Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Cofnod y Trafodion
The Record of Proceedings

Y Pwyllgor Cyfrifon Cyhoeddus

The Public Accounts Committee

19/6/2017

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Lee Waters Bywgraffiad|Biography	Llafur Labour

Eraill yn bresennol
Others in attendance

Yr Athro / Professor Rory Farrelly	Prif Swyddog Gweithredu Dros Dro / Dirprwy Brif Weithredwr a Chyfarwyddwr Nyrsio a Phrofiad y Claf, Bwrdd Iechyd Lleol Prifysgol Abertawe Bro Morgannwg Acting Chief Operating Officer / Deputy Chief Executive and Director of Nursing and Patient Experience, Abertawe Bro Morgannwg University Local Health Board
Mark Griffiths	Cadeirydd, Fferylliaeth Gymunedol Cymru Chair, Community Pharmacy Wales
Dr Karen Gully	Cyfarwyddwr Meddygol, Bwrdd Iechyd Lleol Addysgu Powys

	Medical Director, Powys Teaching Local Health Board
Judy Henley	Cyfarwyddwr Gwasanaethau Contractwyr, Fferylliaeth Gymunedol Cymru Director of Contractor Services, Community Pharmacy Wales
Elen Jones	Prif Ymgynghorydd Polisi, Cymdeithas Fferyllol Frenhinol Practice and Policy Lead, Royal Pharmaceutical Society
Suzanne Scott-Thomas	Prif Fferyllydd, Bwrdd Iechyd Lleol Cwm Taf Chief Pharmacist, Cwm Taf Local Health Board
Carol Shillabeer	Prif Weithredwr, Bwrdd Iechyd Lleol Addysgu Powys Chief Executive, Powys Teaching Local Health Board
Dave Thomas	Swyddfa Archwilio Cymru Wales Audit Office
Judith Vincent	Cyfarwyddwr Clinigol Rheoli Fferylliaeth a Meddyginiaethau, Bwrdd Iechyd Lleol Prifysgol Abertawe Bro Morgannwg Clinical Director for Pharmacy and Medicines Management, Abertawe Bro Morgannwg University Local Health Board
Cheryl Way	Aelod o Fwrdd y Gymdeithas Fferyllol Frenhinol; Prif Fferyllydd, Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro; a Swyddog Arweiniol Cenedlaethol Rheoli Fferylliaeth a Meddyginiaethau, Gwasanaeth Gwybodeg GIG Cymru Royal Pharmaceutical Society Board Member; Principal Pharmacist, Cardiff and Vale University Local Health Board; and National Pharmacy and Medicines Management Lead, NHS Wales Informatics Service
Allison Williams	Prif Weithredwr, Bwrdd Iechyd Lleol Cwm Taf Chief Executive, Cwm Taf Local Health Board

Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol
National Assembly for Wales officials in attendance

Fay Bowen	Clerc Clerk
Claire Griffiths	Dirprwy Glerc Deputy Clerk
Meriel Singleton	Ail Glerc Second Clerk
Katie Wyatt	Cynghorydd Cyfreithiol Legal Adviser

Dechreuodd y cyfarfod am 14:00.
The meeting began at 14:00.

Cyflwyniad, Ymddiheuriadau, Dirprwyon a Datgan Buddiannau
Introductions, Apologies, Substitutions and Declarations of Interest

[1] **Nick Ramsay:** Hello and welcome. Thanks for coming. I welcome Members to this afternoon's meeting of the Public Accounts Committee. Headsets are available in the room for translation and sound amplification. Can Members please ensure that electronic devices are on silent? In the event of an emergency, follow directions from the ushers. No apologies have been received; we are a full complement today. Do any Members have any declarations of interest they'd like to make at this point in time?

[2] **Lee Waters:** Yes, I do. My wife works for Cwm Taf health board.

[3] **Nick Ramsay:** Thanks for that. That'll be noted.

Papurau i'w Nodi
Papers to Note

[4] **Nick Ramsay:** Okay, item 2, our papers to note, and, first of all, the minutes of the meeting held on 5 June 2017. Happy to note those?

[5] **Mike Hedges**: Hapus. **Mike Hedges**: Happy.

[6] **Nick Ramsay**: Secondly, the Permanent Secretary, Shan Morgan, at her introductory session, was asked about the challenges that digitalisation will bring to the Welsh Government. She has written a letter to us talking about the digital action plan 2017-2020. Happy to note the letter?

[7] **Mike Hedges**: Can we keep it available—[*Interruption*.] Go on.

[8] **Lee Waters**: Sorry, Chair—

[9] **Nick Ramsay**: Lee first and then Mike.

[10] **Lee Waters**: Sorry. I'd like to do more than note it, if we may. I'd like to suggest that we consider it further. I think it's a very helpful letter. It does, I think, raise more questions than it answers and I think this is such an important field for the shape and delivery of Government, especially in the face of austerity and the changes we know are coming from the fourth industrial revolution. So, I think it's excellent that the Permanent Secretary has engaged as intensively as she has with it, but I certainly have a series of questions I'd like to further pose on it. I don't know how other Members feel, but I think there'd be merit in us holding a hearing on it in the future.

[11] **Mike Hedges**: I was going to say, Chair—I was going to suggest, that, the next time she comes to see us, it's one of the topics we discuss with her.

[12] **Nick Ramsay**: I would second that. Are other Members happy? Okay, so shall we schedule a discussion? We can discuss this further, as a committee, but we can schedule a discussion. I'm informed that she's coming in the autumn to consider the accounts, so, at that point, we can raise that.

[13] **Lee Waters**: My view, Chair, is that she's given us a draft strategy and a substantial note specifically on digital change in Government, and I think, as a topic by itself, it deserves a focused hearing rather than as part of a broader look into the Government's work.

[14] **Nick Ramsay**: She has agreed to send us a copy of the digital action plan when it's finalised in the summer. But are you saying that you want to consider that further?

[15] **Lee Waters**: I'd like to question her and her officials on it further.

[16] **Nick Ramsay:** And the officials. Okay, well, we can discuss that at some point and we can arrange a time to raise that with her in an appropriate way.

[17] **Lee Waters:** Thank you very much.

[18] **Nick Ramsay:** Okay. Thank you.

14:03

Rheoli Meddyginiaethau: Sesiwn Dystiolaeth 2
Medicines Management: Evidence Session 2

[19] **Nick Ramsay:** Okay, moving on to item 3 and our evidence session on medicines management—we got there in the end; thank you for being patient. The committee took evidence from the Welsh Government on 6 March and agreed to widen the range of witnesses as part of that inquiry. So, can I welcome our witnesses to this meeting on the back of that decision? We do have four of you. I'll ask you to state your names and positions for the Record of Proceedings first, starting on my left.

[20] **Ms Way:** Thank you. I'm Cheryl Way. I'm the hospital pharmacy representative on the Welsh board of the Royal Pharmaceutical Society.

[21] **Ms Jones:** Hi, I'm Elen Jones. I'm practice and policy lead for the Royal Pharmaceutical Society. I also lecture in Cardiff University's school of pharmacy one day a week.

[22] **Mr Griffiths:** My name's Mark Griffiths. I'm chairman of Community Pharmacy Wales and a practising pharmacist in Dowlais Pharmacy, Merthyr Tydfil.

[23] **Ms Henley:** I'm Judy Henley. I'm the director of contractor services for Community Pharmacy Wales.

[24] **Nick Ramsay:** Great. Thank you for being with us today. Clearly, there are a number of you, so this will need careful management from me, as chair. I'm quite happy for one organisation to answer, and, if the other organisation basically agrees, then don't feel you have to chip in on everything. However, if you do have a burning issue then just catch my eye

and I will, of course, bring you in.

[25] Okay. We've got a number of questions. If I can kick off with the first one, do you feel that the NHS in Wales is making appropriate use of the skills and expertise of pharmacists to help support better medicines management and achieve prudent healthcare aims? Who wants to take that?

[26] **Ms Jones**: Shall I make a start?

[27] **Nick Ramsay**: Elen—Elen Jones.

[28] **Ms Jones**: Okay. So, the core expertise of the pharmacist is medicines—not only how medicines work on the body, but how they interact with each other. And, with the ever-increasing complexity of medicines themselves and also the increasing complexities of patients with more and more long-term conditions, it is vital that pharmacists are a real component part of that multidisciplinary team. We are seeing pharmacists being used in different ways to how maybe we've traditionally seen them, in new and emerging roles. Some of those roles include more independent prescribing pharmacists, pharmacists that are working across clusters, and also pharmacists that are working in NHS 111, out of hours, in the clinical hub. So, I think there are lots of developments for pharmacy happening.

[29] **Nick Ramsay**: It was remiss of me not to point out as well that, Elen, you are standing in for Mair Davies, who's unwell today. The director couldn't be with us today, so thank you for stepping in, that's really helpful. Can I ask you further: has sufficient work been done to identify how the pharmacy workforce needs to be planned and developed in order to maximise its contribution? Cheryl Way.

[30] **Ms Way**: I think more work needs to be done. Mair and I did meet with a group within Welsh Government that is looking at improving recruitment and retention of all health professionals in Wales. It is actually very hard to know how many pharmacists are out there working at the moment, and, with all these new and emerging roles, it is causing gaps in other parts of the system. So, there's definitely a need for us to have better ways of planning and working with Workforce, Education and Development Services to try and capture that information and work towards a strategic workforce plan for Wales, really.

