2016. National coordinators tracked the response rates in their country. In some countries, the national coordinators were also responsible for dissemination of the survey links.

If an incomplete survey was submitted, the quantitative data were not used in the results, although any free-text responses were still incorporated. For questions about barriers to implementation, responders were offered multiple choice questions, therefore the sum of portions might exceed 100%.

RESULTS

Response rates

A total of 904 responses were received, which is slightly fewer than the 2015 EAHP Statements survey, which had 952 replies. However, this year's survey had more complete responses (that is, people who completed the survey) than last year (730 this year, 697 last year).⁴ The 2016 survey was completed by 81% of participants, compared with 73% of participants in 2015.

The response rates for 2016 EAHP Statements survey are listed in the [table 1](#), broken down by country. The response rates from the baseline survey are given in the final column for comparison.

Section A

The results showed that 46% (n=339) of responders worked in teaching hospitals. These numbers are only slightly higher than those in the baseline survey (42%, n=423)³ and 2015 Statements survey (43%, n=405).⁴ Hence the samples can be considered to be similar from this point of view. Seventy-five per cent (n=551) of responders represented hospital pharmacies based in general hospitals. Thirty-eight per cent of participants (n=279) indicated that their hospital pharmacy regularly provides service to more than one hospital, with 84% (n=233) providing service to 2–5 hospitals, 8% (n=23) to 6–10 hospitals and 8% (n=23) to >10 hospitals.

Forty-seven per cent (n=342) of hospital pharmacies served hospitals with 100–500 beds, 25% (n=182) hospitals with >500–1000 beds, 21% (n=153) hospitals with >1000 beds, while 7% (n=53) served hospitals with <100 beds. This also confirms that the sample was similar to that of the 2015 survey, where the corresponding percentages were 45%, 24%, 22% and 9%, respectively.⁴

Based on the results of previous EAHP surveys, insufficient staffing (capacity) appeared to be one of the most important barriers to the implementation process. In our sample, 77% of hospital pharmacies employed <10 pharmacists (n=564), 20% between 11 and 50 (n=147) and only 3% (n=19) employed ≥51. Similar numbers for the pharmacy technicians were seen—71% of responders reported that their hospital pharmacy employed up to 10 pharmacy technicians (n=519).

Table 1 Response rates by country

Country	Responses	Requests	Percentage (%)	Percentage (%) (baseline survey)
Austria	27	48	56	47
Belgium	45	172	26	22
Bosnia	12	23	52	33
Bulgaria	17	73	23	14
Croatia	16	36	44	79
Czech Republic	42	104	40	63
Denmark	7	8	88	88
Estonia	10	25	40	64
Finland	16	82	20	17
France	50	1835	3	7
FYROM	13	31	42	22
Germany	82	383	21	31
Greece	32	106	30	62
Hungary	54	111	49	100
Iceland	2	2	100	48
Ireland	32	73	44	5
Italy	36	609	6	11
Latvia	6	45	13	7
Lithuania	9	39	23	50
Luxembourg	3	6	50	58
Malta	3	5	60	50
Montenegro	4	6	67	n/a
Netherlands	18	108	17	35
Norway	20	32	63	56
Poland	21	38	55	7
Portugal	38	89	43	22
Romania	14	66	21	41
Serbia	45	65	69	78
Slovakia	33	76	43	52
Slovenia	22	31	71	57
Spain	39	250	16	17
Sweden	19	37	51	24
Switzerland	17	60	28	43
Turkey	70	821	9	6
UK	30	216	14	36
Total	904	5711	16	18

FYROM, former Yugoslav Republic of Macedonia.

Section B

Box shows all the questions asked in the survey about the 21 European Statements of Hospital Pharmacy from sections 1, 3 and 4, and where applicable, the overall percentage of participants who gave a 'positive response' to the question. Whenever a participant gave a negative response to a question, there was usually a follow-up question of 'What is preventing this?' The percentages shown in this section indicate the mean percentage among the countries regardless of the numbers of participants in the respective countries, not the percentage of all positive/negative responses in the sample (the numbers of positive/negative responses are shown).