[31] **Nick Ramsay**: Rhianon Passmore—supplementary question.

[32] **Rhianon Passmore**: Sorry if I've misheard that. So, is there not an understanding, in a sense, across Wales—is there not a register of pharmacists?

[33] **Ms Way**: There is a register of pharmacists who are practising in Great Britain, and of pharmacy technicians, but we don't actually know where they're working, necessarily. They could have a registered address in Wales but actually be working in England.

[34] **Rhianon Passmore**: So, it's the person's qualification that's probably being tracked. What would solve that? What would be the answer to that understanding in terms of workforce planning in Wales?

[35] **Ms Way**: Well, we know about the managed sector, because they're employees, and we know, to some extent, from the community pharmacy bodies, who actually have employees—there's quite a big locum workforce, who could actually be resident anywhere, and then there's a lot of things changing where people are being employed maybe directly by GP practices, so they're not necessarily part of the pharmacy payroll.

[36] **Rhianon Passmore**: So, really, what I'm getting at: is there a need to have a more directly understood collated data management system of who is there and what they're doing?

[37] **Ms Way**: Yes, and also what we need them to do in the future as well.

[38] **Rhianon Passmore**: Okay. So, that should form the strategic—

[39] **Ms Way**: Yes, and to provide the training for the future roles that pharmacists—the ones that Elen mentioned are developing now. So, certainly, more independent prescribing pharmacists seem to be what people need, and we don't have, so far, the sort of training to train large numbers at the moment.

[40] **Ms Jones**: We currently have around 10 per cent of pharmacists in Wales that are trained as independent prescribers—I think it's 287 independent prescribing pharmacists—but whether they're all getting to use that qualification is something different.

[41] **Nick Ramsay**: So, training is a barrier. Any other areas that you would

identify as being a major area stopping integration? Mark Griffiths.

[42] **Mr Griffiths**: Use of the qualification in primary care—that's always been an issue, but I think, with regard to where we're going with the Government at the moment, that the possibilities could open up for more use of those qualifications in a primary setting.

[43] **Ms Jones**: And—. Sorry.

[44] **Nick Ramsay**: It's all right. Go on.

[45] **Ms Jones**: It may be worth noting that for a pharmacist to become an independent prescriber, it just takes six months, because you already have that core expertise and knowledge. So, it would be a good way to get more people that are able to prescribe to be able to do more services in community and primary care and in hospitals.

[46] **Nick Ramsay**: Would a nationally agreed service specification be a positive step forward?

[47] **Ms Jones**: Yes, absolutely.

[48] **Nick Ramsay**: Is that all yeses? Yes.

[49] **Ms Henley**: In terms of independent prescribing, from the community pharmacy perspective, we've got far fewer community pharmacists who can prescribe at the moment, and a lot of that is to do with actually there being services available for them to access. So, they may have the qualification but they don't have access to a budget to prescribe against, which is what causes some of the issues. We do have—. There's a pilot scheme in operation in Powys at the moment where a pharmacist has been providing independent prescribing since December. He's seeing, on average, 130 patients a month at the moment—so, doing very well—and starting to prove a case to build an evaluation as to where it could go from—

[50] **Nick Ramsay**: I think your initial point, there, that it wasn't the budget, that the two weren't aligned, what were they—? Sorry, I missed the very first thing you said.

[51] **Ms Henley**: For a pharmacist to prescribe, they have the qualification, but unless there's an NHS budget aligned to them, it's the—where does that

sit? Does it sit within the GP or does it sit in a different stream within the health board?

[52] **Nick Ramsay:** Yes. Good. Thank you. Lee Waters.

[53] **Lee Waters:** Can I just ask: it seems to me there's a potential issue here of different sets of professional vested interests at play, because you've got one set of independent private contractors in the pharmacy and another set of independent private contractors in the GPs. There seems to be a vested interest for neither of them to let go—for one to slice up the cake and the other to let them have it. So, to what extent do you think is the business set-up of that contractor model a complicating factor in working out what's best for the patient?

[54] **Ms Henley:** I suppose the example in Powys shows that working very well, where the GP has fully accepted the pharmacist prescribing against a specified formulary, and the GP practice will triage patients to the community pharmacist to see those patients. It's about freeing up workload from a GP perspective, so, where we've got GP practices that are struggling to recruit, actually having a community pharmacy service may actually help to free up even more capacity. We've already got that a little bit with the roll-out of common ailments as well, where patients can be directed to community pharmacies where that's been rolled out.

[55] **Ms Jones:** I think that example that Judy was giving in Powys—for more common ailments the GP practice saw a decrease of 21 per cent in the amount of appointments for more common ailments, which, of course, allows them to spend more time on more complex diagnosis.

[56] **Lee Waters:** But you've just been telling us about the professional skill set you're working with. They're capable of doing far more than the run-of-the-mill stuff, so how do we free up that potential to best serve the needs of the patient?

[57] **Ms Jones:** I would say we also have a really good workforce of pharmacy technicians who are registered professionals. We have 1,617—

[58] **Lee Waters:** Sorry, you're not engaging with my point.

[59] **Ms Jones:** Oh, sorry.

[60] **Nick Ramsay**: Lee, what question are you trying to ask?

[61] **Lee Waters**: Well, a fairly simple one. The professional boundaries could be getting in the way of allowing pharmacists to do as much as they possibly can, not simply do the dross that the GPs don't want to be bothered with. So, what is it that needs to change in the model that we're talking about to free up that resource?

[62] **Ms Jones**: To free up the pharmacy resource, you mean?

[63] **Lee Waters**: To get pharmacists doing as much as possible.

[64] **Ms Jones**: Yes.

[65] **Lee Waters**: Is it the contractual model? Is it cultural? Is it a lack of qualifications? What's the issue?

[66] **Nick Ramsay**: Mark Griffiths.

[67] **Mr Griffiths**: I think from the point of view of the common ailments scheme, obviously that's going to be rolled out throughout Wales over the next number of years. As that develops I'm hoping that within the primary sector it could well be that the GPs would understand that there would be more and more use to be made of independent prescribers. I think at the moment it is difficult for GPs in busy practices to understand what a pharmacist independent prescriber can do for them, and that's the issue at the moment, I think.

[68] **Lee Waters**: Can I just, finally—? My initial question was trying to tease out whether or not it was more than just they're too busy to understand. Does the system of the independent contractor model actually mean they've got a vested interest in not understanding?

[69] **Nick Ramsay**: So, is the model—? I think the point is: is the model itself inhibiting?

[70] **Mr Griffiths**: The system works at the moment. If you have an independent prescriber in a primary care setting and you want that independent prescriber to work in a GP practice then they are contracted to work in that GP practice. So, the GP practice would pay for that pharmacist to work for them, and that is the only way they would have access to a

prescribing budget, normally. So, there are barriers, yes.

[71] **Nick Ramsay:** Rhianon, did you want to come in on this?

[72] **Rhianon Passmore:** Just to muddy it further in terms of if it's structures or cultures or both, in terms of Choose Pharmacy, you mentioned the independent prescribing pilot in north Wales, those models are out there and, obviously, in terms of the one, it's going to be rolled out 'majoritively'. What needs to change to be able to make better use, then, of (a) independent prescribing, and (b) further usage and further buy-in of the Choose Pharmacy model?

14:15

[73] **Ms Henley:** So, in terms of independent prescribing, there are barriers to training huge numbers of pharmacists to get them to become independent prescribers, not because of the length, of course, but because of the mentoring model and the need to release the pharmacist to attend the training, which obviously requires backfill and everything else as well. So, that has been a bit of a barrier in terms of actually—

[74] **Rhianon Passmore:** So, there's a capacity issue there in terms of the infrastructure around the ability to be able to train.

[75] **Ms Henley:** Yes, and it also needs a GP to support, from a training and mentoring purpose. If you've got a GP practice that's already struggling, and already under capacity to actually find a GP to support that process, it becomes a bit of a vicious circle.

[76] **Rhianon Passmore:** Finally, then: in terms of the ability to—who pays for what—. I believe it's the health board that pays for the Choose Pharmacy. It sits with them in terms of funding for that; and then, I think, independent prescribing—you say that budget would sit with the local practice. Is that right or is that wrong? So, the budget to be set against the independent prescriber that currently, within this pilot model, in its infancy, would come from the GP practice. Is that correct?

[77] **Ms Henley:** The pilot that's running in Llanidloes is being paid for by the health board, so it's not being picked up by the GP practice as such. In terms of, I suppose, future funding models, there would need to be—

[78] **Rhianon Passmore**: Clarity.

[79] **Ms Henley**:—clarity as to exactly how that would work. But in terms of Choose Pharmacy and common ailments, that's an enhanced service, so it's paid for out of health board funding.

[80] **Nick Ramsay**: And, on Choose Pharmacy, Mike Hedges.

[81] **Mike Hedges**: I visited two GP surgeries with pharmacies attached—one last week, as part of this investigation, and one during the summer in my constituency of Swansea East. So, one in Llanelli and one in Swansea. I found that the pharmacy and GP practice were working very closely together. Is that atypical and I just managed to visit two good examples, or is it typical?

[82] **Nick Ramsay**: Mark Griffiths.

[83] **Mr Griffiths**: We like to work as closely as we possibly can with the GP practices because, at the end of the day, my primary concern is patient care. So, if we work closely with the doctors, then the patient generally benefits from that.

[84] **Mike Hedges**: But is that what's happening on the ground now? I've seen two or three very good examples of it—two in my constituency and one outside—but I often find out, when I go visiting places, it's only the places with best practice they want me to—[correction: visit]. They either invite me to—[correction: visit]. Or the people themselves invite me to—[correction: visit]. People with the worst practice tend to have less interest in seeing me. So, have I just gone and seen good practice because there's isolated good practice or is it the fact that there's lots of good practice and I was just seeing part of it?

[85] **Nick Ramsay**: Judy Henley, you look like you're dying to answer this question.

[86] **Ms Henley**: As Mark said, we need to work closely with our GP colleagues, otherwise we would struggle from a business perspective. I work infrequently now as a community pharmacist, but I will spend a proportion of my day, every day I work, speaking to the GP practice. So, you need to build a good relationship to make it work for your patients rather than anything else.

[87] **Mike Hedges**: I'm quite happy with everything everybody has said, but

can I ask this question a different way? Is it normal to have good relationships between GPs and pharmacy practices, to see them working closely together and for the benefit of patients, or are there, in some cases, some barriers, often artificial, set up?

[88] **Nick Ramsay:** Elen Jones, did you want to come in on this one?

[89] **Ms Jones:** From our experience, there are good working practices and, as Judy said, it's beneficial for both parties to have that. So, yes—

[90] **Mike Hedges:** Everyone?

[91] **Ms Jones:** I can't say 'everyone'—

[92] **Mike Hedges:** Almost everyone?

[93] **Ms Jones:** —but from my experience—and I'm a community pharmacist by background as well—those working relationships are essential for your patients, and that's what comes first.

[94] **Nick Ramsay:** Mark Griffiths, did you want to comment?

[95] **Mr Griffiths:** Obviously, I've been a qualified pharmacist for 30 years, all of it working in community pharmacies. So, I spent five years as a locum, so I travelled all around the valleys of Wales and it's very, very rare in that time that I've ever come across a pharmacy that didn't have a great relationship with their GP colleagues. It's a commercial situation, so it's in the pharmacists' interests to be as pally with the GPs as they possibly can, but at the end of the day, the most important part of that is patient care.

[96] **Mike Hedges:** Can I move on, then, to the discharge of medication review? It's something that a number of GPs who are friends of mine have concerns about—that not enough information is coming out of the hospital quickly enough in order to make life easier and to know exactly what is happening. Sometimes it's just medication that they had in hospital without any indication of what they may need in the future and also without any indication of what they've actually had wrong with them—just the medication. Do you recognise that? Is it possible for electronic discharge information to provide enough information for you to be able to help with the discharge of medication review?

[97] That takes me on to another thing I'm very concerned about, which is polypharmacy. We test every medicine, every tablet, against relatively young, relatively fit people on their own, and then we give it with large numbers of other items to somebody who's very old, and we think it's going to work in exactly the same way. So, I have some concerns about that. Are you in a position to start reviewing that?

[98] **Nick Ramsay:** Judy Henley.

[99] **Ms Henley:** Sometimes, in terms of the discharge of medicine review, part of the roll-out of the Choose Pharmacy platform will aid the pharmacies in getting the information quicker. So, one of the programmes on that platform means that we will be able to receive an electronic form of the discharge letter direct from the hospital, which means that we'll be able to see their information and be able to carry out that review without requiring the patient to walk in with the information, which is a barrier, because when patients are being discharged from hospital, probably the last thing on their mind is telling their community pharmacist that they've been in. So, that will help to drive the information to us because it hasn't always been as quick as it could have been. So, with the roll-out of Choose Pharmacy across Wales, that will actually help to increase the flow of information.

[100] **Mike Hedges:** Is it happening now?

[101] **Ms Henley:** In some of the health boards where they've gone live, yes, it is. It also requires from the hospital end for them to have gone live with the electronic discharge process, which I suspect Cheryl will be able to give more information about.

[102] **Ms Way:** We are live in five health boards, but there are different stages of roll-out, so Cardiff and Vale actually has at least 70 wards where all their discharge letters go out through the Welsh clinical communications gateway to GP practices, but also into the Choose Pharmacy application if the patient has nominated that pharmacy as the pharmacy they want to receive that information. They also get an e-mail when the patient's discharged so they know that the patient's actually left the hospital.

[103] **Mike Hedges:** And my last question is: it almost starts with—why wasn't it done before with emergency medicine services? Somebody who regularly needs asthma pumps, for example, has to get a GP to sign a prescription for them to go to the pharmacist to get an asthma pump, the

pharmacist knows they need an asthma pump, because they've been giving them asthma pumps over a long period of time. They've forgotten, or one pump didn't work as effectively or as long as they expected it to, and all of a sudden they're without a pump. This idea of actually just going to the pharmacist and getting it rather than actually having to go and find a doctor, perhaps even an out-of-hours doctor, for something that is relatively straightforward. I'm not sure why it hasn't happened before. I'm sure you welcome it happening. What stage are we at with this? This could save an awful lot of time for GPs and an awful lot of worry for patients.

[104] **Nick Ramsay**: Mark Griffiths.

[105] **Mr Griffiths**: First and foremost, if it is a prescription-only medication, then you have to have a prescription so there can't be any doubt. So, if somebody comes to the pharmacy and they don't have a prescription, then I'm in a very difficult position as to whether I can give them that medication or not. So, the emergency supply service means that I can do that. I can do that, and I have direct experience of that because one of my pharmacies is an emergency supplier—

[106] **Mike Hedges**: I was going to say that often you'll be giving it to people who are your own customers. You might have a bit of doubt with somebody coming along who's not one of your customers, but somebody who comes along regularly—you know they need this asthma inhaler, you know they regularly have it, they've just been inefficient in getting a prescription, and that's no reason for them to end up in hospital.

[107] **Mr Griffiths**: There is legislation in place that means, technically, if I give out a medication without a prescription, then the general pharmaceutical committee could come to me and put me in a situation where I could be prosecuted and, ultimately, struck off for giving a prescription-only medication out. With the emergency supply service, that obviously doesn't cause a problem. I have it in one of my pharmacies and it is a very, very useful service. I think the data are starting to arrive where we're seeing that it's keeping people out of accident and emergency. It's keeping them out of the doctors' surgeries on Friday afternoons when they're too busy to be able to slot these people in. So, I'm a firm advocate of the service. It should be rolled out throughout Wales, in my opinion.

[108] **Mike Hedges**: Thank you. I'm in total agreement with you, I think it should be rolled out as soon as possible, because it takes pressure off the

GPs and it takes worry off the patient who has to go and book into an out-of-hours service or try and queue in the GP's surgery to try and get something that everybody knows that they need.

[109] **Mr Griffiths**: I think the two aspects of the emergency supply service, which are—obviously, if it's a regular patient of yours, you have their patient medication record on your system, so you—

[110] **Nick Ramsay**: I can see consensus has broken out, so I think that's always a good point to move on to the next question, before you talk yourselves into a disagreement—[*Laughter.*]—which has happened in some of my meetings. Mohammad Asghar.

[111] **Mohammad Asghar**: Chair, I would like to say as a follow-up to Mike's point here, very seriously, this is the experience of a constituent—a person had an experience. His wife had a knee operation and the hospital gave a high-potency medicine prescription to go and get from the chemist. The person went to the chemist, and the chemist totally refused. She would not give that medicine because it was written by fountain pen, even though the consultant put his own registration number and everything, and you can imagine—a Friday afternoon, 6.30 p.m., you can't get a hold of anybody else and that was the scenario. Believe me: it was me. It was not somebody else. They refused my wife's medicine. So, that is a serious point that Mike raised. It is there at the moment. So, Chair, that's got to be taken notice of.

[112] **Nick Ramsay**: Sorry, what was the excuse?

[113] **Mohammad Asghar**: The medicine was not given by the chemist or the pharmacist because—. It was high potency, and it was written by fountain pen, the prescription—fountain pen, and the excuse the pharmacist made was that it should be capsules not tablets, or tablets not capsules. But it was the same medicine. It was just a high-potency painkiller, but, never mind, I'll come to the question. There is an issue on that, so please look into it. The thing is serious.

[114] **Nick Ramsay**: We have no prejudice against fountain pens in this committee, by the way—[*Inaudible.*]

[115] **Mohammad Asghar**: But, generally, I am very pleased with the pharmacy—no problem on that. Are you all happy or comfortable with the increasing use of the homecare medicines service in Wales, especially in the

light of this Hackett report in England? What sort of measures have you taken to eliminate those sorts of risks? All witnesses can answer.

[116] **Nick Ramsay:** Elen Jones. No, Cheryl.

[117] **Ms Way:** The Royal Pharmaceutical Society has worked with the All Wales Medicines Strategy Group to provide guidance to the profession on how homecare medicine should be managed, which takes many of the recommendations from the Hackett report. So, I feel now, a few years on, that we actually do have good financial and clinical governance of homecare medicines, which can offer a convenient service for certain patients.