Questions where <50% of participants gave a positive response have been indicated in boldface, and questions where >75% of participants gave a positive response have been indicated in italics. The table shows generally the highest level of implementation in section 3 (Production and compounding), where all questions exceeded two-thirds of positive responses. The results in section 1 (Introductory statements and governance)

Box Survey questions and percentage of positive answers

EAHP survey questions

Section 1: Introductory statements and governance

- ▶ **S1.1 The pharmacists in our hospital work routinely as part of a multidisciplinary team (46% of responses were positive.)**
- ▶ S1.3 Our hospital is able prioritise hospital pharmacy activities according to agreed criteria (66% of responses were positive.)
- ▶ S1.5 The pharmacists in our hospital are engaged in the supervision of all steps of all medicine use processes (67% of responses were positive.)
- ▶ **S1.5.2 Do you have an approved human resource plan in place to address this? (22% of responses were positive.)**
- ▶ S1.6 At least one pharmacist from our team is a full member of the Drug & Therapeutics Committee or equivalent (86% of responses were positive.)
- ▶ S1.6.2 The pharmacists in our hospital take the lead or have an active role in coordinating the activities of the Drug & Therapeutics Committees or equivalent (88% of responses were positive.)
- ▶ S1.7 The pharmacists in our hospital are involved in the design, specification of parameters and evaluation of ICT (information and communication technology) used within medicines processes (64% of responses were positive.)

Section 3: Production and compounding

- ▶ S3.1 The pharmacists in our hospital check if a suitable product is commercially available before we manufacture or prepare a medicine (89% of responses were positive.)
- ▶ S3.2 When medicines require manufacture or compounding, we either produce them in our hospital pharmacy or we outsource to an approved provider (85% of responses were positive.)
- ▶ S3.3 The pharmacists in our hospital undertake a risk assessment to determine the best practice quality requirements before making a pharmacy preparation (81% of responses were positive.)
- ▶ S3.4 The pharmacy in our hospital has an appropriate system in place for the quality assurance of pharmacy prepared and compounded medicines (73% of responses were positive.)
- ▶ S3.4.2 The pharmacy in our hospital has an appropriate system in place for the traceability of pharmacy prepared and compounded medicines (81% of responses were positive.)
- ▶ S3.5 Our hospital has appropriate systems in place for the preparation and supply of hazardous medicines (67% of responses were positive.)
- ▶ S3.5.2 Our hospital has appropriate systems in place to minimise the risk of exposing hospital personnel, patients and the environment to harm from hazardous medicines (76% of responses were positive.)
- ▶ S3.6 Our hospital has written procedures that ensure staff are appropriately trained to reconstitute or mix medicines in a patient care area (67% of responses were positive.)
- ▶ S3.6.2 Were pharmacists involved in approving these procedures? (78% of responses were positive.)

Section 4: Clinical pharmacy services

- ▶ S4.1 The pharmacists in our hospital play a full part in shared decision-making on medicines, including advising, implementing and monitoring medication changes (52% of responses were positive.)
- ▶ S4.2 All prescriptions in our hospital are reviewed and validated as soon as possible by a pharmacist (51% of responses were positive.)
- ▶ S4.2.2 Does this review and validation by a pharmacist take place prior to the administration of medicines? (88% of responses were positive.)
- ▶ S4.3 The pharmacists in our hospital have access to the patients' health record (59% of responses were positive.)
- ▶ S4.3.2 The pharmacists in our hospital document their clinical interventions in the patients' health record (56% of responses were positive.)
- ▶ S4.3.4 We analyse these clinical pharmacy interventions to inform quality improvement plans (80% of responses were positive.)
- ▶ S4.4 The pharmacists in our hospital enter all medicines used onto the patient's medical record on admission (24% of responses were positive.)
- ▶ S4.4.2 The pharmacists in our hospital reconcile medicines on admission (39% of responses were positive.)
- ▶ S4.4.4 When reconciling medicines, the pharmacists in our hospital assess the appropriateness of all patients' medicines, including herbal and dietary supplements (40% of responses were positive.)
- ▶ S4.5 The pharmacists in our hospital contribute to the transfer of information about medicines when patients move between and within healthcare settings (39% of responses were positive.)
- ▶ S4.6 The pharmacists in our hospital ensure patients and carers are offered information about their medicines in terms they can understand (51% of responses were positive.)
- ▶ S4.6.3 Have the pharmacists in your hospital received appropriate education and support to help them explain the risks and benefits of medicines, in terms patients/carers can understand? (65% of responses were positive.)
- ▶ S4.7 The patients in our hospital are informed when medicines are used outside of their marketing authorisation (57% of responses were positive.)
- ▶ S4.7.2 Do hospital pharmacists do this? (40% of responses were positive.)
- ▶ S4.8 Do you have an agreed strategic plan for the development of clinical pharmacy services in your hospital? (42% of responses were positive.)