[118] **Ms Jones:** One thing, though, we are very supportive of is that these patients still get access to a pharmacist. If the medicines are delivered, they should still be able to speak to a pharmacist about any of their medicines queries as well.

[119] **Mohammad Asghar:** But there was an element of risk being mentioned in that report. Have you done anything about that? That should not happen in Wales.

[120] **Ms Jones:** It's due to that report and the element of risk that was highlighted that we've produced the handbook, as Cheryl said.

[121] **Ms Way:** And it is being audited, I understand, by the Wales procurement pharmacist to ensure that all those things have been implemented across all the health boards in Wales. I certainly know that most health boards have a dedicated pharmacy-based homecare team that look after that group of patients, working closely with the prescribers and the nurses who also monitor those patients from the hospital site.

14:30

[122] **Nick Ramsay:** Thank you. Neil McEvoy, some questions on out-patient dispensing, I think you had.

[123] **Neil McEvoy:** Yes, on whether you think there are clear benefits in moving towards out-patient dispensing in the community. So, that's open for each one of you, really.

[124] **Nick Ramsay:** Mark Griffiths, you kick off.

[125] **Mr Griffiths:** This has been one of my favourite topics for a long time. I firmly believe that when a patient leaves hospital, they should have a prescription that can be dispensed in the community pharmacy of their choice, because that means that it can tie in with the medication that they're previously on so you can check that out. Also, you can do a discharge MUR on them straight away, and you have more experience of that patient than them coming out of hospital with the medication and then eventually it gets to the doctors, and then eventually we get the prescription a week, month, whatever later. I think the system, if that was in place, would cut down on potential errors, definitely.

[126] **Ms Jones:** I would agree that it could help with patient choice. It's important that we think about the patient first here, and, if they already have a good relationship with their community pharmacy, which most patients do, it could be very beneficial for them.

[127] **Ms Way:** I think the waiting times in hospital out-patient pharmacies can be very long, and they've already often been there for a considerable amount of time in other clinics. So, giving them the choice to take a prescription at a more convenient time for them is something I'd support.

[128] **Neil McEvoy:** Do you see any downsides?

[129] **Ms Way:** There is a possibility that the community pharmacy may not immediately have the medicine in stock if it's something new, but most community pharmacists, I believe, can access supplies within a very short time, so it's unlikely they'd have to wait very long.

[130] **Neil McEvoy:** Are you aware of what progress has been made towards dispensing for out-patients in the community?

[131] **Ms Way:** I understand quite a lot of health boards are adding that to their portfolio. I don't think we'll ever be able to send all out-patients to community pharmacies. They have a choice to come to the hospital pharmacy, and some medicines are not available through community pharmacies and have to be dispensed in the hospital. There's certainly a lot of clinical trials medicines and things like that that only go through hospitals, but I think all health boards are using it to a greater or lesser extent to improve patient choice.

[132] **Neil McEvoy**: Do you think anything can be done to encourage all health boards to move a lot more quickly and fully along this line?

[133] **Ms Way**: I think some of them do it quite a lot. Certainly, Aneurin Bevan have embraced it and do very few out-patients themselves within the hospitals. Cardiff and Vale are moving towards it. I know Cwm Taf do so as well, and ABMU.

[134] **Neil McEvoy**: Okay. So, the only practical problems that you could see would be if the drug wasn't there, and that's it really in terms of downsides.

[135] **Mr Griffiths**: Delay would probably be in the region of 12 to 15 hours, that's all.

[136] **Nick Ramsay**: The network for pharmacies to get a hold of the pharmaceuticals at short notice seems to be pretty good.

[137] **Mr Griffiths**: Well, you have three what we call 'mainline wholesalers' available in Wales, which are Alliance, AAH, and Phoenix, and most of those deliver twice a day. They're based out of Swansea and Cardiff. So, access to pharmaceuticals is not really a problem.

[138] **Nick Ramsay**: Okay. Mike Hedges, supplementary question.

[139] **Mike Hedges**: Surely the simplest thing is that, for most medications, you'd give them the opportunity to go to their local pharmacist, but if something is on trial or specialist, tell them they've got to go to the hospital pharmacy. Would that not reduce queues in hospital pharmacies with not everybody having to go there, but only those going for certain specialist medicines and tablets?

[140] **Ms Way**: Yes. We'd agree with you, yes.

[141] **Mike Hedges**: I was trying to ask you a question then, rather than a statement, or Nick would shout at me. [*Laughter*.]

[142] **Nick Ramsay**: I don't shout at you, Mike. Well, only occasionally. Mohammad Asghar, do you have any supplementary questions to that?

[143] **Mohammad Asghar**: Thank you very much. I'll just ask the witnesses whether out-patient dispensing in the community would cause practical

problems for patients who could not get immediate access to community pharmacy.

[144] **Ms Henley:** If it was particularly on an out-of-hours basis, then the hospital pharmacy could still pick those up in those situations. In terms of patients who are housebound, a lot of community pharmacies provide delivery services for free to patients, so they would be able to support in that way. It may be a case of needing the hospital to fax even the prescription to the pharmacy to give them that information in advance, rather than sending the patient home with the prescription, because if the patient is housebound, the prescription is with the patient in their home, rather than needing to be in the pharmacy.

[145] **Ms Jones:** I think that's a good point—that good working relationships between community and hospital pharmacy teams will help to enable that process, by phoning ahead so that we can order in time.

[146] **Mr Griffiths:** We regularly get phone calls at 5 o'clock on a Friday to say, 'Mrs Jones is coming out of hospital tonight. She's been on a community tray. Please can you get a community tray ready for her when she comes home?' It puts a lot of pressure on us, but we do it.

[147] **Nick Ramsay:** Lee Waters.

[148] **Lee Waters:** Can I just follow up on that in terms of the IT systems? You mentioned faxing. It seems that the NHS and conveyancing solicitors are the only people left still using faxes. Are the IT systems in place, do you think, to make this run as smoothly as it could?

[149] **Ms Henley:** I suppose the issue is if it's a prescription itself, because the IT system for sending information in relation to discharge is a discharge letter that doesn't have the doctor's signature on it, or isn't actually a prescription as such. And it's the legal requirements of needing that prescription in your hand. So, we can dispense—. We can get prescriptions ready against a fax, but we need the actual prescription in our hand to be able to provide it.

[150] **Lee Waters:** Is there a smarter way of doing that?

[151] **Ms Way:** In England, they [*Inaudible.*] prescriptions, but we don't have that system in Wales currently.

[152] **Lee Waters**: Right. Do you think we ought to?

[153] **Ms Way**: I think there is probably a need for it going forward.

[154] **Lee Waters**: So, what's holding that up?

[155] **Ms Way**: I'm not sure that a clear case has been made for it and anybody charged with taking it forward at this stage. There are some discussions going on about it. Certainly, it's part of the requirements with the—

[156] **Nick Ramsay**: How long has it been operating in England?

[157] **Ms Way**: A long time—probably at least 10 years.

[158] **Nick Ramsay**: Because I remember this question—well, I've been here now 10 years as an Assembly Member—being asked many times in different committees over the years. So, the case still hasn't been made fully, or is it just dragging its feet?

[159] **Ms Way**: We decided to do something different in Wales, and we incorporate the 2D barcode onto prescriptions. So, we have a sort of electronic way of transferring the information, but we still require a paper copy of the prescription. We haven't got a way of generating or sending an electronic—

[160] **Lee Waters**: I don't understand why that needs to be. I don't understand why that is. Why do we need a paper copy of the prescription?

[161] **Ms Way**: It's because the signature is a legal requirement.

[162] **Lee Waters**: But you just said they do it in England.

[163] **Ms Way**: They've got an advanced electronic signature system in England, which we don't have.

[164] **Lee Waters**: So, my question stands: why can't we do that?

[165] **Ms Way**: I understand it's quite complicated, expensive—

[166] **Lee Waters**: Well, no more complicated than it was in England, presumably.

[167] **Nick Ramsay**: Mark Griffiths.

[168] **Mr Griffiths**: I think you need to bear in mind that electronic transferrable prescriptions, which is what it is England—that's what it's called in England—has been rolled out over a number of years, but it's not fully rolled out yet because there have been so many teething problems with it. For instance, before Christmas last year, there were problems and the spine was down, and they couldn't get prescriptions.

[169] **Nick Ramsay**: So, there is a flipside to this, which is that everyone would then complain that they couldn't get their prescriptions.

[170] **Mr Griffiths**: Exactly. Being a practising pharmacist, I'm not a firm advocate of electronic transferrable prescriptions. I like what we've got in Wales with the 2D barcoding. It makes the system work very smoothly, and I just think, as you say, there can be issues, but I think we can work these things out amongst ourselves. We don't have to go down the route of what they've done in England, because it has been a tortuous route.

[171] **Nick Ramsay**: So, are you waiting to see when the full roll-out happens what lessons are learnt from it, and then do it in the way that is best?

[172] **Mr Griffiths**: Maybe that's what will happen, I don't know, but we've gone down the route we've chosen and we don't seem to have any issues with that with practicing pharmacists in primary care at the moment. The barcoding works really well.