Table 2 Five questions with the lowest mean percentage of positive responses across the different countries

Question	Mean (2016 survey)(%)	Mean (baseline survey)(%)
S4.4 The pharmacists in our hospital enter all medicines used onto the patient's medical record on admission	24	29
S4.5 The pharmacists in our hospital contribute to the transfer of information about medicines when patients move between and within healthcare settings	39	44
S4.8 Do you have an agreed strategic plan for the development of clinical pharmacy services in your hospital?	42	n/a
S1.1 The pharmacists in our hospital work routinely as part of a multidisciplinary team	46	59
S4.6 The pharmacists in our hospital ensure patients and carers are offered information about their medicines in terms they can understand	51	64

showed mixed results. The smallest number of positive responses appeared in section 4 (Clinical pharmacy services), where most first level questions got $\leq 50\%$ positive responses.

The five first level questions which received the least positive responses were identified (table 2), and were subjected to a more in-depth analysis. These five questions related to Statements 4.4, 4.5, 4.8, 1.1 and 4.6.

Questions relating to Statement 4.4: All the medicines used by patients should be entered on the patient's medical record and reconciled by the hospital pharmacist on admission. Hospital pharmacists should assess the appropriateness of all patients' medicines, including herbal and dietary supplements.

Figure 1 shows the percentage of respondents who gave a positive response when asked if pharmacists enter all medicines used onto the patient's medical record on admission. Overall, the mean response for countries was 24% positive only (n=214). With the exception of Spain, Turkey, the Netherlands and the UK, in every country surveyed less than half of the respondents

gave a positive response. When this question was originally asked in the 2015 baseline survey it had a similarly negative response (29% of responses positive), indicating that many pharmacists do not perform this activity and no or very little progress overall has been made towards implementing it.

To further understand this, respondents were asked what is preventing pharmacists from entering medicines onto patient's medical records (multiple choice). The most frequent overall response was that other healthcare professionals do this, with 314 out of 516 negative responses (61%) responses in total. This was also the main reason given in the free-text responses to the same question in the 2015 baseline survey.

Another major barrier identified was lack of capacity, with 253 (49%) responses, suggesting many pharmacists do not have time to perform this activity. Not being considered to be a priority by managers was also raised as a large barrier, with 153 responses (30%). Since so many responses say other healthcare professionals do this activity already, it may be that managers do not

Figure 1 Percentage of respondents who gave a positive response to the statement 'The pharmacists in our hospital enter all medicines used onto the patient's medical record on admission'. FYROM, former Yugoslav Republic of Macedonia.

Figure 2 Percentage of respondents who gave a positive response to the statement 'The pharmacists in our hospital contribute to the transfer of information about medicines when patients move between and within healthcare settings'. FYROM, former Yugoslav Republic of Macedonia.

see the value in implementing any changes to a system already in place, especially if the existing pharmacists are working at full capacity already.

It is encouraging that there were few responses saying the pharmacist did not consider it to be a priority ($n=17$, 3%), the pharmacists don't have the confidence to do this ($n=30$, 6%) and reluctance from the medical staff to support/allow this ($n=57$, 11%). There were also comments in the 'Other' section from Germany and Portugal saying it is their intention to implement this soon.

Questions related to Statement 4.5: Hospital pharmacists should promote seamless care by contributing to transfer of information about medicines whenever patients move between and within healthcare settings.

The responses to the question 'The pharmacists in our hospital contribute to the transfer of information about medicines when patients move between and within healthcare settings' are shown below in Figure 2. The mean response for countries was 39% positive ($n=302$), showing this statement is not currently implemented widely across European hospitals. This response is slightly lower than the result from the baseline survey, which was 44%, indicating that progress has not been made in implementing change. As with other questions about clinical pharmacy services, the positive response rate between countries was variable, and it can be seen that some countries have focused more on development of these services.