[173] **Lee Waters**: Well, there are plenty of issues that the auditor general has picked up. The system isn't as efficient as it could be, and I take your point about IT glitches, but it's slightly perplexing that you feel no desire to move that way at all.

[174] **Mr Griffiths**: You are looking at an issue that probably happens a couple of times a month, or whatever. Most of the time, the system works really smoothly. There are no issues with it.

[175] **Nick Ramsay**: I just want to bring Rhianon Passmore in. I'll bring you back afterwards, Lee, but I know that we're treading on toes here with

Rhianon's questions. There's a bit of—.

[176] **Lee Waters**: Sorry.

[177] **Nick Ramsay**: Well, no, it's not just you; I've done it as well, and, as Chair, I should know better, really, than nicking my members' questions.

[178] **Rhianon Passmore**: It's my pleasure.

[179] **Nick Ramsay**: So, if you want to come in, Rhianon, I'll bring you back then, Lee.

[180] **Rhianon Passmore**: Basically, in terms of some clarity, what you're actually saying, then, is that although they have got an advanced electronic prescribing system in England, there's also a downside within that, and there may or may not be a school of thought that we will wait and see what occurs before we pick up the lessons learnt. So, I was just going to read out this to you: the auditor general recommended that,

[181] 'The Welsh Government, NHS Wales Informatics Service (NWIS) and all health bodies should agree a detailed, time-bound plan for implementing electronic prescribing systems in secondary care'.

[182] So, the Welsh Government's response—and this is where I was going to come in—to that recommendation shows that the informatics system has now established the Welsh hospital electronic prescribing and medicines administration project. So, that work is ongoing, to define the scope. So, are we talking about one and the same thing here?

[183] **Mr Griffiths**: No.

[184] **Rhianon Passmore**: Right. So, when we say 'electronic prescribing', we're not talking about the advanced electronic prescription with a barcode on it. No. Okay, that's perfectly fine, then.

[185] **Ms Way**: That's purely hospital based

[186] **Rhianon Passmore**: Hospital based. Right, thank you for clarifying that for me, then. So, in terms of the electronic prescribing hospital system that I'm referring to, and medicines project, what progress has been made?

[187] **Ms Way:** A project team has been set up, led by a hospital consultant as the senior responsible officer. A business plan has been drafted. It's going to the national informatics management board on 4 July, and hopefully then on to Welsh Government, if they're happy with it. Obviously, it's a big project that will cost tens of millions of pounds and take a number of years to implement. So, it's a major piece of work for us to undertake within the NHS in Wales, but there's been good engagement with all health boards over it.

[188] **Rhianon Passmore:** What, in your opinion, needs to happen to make it realise its timescales?

[189] **Ms Way:** It's a big change management problem as well as the technology implementation, so it will involve nurses, doctors and pharmacy staff all changing the way they work. We'll need access to far more devices at ward level, and everybody trained, so it's actually a big piece of work to implement. It can be done, but it will take a lot of commitment from everybody involved.

[190] **Rhianon Passmore:** This is the way forward, and it's a very tight timescale that was mentioned in what I read out to you. When you say that we need cultural change and infrastructural change, can you articulate in a little bit more detail for me those steps in terms of how you think that can happen?

[191] **Ms Way:** Well, we have some change management people with NWIS who are working closely with us, which will help, and we're engaging with all the health boards, so at least they have an understanding of what's coming. Obviously, we have to go through a public sector procurement to actually buy the system, and we will be involving everybody in that specification and tendering exercise. We do have experience from other places in England and Scotland that are doing this already to learn from. There is quite a lot of information available out there, from the experience of other people in putting these in, that we're reading up on and will use as part of the implementation.

[192] **Rhianon Passmore:** Do you feel that, with that roll-out, 2018-19, we are in a good position to be able to realise the ambition of that project being rolled out?

[193] **Ms Way:** What the project's proposing currently is that we will first change the hospital pharmacy system, so that's the first procurement, and

then we'll procure the electronic prescribing system afterwards. So, the timescales will be later for the actual e-prescribing implementation. I think they're very challenging timescales, but you sort of don't really know until you start it and you see what some of the problems are. It might actually go better than we think, because we've done a lot of groundwork through things like implementing the medicines transcribing and e-discharge system within secondary care. So, there's a lot more technology out there and a lot more people involved currently than there were maybe five or 10 years ago.

14:45

[194] **Rhianon Passmore:** And do you feel that the right people are being engaged across the board and gamut of everyone that's involved in this significant programme?

[195] **Ms Davies:** I believe so. We are engaging with medical directors, nurse directors, chief pharmacists, IT people—you know, everybody who we think needs to be involved with such a large project.

[196] **Rhianon Passmore:** And in regard to the priority that's being attached to this from Welsh Government and from those who are actually delivering this change management and the infrastructure to go with it, do you feel that that is sufficiently highly placed in terms of priority?

[197] **Ms Way:** I think so and I believe so, but I think it will need Welsh Government to support it with some capital investment for it to actually be realised.

[198] **Rhianon Passmore:** Okay. And in terms of that statement, of supporting capital investment, is there any figure that you have attached to that in terms of how well placed you are to be able to focus on that?

[199] **Ms Way:** I have seen the business case, and it's in the order of £30 million to £40 million for the overall costs of that project, over seven years, I believe, currently.

[200] **Rhianon Passmore:** Okay. And is that sufficient, in your mind?

[201] **Ms Way:** It's our best estimate at the moment. Obviously we haven't gone out to tender yet, so we don't know all the prices. They're just estimates at the moment.

[202] **Rhianon Passmore:** Okay. If the implementation does begin in 2019 as expected, when do you think electronic prescribing as we've just restated it will be fully rolled out in Welsh hospitals?

[203] **Ms Way:** I think the 2023 target is ambitious. From my experience of working within NWIS and within a health board, you do find other projects get in the way, and there are actually papers that have been written on this. It's how many other things you're trying to do at the same time that can make it challenging. So, if, say, a health board is rolling out a new radiology or a new pathology system, there's only so much capacity that they can deal with. So, it's that sort of thing that might make it slower than we'd like it to be, because we have to take all that into account.

[204] **Nick Ramsay:** Okay. First of all I took Rhianon's question, and now you've taken Neil's.

[205] **Rhianon Passmore:** No, no—it's clearly here, at the bottom of page 48.

[206] **Nick Ramsay:** Okay. Neil, before I go back to you, Lee, did you want to come back in? Right. Neil Hamilton on this subject.

[207] **Neil Hamilton:** On the face of it, it shouldn't be that complicated to set up a system that simply tells a variety of people what drug to dispense. I have some difficulty in understanding quite what the technical problems here might be that involve such an immensely long timescale for implementation, with all the caveats that you built into that in the evidence you've given this afternoon. We know, of course, that the history of the NHS generally in relation to these big IT projects is, how shall we say, variable, and so I can understand why you might be nervous about this, but it must be inevitable in the longer term that the days of paper are going to be numbered, and that this is a better way of working.

[208] **Lee Waters:** Not in NHS Wales it isn't.

[209] **Neil Hamilton:** No, well, evidently. So, what exactly is the real technical problem here that is getting in the way of this?

[210] **Ms Way:** It's not a standalone system. It's not as easy as just having a medicines chart. It involves a lot of different people. So, the doctors have to prescribe, the pharmacists have to check that and arrange the supply, and

then the nurses also have to use it to record every administration of every drug. But it also has to interface with a lot of other systems, so it needs to recognise all the people using it. They all have to be registered on the system and trained to use it. It has to recognise the right patient, so it needs to be linked into the demographic service. We want it to also be able to take that information and send it out to primary care when the patient leaves, so we need to integrate it into the Welsh clinical communication gateway and Choose Pharmacy. It's actually quite a big integration piece as well as just allowing someone to prescribe. You also need to programme it to only show the drugs that you want used according to your formularies within that area, so it won't allow them to prescribe everything. There's actually quite a lot of work. It's probably more complicated than it would seem on the surface.

[211] **Neil Hamilton**: I can't claim in any way to be a computer expert, but even an old fossil like me brought up in the days when we all wrote on goatskin parchment has become moderately computer literate. Yes, you do have to have systems that are capable of talking to one another, and we see this problem all the time in Government computer systems that can't. We see it, for example, in payments to farmers where the English system for dispensing subsidies to farmers can't communicate with the Welsh system. But within NHS Wales, presumably, the different health boards are using similar computer systems, or are they not? And is there something there that creates barriers that will potentially open us up to all sorts of difficulties when we're trying to have an integrated system?

[212] **Ms Way**: Actually, I think we are a lot more integrated in Wales than they are in many other countries, and I think that's because we do have a once-for-Wales approach, and we do have an integrated informatics service. It's just that we've never actually had an electronic prescribing system within the hospitals in Wales, and we are trying to do it across the whole country as one project—

[213] **Nick Ramsay**: GPs would be pretty much in favour of that, wouldn't they?

[214] **Ms Way**: I would think so.

[215] **Nick Ramsay**: But the evidence that we took—because there's a flip side to this—. On our visits to the surgeries, GPs told us that they sign so many prescriptions that unless there is something really glaring that stands out, they won't put a massive amount of thought into each one. They will put

the necessary thought, but no more than that. So, they'll be signing almost on a conveyor belt and it would take something really erroneous to pop up before them for them to question it. So, in many ways, an electronic system—. There's a tendency to think that having the human brain there involved at every point is a great thing but, actually, an electronic system could do that pretty well, couldn't it?

[216] **Ms Way**: Yes. GPs have electronic systems and they do get alerted. Our problem in hospitals is that we don't have that, and also we don't tend to repeat things because we have lots of different patients coming in all the time on lots of different medications that change a lot when they're in hospital. So, it's quite a different sort of prescribing situation from GPs. But the way the GP systems are managed is a good model, I feel, in Wales where they are managed centrally. There are only two systems; there's standardisation and there's central support for them.

[217] **Nick Ramsay**: Mike Hedges, did you want to come in on that?

[218] **Mike Hedges**: I'm just trying to take the current manual system and then look at the new computerised system and trying to see how they fit together. Now, tell me if I've got it wrong on the manual system, but under the current manual system, a doctor will write a prescription and that prescription will then be sent to the pharmacist internally, either by fax or physically carried.

[219] **Ms Way**: If we're talking about hospitals—

[220] **Mike Hedges**: In hospitals, yes. And in the community it'll be written by—. You go in, a doctor writes you a prescription, you pick it up and then you carry it off to a pharmacist. There's none of this checking you just talked about, which is coming into the new system. If I go to my GP, which I did a couple of weeks ago—he gave me a prescription, I picked it up; he forgot to sign it, but that's another problem—and I then took it to the pharmacist who said he'd get it signed for me and then I was given it. It might as well have gone electronically as gone by me carrying something. There were no checks done on it that I know of at any stage in there. All that happened is he wrote something on a piece of paper, I picked it up, I took it to my local pharmacist, and my local pharmacist gave me the cream. I'm not quite sure why that can't be done electronically, instead of him writing it out, handing it to me and me carrying it. Why can't you just send it electronically to the local pharmacist? I don't understand why all these complications of having all

these checks and balances in there, which do not exist in the manual system, all of a sudden get implemented in the electronic system. This is—dare I say it—a standard health service computerised system where they over-specify it. Or have I got it wrong?

[221] **Ms Way:** I think we're talking about two different things. Hospitals work very differently from—

[222] **Mike Hedges:** Can you talk me through the manual system in a hospital where somebody's lying in a hospital bed and they need some medicine? So, what actually happens?

[223] **Ms Way:** Well, largely, in hospitals, a lot of the medicines are already kept on that ward, not dispensed individually for patients. The pharmacist generally visits the wards with the pharmacy technician. So, the charts don't go down to the pharmacy; the pharmacy goes up to the patients. Then, every time a nurse administers a medicine, they have to sign for it. So, the doctors are prescribing, the pharmacists are checking and the nurses are administering, and that's all done within that one chart. So, it's a slightly different situation. And there are a lot of changes to that happening during the patient's stay. So it's not one prescription; it's a lot of different prescriptions, really, that get written during that time.

[224] **Mike Hedges:** I'm not going to get any further with this, but I just think that there's a serious danger of whoever is designing this going through the standard Welsh/British health service problem of over-specifying something, which means that it gets more things to go wrong in it. Those are just my thoughts on the matter, and I assume you disagree with that.

[225] **Nick Ramsay:** Those are Mike's thoughts, so I don't think you have to—[*Inaudible.*] Neil Hamilton.

[226] **Neil Hamilton:** I'll just ask one more question, prompted by what we've just heard. At the moment, the Welsh Government expects the procurement of systems to be completed in 2018-19, and the implementation beginning in the early part of 2019. But you've just said that you're envisaging a seven-year roll-out period before the whole system is complete. Would that be seven years from 2019 or seven years from now?

[227] **Ms Way:** I think the seven years is the entire life of the project, and there are two parts of it: one is procuring a hospital pharmacy system to

replace our current one, which is old. So, that would be the first couple of years: procurement and implementation. And, in parallel with that, we'd be procuring and implementing the electronic prescribing. The total of those two would be the seven years in the project plan.

[228] **Neil Hamilton**: That seems an immense length of time for a project of this kind, however big the NHS is in Wales. I was rather surprised that we can't telescope that process.

[229] **Ms Way**: It might be possible. If you put more resource into it, you might be able to do it sooner. But the way we've scoped it, that's what we're working towards.

[230] **Neil Hamilton**: Do you think that NWIS has given this sufficient priority, then, within its budget and within its forward programme of work?

[231] **Ms Way**: I think they have now. I think they are giving it sufficient priority, but it isn't just dependent on NWIS; it's dependent on Welsh Government and the health boards as well.

[232] **Neil Hamilton**: So, if they gave it a higher priority, it could be achieved more quickly.

[233] **Ms Way**: Possibly, if more money was invested in it for more people to do it.

[234] **Neil Hamilton**: Have you any idea what sort of money we're talking about?

[235] **Ms Way**: I'd have to go back and re-examine the cost to do that.

[236] **Nick Ramsay**: Back to Lee Waters.

[237] **Lee Waters**: You mentioned earlier that, in England, the primary setting there is motoring ahead, albeit with some glitches. But there there's a drive and ambition to try and modernise the system, and I don't detect any drive or ambition from the pharmacist sector here, at all, to try and drive change. Bearing in mind this was recommended in 2007, when Uber and Twitter didn't exist, and it's going to be brought in at the very least—and you suggested this is too ambitious—by 2023. We need to think about the outside context and about the patient. You mentioned, Mark Griffiths, the

primacy of the patient in all this, and the patient's needs don't seem to be considered very much. Patients are going to be living in a very different world in 2024-25 or later, when this gets implemented, than they were in 2007 when this was first identified as a need. So, where is the patient's voice? Because, clearly, the drive and the ambition and the pressure is not coming from your sector, based on what I've heard today. How do you, as a sector, bear in mind what the patient might want? I hear a lot about what's convenient for you, because you like your bits of paper and your barcodes, but where's the drive? Where's the patient voice in all of this?

[238] **Ms Jones:** For us, one thing that we are very set on is that we do want read-and-write access to the patient record or to the GP health record to enable us to get a clear picture of what medication has been prescribed to a patient. For us, the driving force behind that is patient safety. Currently, when we work as pharmacists, for example, in the community, the information that we have on our screens is what we have previously dispensed for that patient. We can't see the information about why that medication has been given to the patient. So, we don't see a diagnosis, and if that patient has gone to another pharmacy for a supply, we can't see the other medication that has been given to them. So, one key problem for us is that we haven't got that full picture.

15:00

[239] So, as a professional body, that is something that we are really driving behind: the need to get both read and write access to the record. My belief is that it should be that patient record and that they can give access to any healthcare professional that they think should have access to it, so that we can really know what we are supplying. One thing that we try to do is reduce the use of antibiotics where it's not necessary. For us, as pharmacists, it's difficult to know why it was prescribed in the first place, which makes our job quite difficult, and also it's not fair to put that burden on the patient to remember all the information that they've been given from the GP. So, one thing that we are very keen on and driving is that read and write access.

[240] **Lee Waters:** Okay, perhaps I can move this on to waste, Chair, if that's—

[241] **Nick Ramsay:** Hang on a minute. Mohammad Asghar, did you have a very quick question?

[242] **Mohammad Asghar**: Yes, because Elen just mentioned antibiotics. There are 20-odd types of antibiotics and doctors know what they're doing, so, how are chemists going to work out which are good and which are not? I think that is the doctor's job. They give you them for different reasons, so, it's not chemist—[*Inaudible.*]—unless it's only just ordinary antibiotics.

[243] **Ms Jones**: What I would say is antibiotic stewardship is everybody's business, from the patient to the doctor to the pharmacist. It's important that we're working together, that we're giving consistent messages to patients. If a patient is going in and seeing a doctor and the doctor says, 'You don't need an antibiotic for this diagnosis', we need to be able to offer the same information, and I think that's in fairness to the patient as well.

[244] **Nick Ramsay**: Okay. Back to Lee.

[245] **Lee Waters**: Yes, so, to change subjects then, I'll move on to medicines wastage. What suggestions do you have for reducing medicines wastage?

[246] **Ms Jones**: Shall I kick us off?

[247] **Nick Ramsay**: Elen Jones.

[248] **Ms Jones**: I would say that the biggest waste of medicines is the medicines that aren't taken by a patient for whatever reason. So, there are a number of reasons why a patient might not take the medicine as it's been prescribed. They may not have understood the importance of that medication. They may be getting side-effects from the medicine and they haven't shared that information with the healthcare professional. So, one of the key priorities for us is making sure where there is a medicine, there is a pharmacist to be able to support that patient to understand why it's been prescribed, and to give them advice and support should they come across any issues that they're having whilst they're taking that medicine.

[249] **Nick Ramsay**: Mark Griffiths.