When asked what are the barriers to pharmacists contributing to the transfer of information about medicines when patients move between and within healthcare settings, the most frequent response was that other professionals were doing this already (229 out of 428 negative responses, 54%) and lack of capacity (202 responses, 47%). Not considered to be a priority by my

managers also had 118 responses (28%). From the 'Other' category were several comments from different countries saying they have electronic systems and records in place that automatically do this task without needing the pharmacists' intervention.

Questions related to Statement 4.8: Clinical pharmacy services should continuously evolve to optimise patients' outcomes.

Figure 3 shows the percentage of respondents who gave a positive response when asked 'Do you have an agreed strategic plan for the development of clinical pharmacy services in your hospital?'. The mean positive response rate for this question was 42% ($n=329$), and aside from a few outliers, this result was fairly consistent across countries. This question was not asked in the pilot survey, so there are no baseline data with which to compare. The main barriers to implementing this statement were identified as 'not being considered a priority by managers/clinicians' (239 of 401 negative responses, 60%) and limited capacity (206 responses, 51%). Again, there were few responses stating 'not considered to be a priority by me', suggesting that many pharmacists see being involved in more clinical pharmacy services to be important.

Of the 37 free-text responses from the 'Other' category, 11 say they are currently working on a strategic plan and 10 say they have a strategic plan, but are unable to implement it owing to lack of capacity or lack of interest from managers.

Questions related to Statement 1.1: The overarching goal of the hospital pharmacy service is to optimise patient outcomes through working collaboratively within multidisciplinary teams in order to achieve the responsible use of medicines across all settings.

Figure 4 shows the percentage of respondents who gave a positive response to the statement 'The pharmacists in our hospital work routinely as part of multidisciplinary team'. It can

Figure 3 Percentage of respondents who gave a positive response to the question 'Do you have an agreed strategic plan for the development of clinical pharmacy services in your hospital?'. FYROM, former Yugoslav Republic of Macedonia.

Figure 4 Percentage of respondents who gave a positive response to the statement 'The pharmacists in our hospital work routinely as part of a multidisciplinary team'. FYROM, former Yugoslav Republic of Macedonia.

be seen that the pharmacists from many countries do not work as part of a multidisciplinary team, which was also identified as a major concern in the 2015 baseline survey. The mean positive response rate for countries was 46% (n=348), which is lower than the 2015 baseline survey rate, which was 59%. Respondents who gave a positive response to the question were asked 'What type of multidisciplinary activities are you involved with?' (multiple choice question). Membership of multidisciplinary committees (n=305), specific therapeutic subgroups (n=289) and educational activities (n=258) all received many responses. It is interesting to note that the activities involving interaction with patients (multidisciplinary ward rounds (n=196) and consulting with patients about medicines (n=191)) received fewer responses. The 37 'Other' free-text responses offered a wide range of activities, but responses about patient safety were raised several times.

Respondents who gave a negative response to the initial question were asked 'What is preventing you or your pharmacists from routinely working as part of multidisciplinary team?'. Limited capacity was the main barrier identified by a large margin (278 of 382 negative responses (73%)). The responses from the baseline survey also identified limited capacity (specifically lack of funding and availability of clinical pharmacists) as the main barrier.

Not being considered a priority by managers and reluctance from other medical/nursing staff to allow this also received a lot of responses (n=152 (40%) and n=95 (25%), respectively). From the 'Other' free-text comments, and from comments from the baseline survey, it is suggested this might be because managers and other medical staff are not aware of the full extent of pharmacists' skills. The remaining free-text comments referred to

not having enough clinical pharmacists available to perform any multidisciplinary activities.

Questions related to Statement 4.6: Hospital pharmacists, as an integral part of all patient care teams, should ensure that patients and carers are offered information about their clinical management options, and especially about the use of their medicines, in terms they can understand.

When asked if hospital pharmacists ensure patients and carers are offered information about their medicines in terms they can understand, the mean percentage of positive responses for a country was 51% (n=395). This is a much less positive response than when the question was asked 2 years ago in the baseline survey (64% positive). Figure 5 shows the results broken down by country, which shows that the response between countries is mixed, with a large range between results.

Participants who said they had offered patients information about their medicines in terms they can understand were then asked which patients they did this for mostly. The most common response was doing this for all patients, with 165 responses. However, a large number of respondents said they mainly do this only for inpatients (130 responses) or outpatients (100 responses).

The participants who indicated that they do not offer patients information about their medicines in terms they can understand were asked to identify what barriers were preventing this from happening. As with the other questions looked at in this report, the most frequent barrier listed was a lack of capacity (192 out of 335 negative answers, 57%), followed by 'other healthcare professionals do this' (179 comments, 53%). Only six (2%) respondents selected 'not considered to be a priority by me' as an

Figure 5 Percentage of respondents who gave a positive response to the statement 'The pharmacists in our hospital ensure patients and carers are offered information about their medicines in terms they can understand'. FYROM, former Yugoslav Republic of Macedonia.

option. The majority of the ‘other’ free-text comments referred to pharmacists having no contact with patients in their roles.

Participants were also asked ‘Have the pharmacists in your hospital received appropriate education and support to help them explain the risks and benefits of medicines, in terms patients/carers can understand?’. It is interesting to compare the results with Figure 5, as a simple assumption might be that pharmacists saying they are not offering information about medicines to patients might not have received any training to perform this activity. However, this is not the case as the mean positive response rate for countries was 65%. From this and Figure 5, it can be seen that pharmacists feel capable of performing this activity, but other barriers such as limited capacity are preventing it.

DISCUSSION

The 2016 EAHP Statements survey completes the first 2-year cycle of the EAHP Statements. There are several limitations to this report. The first and most important limitation was that the number of responses from some member countries was small, and hence did not allow a precise statistical evaluation at a country level. The reason for this is that some countries have a much smaller population and therefore a much smaller number of hospitals. The second limitation was the need to find a balance between the length of the questionnaire (and the workload for responders) and level of detail sought in identifying the main barriers to implementation.

Despite these limitations, the survey results provide an up to date picture of the state of our profession in Europe in relation to the Statements. The most challenging Statements in sections 1, 3 and 4 for implementation remain those related to clinical pharmacy services, and participation of hospital pharmacists in multidisciplinary teams.

What this paper adds

What is already known on this subject

- The 2014/2015 European Association of Hospital Pharmacists (EAHP) baseline survey, the first survey of the new EAHP line of surveys, provided general knowledge of the baseline level of implementation of the European Statements in all six sections.

What this study adds

- This paper deepens our knowledge of the level of implementation of sections 1, 3 and 4 of the Statements and identifies the main barriers to, and drivers of, implementation.
- The most challenging Statements for implementation in hospital pharmacies in the sections listed above are: clinical pharmacy services and participation in multidisciplinary teams.
- The most important barrier to implementation is insufficient capacity and different priorities of hospital and health system managers.

The main barrier identified was insufficient capacity to undertake these services, and the results of this survey confirm the finding from the EAHP baseline survey. The numbers of hospital pharmacists and pharmacy technicians remain small in many European countries. Forty-six per cent of hospitals in this survey had 500 beds, but 77% of hospitals had up to 10 pharmacists.

Significant improvement in staffing levels cannot be a short-term goal, but EAHP will provide support to help develop business cases, and the self-assessment tool will enable head pharmacists to have real-time information to discuss with hospital and health system managers. The answer ‘not being considered a priority by my managers’ was quite often mentioned, and here we see even greater opportunities for speeding up implementation and raising awareness about the Statements and their impact on patients and healthcare systems. The level of awareness, implementation readiness and willingness was also measured in this survey (more details in report) showing a clear increase in awareness.

The next surveys, in autumn 2017 and 2018, focusing on sections 2, 5 and 6 and 1, 3 and 4, respectively, will re-examine the sections described in the first cycle of surveys. This will provide an opportunity to further compare the results and track any progress.

CONCLUSION

The main objective of the 2016 EAHP Statements survey was to provide an assessment of the level of implementation of sections 1, 3 and 4 of the Statements throughout European countries and to identify the main barriers to, and drivers of, implementation. This enables the EAHP to prioritise efforts in implementation and education. This objective has been reached, thanks to the enormous efforts of national coordinators and all of our members who responded to the survey. The data will now be used to inform the EAHP Statements implementation project as well as other major projects of EAHP.

Contributors PH, AB, JS and JU planned the study and designed the questionnaire. NG set up the online form, sent the questionnaires to responders and tracked the responses. NG, JU and PH conducted the survey, and carried out data evaluation and statistics. PH, AB, JU and NG prepared the manuscript.

Competing interests None declared.

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