[250] **Mr Griffiths**: If I can just use one example of how a pharmacist's intervention can—. It's not strictly about waste, but it's about patient care and how it works in pharmacy. I had a patient come in to me two weeks ago with extreme tiredness, looking particularly pale, and I thought, 'Hm, he's not looking well; I'm going to have a look at his records.' About two years ago, he was prescribed some omeprazole. I gave him a medicines use review,

told him—explained to him what it was all about, why he should be taking them, and he took them for two months. He'd stopped taking them. So, I went back out and I spoke to him and I said, 'You were dispensed omeprazole two years ago. You took them for two months; why did you stop taking them?' 'Well, they weren't making any difference to me. I'd been in hospital, I'd had my five pints of blood, and I was feeling great, so I didn't need to take the omeprazole anymore.' So I said, 'So, you're now manifesting yourself here with the same symptoms that you had two years ago. Why do you think you should have been taking the omeprazole? I explained to you when I did the MUR why you should be taking them.' Therefore, he went back to the GP and he's now in the process of going to the hospital to be given some pints of blood. So, there's a reverse side of waste, in that you think that the patient doesn't need it, but when you do an MUR, you realise that it is really important that they take the medication.

[251] **Lee Waters:** Okay. With respect, Mark, I don't deny the importance of pharmacists. In fact, I think we're not using pharmacists enough. My question to you was how we reduce waste, and I've had two answers that tell me that we need to use pharmacists more, not telling me how we can reduce waste. So, do you have any ideas? For example, we've had evidence as part of this inquiry that patients are routinely being prescribed things that they've asked not to be prescribed. They've agreed with the doctor and the pharmacist they don't want it anymore, but when they put their repeat prescription in, they're just doled out nonetheless. So, obviously, there's a financial incentive for pharmacists to dispense as much medicine as possible. It's a perverse incentive. So, how is it that we can reduce waste, and why is it that people are being prescribed things that they've asked not to be prescribed?

[252] **Mr Griffiths:** Well, I think there are three parts of the waste argument: there's the patient, the doctor and the pharmacist. Obviously, when a patient asks for their repeat medication, if they use a repeat medication service within a pharmacy, then they are asked every time they request their prescription what medication they require. So, for instance, if they have 10 items on the screen, if it's not me, it's one of my technicians, and they would go through and say, 'Do you need this one? Do you need this one? Have you got enough paracetamols this time? Do you need your Gaviscon—whatever?', and then the prescription is ordered on what that patient has requested. On occasion, we've requested six items, eight items, and 10 items come back because whoever's been doing the writing of the prescriptions in the doctor's surgery—for want of a better phrase—is just going 'click', and everything's

being dispensed. So, that's one side of it; that is one problem.

[253] **Lee Waters:** And if somebody—. I'm going to ask you to provide the answer in a second, but on that point specifically, if somebody comes to you with five items in their prescription because that's been put by the doctor, and they only want two of them, you don't have to dispense the five.

[254] **Mr Griffiths:** So, I dispense the two, and I put 'not dispensed' next to the other items on the prescription.

[255] **Lee Waters:** Well, there's a raft of anecdotal evidence to suggest that often doesn't happen, not least the evidence we've found in this inquiry and my own personal experience, where you're constantly being given things you haven't asked for, and there's a financial incentive for the pharmacist to do that.

[256] **Mr Griffiths:** Well, I can only speak from my own personal opinion—

[257] **Lee Waters:** So can I.

[258] **Mr Griffiths:**—and I just scratch the item out on the prescription and put 'not dispensed' in the box.

[259] **Nick Ramsay:** I don't think you're going to agree on this one. I thought the earlier consensus would have—

[260] **Ms Henley:** There is a financial incentive to carry on dispensing. But, from a pharmacy perspective, we won't necessarily know what the patient wants. So, we do, obviously, ask patients to check before they leave the pharmacy because as soon as they walk out with the medication and they take it home and then two weeks later bring it back and say, 'Actually, I didn't need this', we can't reuse it. So, once it's left the pharmacy, you're not allowed to legally re-dispense it.

[261] **Lee Waters:** Sorry, as far as I've understood the evidence you've given to date, it's how important the role of the pharmacist is because they're closer to the patient, they understand their needs and they're able to check their records. You're now telling me you don't always know what the patient wants.

[262] **Ms Henley:** A lot of prescriptions are collected not by the patient

themselves. So, if somebody other than the patient is collecting that medication, that person won't necessarily know that what they've got in the bag—

[263] **Lee Waters:** Fair point.

[264] **Ms Henley:** —isn't appropriate for that patient. So, there are significant difficulties there.

[265] **Lee Waters:** So, how do we change that then? Because my question stands: how do we eliminate waste?

[266] **Ms Henley:** So, in terms of reducing waste, there is, as part of our essential services that every pharmacy has to provide, something called 'repeat dispensing', but it's underutilised in Wales. It actually helps to free up GP time as well. It's where the GPs can prescribe in batches of prescriptions of anything up to a full year's worth of medication. That batch then stays with the pharmacy, but one of the requirements of that service is that you check with the patient as you're handing it out, 'Do you need all of these items?' every time. It still won't stop it in terms of, potentially, a carer or somebody picking it up, but, hopefully, if it causes a problem that first time, the carer would then say, 'Well, I was asked when I picked up your medication did you need everything', so that next time they'd actually get that information from the person they care for when they come to collect it. That helps to reduce waste, because if we can take it out of the bag before it has left the pharmacy, we'll put 'not dispensed' on it and it reduces waste.

[267] **Lee Waters:** And why is that underutilised in Wales?

[268] **Ms Henley:** Partly because it requires workload in putting it in place to start with. So, GPs have to put the patients on to that service to start with, which requires significant work upfront, but then saves them work down the line. It is undergoing a bit of a relaunch at the moment with more materials, which will go out to all GP practices and to all community pharmacists, to actually help them to support patients in going onto that service, but it's something that we've had as part of our contract since 2005. So, it is something that we can do that will actually help to potentially reduce waste.

[269] **Lee Waters:** If you've been at it since 2005, and you're saying it's underutilised in 2017, it suggests to me that the system is not reaching its full potential. Other than relaunching it—. Maybe this isn't going to work.

[270] **Ms Henley:** It needs to work better in relation to pharmacists working with GPs to get patients signed up to it.

[271] **Lee Waters:** So how do you do that?

[272] **Ms Henley:** Some of the conversations we've already started to have with GPs in relation to—and some of the additional material that we're providing to pharmacies actually help to support the workload of how you work through it with the GP and who identifies the patients. Because, originally, it was seen as being the GP's responsibility to identify which patient they put on, which meant it only happened as part of a consultation—

[273] **Lee Waters:** So, how do we, in theory, acknowledge there was a perverse incentive for pharmacists to dispense things when a patient may not want or need those things, because that's how they get paid? That's a fact of life. How is it that we can re-engineer the incentive system so that the pharmacist is incentivised not to dispense unless it's needed?

[274] **Ms Henley:** We do have some not dispensed schemes in some parts of some health boards, where it goes through a similar process to that which repeat dispensing would use anyway, where you double-check with the patient whether they definitely need everything and how many they've got at home, all the time. So, it increases workload from the pharmacy perspective, but they get financially rewarded for taking part in that service. But that's not widely available in every health board across Wales.

[275] **Lee Waters:** Why?

[276] **Nick Ramsay:** Well, I presume that they're schemes that are decided by each health board policy, aren't they?

[277] **Ms Henley:** They are, yes—

[278] **Nick Ramsay:** There's a central intervention there.

[279] **Ms Henley:** And they're a clinicians service, so it's not a national service as such.

[280] **Nick Ramsay:** Perhaps that's something we could look at as a committee.

[281] **Lee Waters:** Rather than you giving me the evidence, Chair, if the witnesses could tell me why they think this isn't being rolled out further. What are the barriers?

[282] **Mr Griffiths:** Part of the reason I think is that, for instance, in the last five years in Cwm Taf, there have been 620,000 items extra dispensed. So, I think, in 2005, there wasn't the pressure on GPs that there is now. Also, with the fact that there are fewer and fewer GPs, there is more and more pressure on the GPs. So, before, they couldn't see the benefit to them of these systems, now they can see that it is decreasing their workload, and therefore they are now more interested in doing these things.

[283] **Lee Waters:** Okay. Thank you.

[284] **Nick Ramsay:** Rhianon Passmore.

[285] **Rhianon Passmore:** On that particular point, though, obviously these are locally led initiatives, locally agreed at a very local practice level it looks like, and some health boards seem to be more satisfied with the no-dispense schemes than others, in terms of their priority. I absolutely take your point on board in terms of capacity and workload, and 'If it's not my core business, I don't need to do it', and I agree that culture is changing in terms of GP practice management, that they can now see that the community pharmacy scheme is taking pressure and workload off, but with regard to that national lead—that national direction—around no-dispense schemes, bearing in mind how important I presume we think they are, and I presume from what we've said that we would tend to have consensus that they are important, they do make a difference in terms of waste, and that is obviously the premise I base my question upon: where's that coming from, then, in terms of at a national level as to how we say, 'This is important', and who is supposed to be driving it? Is it the medical profession or is it the pharmacy professions? Who takes the lead on that?

[286] **Nick Ramsay:** Going back to my earlier evidence, the question that Rhianon's asked—. Yes, where should this be coming from? You say now that the doctors, or the GPs, are realising that perhaps they didn't value this type of approach before. Should it come from the health board; should it come from you guys; or should there be more direction strategically from above that, from the Welsh Government?

[287] **Mr Griffiths:** Well, each health board is autonomous, isn't it? So, it's up to them to make their decisions on what they consider to be their priorities. So, I think different health boards are taking more priority on repeat dispensing. So, they will then put pressure on the GPs. I would like to have a repeat dispensing service in place in my area. So, I would be quite happy to—. I have spoken in the past to my local GP surgery about it, and it just fell on deaf ears. Maybe now, with a little bit of back-up from the health board, you will get more of a buy-in.

[288] **Ms Jones:** Can I add as well that there are new and emerging opportunities with the development of clusters? We've got more pharmacists now working within GP practices, who can liaise with their community colleagues. So, this could be a real opportunity to get things moving as well.

[289] **Mr Griffiths:** Yes.

[290] **Rhianon Passmore:** Sorry, Chair, but in terms of the actual question itself, that's good practice, and I hope those pilot schemes continue and are rolled out across Wales. Whose job would it be, in terms of professional sector, to be able to roll out these no-dispense schemes, so that they are not just localised in local health boards in a fragmented way? Who should be taking the lead on it? Is it your profession, as pharmacies—the importance of these schemes—or is it GP led?

15:15

[291] **Mr Griffiths:** It would be the health board, because it's an enhanced service that the health board would have to commission.

[292] **Rhianon Passmore:** Okay, so you'd firmly put it back to the local health board commissioning.

[293] **Mr Griffiths:** Yes.

[294] **Rhianon Passmore:** Okay.

[295] **Ms Way:** I'd say, with the repeat dispensing scheme, there is some work going on centrally with that through the prudent prescribing implementation group as a sub-group that's been leading on that. So, there is a central focus on that.

[296] **Rhianon Passmore:** So, you wouldn't push it back further than the local health boards to the prudent prescribing—

[297] **Ms Way:** For the repeat dispensing, I know they've particularly done work around that.

[298] **Rhianon Passmore:** Okay, so, obviously, that work—is it just started, emergent, or has it been going for a while?

[299] **Ms Way:** I think they've produced documents that they're about to share, aren't they? They may have been shared already, but recently.

[300] **Rhianon Passmore:** So, it's imminent.

[301] **Ms Way:** Yes.

[302] **Rhianon Passmore:** Okay.

[303] **Ms Jones:** And, I think, once the service is in place, it's all of our responsibility to get behind it, then, to make sure that professionals know that it is there and can be accessed.

[304] **Rhianon Passmore:** Okay.

[305] **Nick Ramsay:** Neil Hamilton.

[306] **Neil Hamilton:** One of the problems, it seems to me, with the complicated conditions is that people are prescribed a cocktail of different drugs and they come in different sized packets, and so you can find at the end of a particular course that you've got a load of some things left. You then get a repeat prescription, and so the same process sets in train again, and, before you look around, you've got enough left in your cupboard to open your own pharmacy, for certain limited purposes anyway. I know this from my personal experience of my mother in her latter days, where she had an entire cupboard full of things, all out of date and so on, but there was a massive amount of waste built up. If that's then replicated tens of thousands of times around the country, we're dealing with serious problems. I don't know whether the answer to this is that, as the NHS is, to all intents and purposes, a monopsonistic purchaser of drugs, it could dictate the packet size so that you have the opportunity as pharmacists then to prescribe combinations of tablets that are not going to lead to endemic waste of this

kind.

[307] And, as regards what you've just said about patients and you as pharmacists finding out whether the patient either wants or needs a particular drug, where is the doctor in all of this? The doctor should be monitoring the progress of patients, and therefore there shouldn't be an open-ended, for-all-time repeat prescription. There ought to be a regular check—be it three months, six months, a year, or whatever, depending on the nature of the condition—whereby these repeat prescriptions are time limited and must be renewed with a proper assessment of the patient's needs at the time. The patient is utterly incapable of deciding what he or she needs; they're not medically trained to do that. You can't force a patient to take any medicine he doesn't want to take, obviously, but, as professional people, your obligation towards the patient is to tell them what they need. If they don't decide to take that advice, that's a matter for them, of course, but you've fulfilled your function in all of this.

[308] **Nick Ramsay**: Mark Griffiths.

[309] **Mr Griffiths**: Most surgeries will have their patients in for clinical reviews at the absolute limit of 12 months, or six months, three months, depending on what medication they're on and how closely they have to monitor what they're taking. So, most repeats are sanctioned for 12 months maximum and then they have to go into the surgery for a clinical review, and then they check that the medication is appropriate.

[310] **Nick Ramsay**: Okay, great. Can I thank our witnesses, Cheryl Way, Elen Jones, Mark Griffiths and Judy Henley for being with us today? It's been really helpful. We will send you a transcript of today for you to check before we finalise it, just for any glaring errors that you pick up on. Thank you for being with us. Our next witnesses won't be with us for 10 minutes, so we will take a short break. Thank you.

Gohiriwyd y cyfarfod rhwng 15:19 ac 15:31.
The meeting adjourned between 15:19 and 15:31.

Rheoli Meddyginiaethau: Sesiwn Dystiolaeth 3
Medicines Management: Evidence Session 3

[311] **Nick Ramsay**: I welcome Members back to this afternoon's meeting of the Public Accounts Committee. Can I also welcome our array of witnesses to

this afternoon's evidence session, which is evidence session 3 on medicines management? Would you like to give your names, positions and organisations for our Record of Proceedings, starting, it's probably easiest, on the left with Judith?

[312] **Ms Vincent:** I'm Judith Vincent. I'm the clinical director for pharmacy and medicines management, aka chief pharmacist, in Abertawe Bro Morgannwg University Local Health Board.

[313] **Professor Farrelly:** Good afternoon and hello. I'm Rory Farrelly. I'm currently interim chief operating officer and director of nursing and patient experience in ABMU health board.

[314] **Dr Gully:** Good afternoon. I'm Karen Gully and I'm medical director at Powys Teaching Local Health Board.

[315] **Ms Shillabeer:** Good afternoon. I'm Carol Shillabeer and I'm the chief executive in Powys Teaching Local Health Board.

[316] **Ms Scott:** Good afternoon. I'm Suzanne Scott-Thomas. I'm clinical director of medicines management and pharmacy in Cwm Taf Local Health Board.

[317] **Ms Williams:** Prynhawn da. Allison Williams, chief executive, Cwm Taf health board.

[318] **Nick Ramsay:** Well, we've still got some time left for some questions, I'm pleased to say [*Laughter.*] Clearly, this session on medicines management is going to take some people management, so, if I'm moving things on at any point in time, it's just to try and get through as much as possible. And don't feel that all of you need to come in on any question; I shall look to see who catches my eye as to who wants to lead on that, but if you do have a burning issue that you want to come in on, then please just look at me and I'll bring you in when I can.

[319] If I fire off the first question, can I ask you what the health boards are doing to ensure that medicines management receives sufficient profile in your organisations? Who wants to take that? We'll start on the right with Allison Williams.

[320] **Ms Williams:** I think it's really important, even prior to the issuing of

the Wales Audit Office report, the profile of the chief pharmacist in the organisation. In Cwm Taf, Suzanne is not just the chief pharmacist but also the clinical director for the whole of the medicines management function. The clinical directors are direct reports to executive directors within the organisation—so, a direct report at senior manager level to the director of primary community and mental health, who also has an executive lead for medicines management within the organisation.

[321] We have the reporting through the various sub-committees of the board, and so there is a high profile at board level not just of the expenditure issues, but also of the quality issues related to medicines management, which feature highly within our quality and safety sub-committee of our boards. So, the whole spectrum of medicines management is visible and there's a direct line of sight from the board to the function in primary and secondary care.

[322] **Nick Ramsay:** And what information on medicines management gets considered by the board and its sub-committees?

[323] **Ms Williams:** It is variable and some of it is issue by issue. There is financial information; there are specific quality indicators that are reported through the various dashboards that we produce on performance; the decisions around implementation of high-cost drugs, so, NICE-approved drugs and the All Wales Medicines Strategy Group-approved drugs; and also, now, the timescale and the compliance for implementation of the two-month target around the introduction of the drugs into practice as well.

[324] **Nick Ramsay:** Right to the other end of the panel, now, and Judith Vincent.

[325] **Ms Vincent:** In ABMU, it's very similar to what has just been described. We have a quality and safety committee, where I produce quarterly reports across the breadth of what Allison has just described to you. We also provide information to each of our six delivery units. The reorganisation of the structure in ABM over the past couple of years has afforded us an opportunity to take that in at a different level. So, they each have a monthly report, which, again, picks up some of the issues pertinent to their own unit, but also picks up reporting on patient safety dashboards, et cetera. So, there are regular reports going in at a number of different levels within the organisation.

[326] **Nick Ramsay:** Carol Shillabeer.

[327] **Ms Shillabeer:** Thanks very much. So, yes, just to confirm, the head of medicines management reports to an executive director. It has been the executive director for primary and community care, but we're just realigning that now to Karen's portfolio as medical director, and that will take place soon.

[328] Just to give you a little flavour of the types of reports that go, over the last six months or so, five papers to board committees from medicines administration audits, medicines management reports—we're also restructuring because we've expanded our medicines team—some policies and medication omissions audits as well. So, that's the type of flavour largely. It's not just about costs, but also about effectiveness, and about working right across the spectrum, particularly primary and community care, and with other partner, such as social care, in the medicines administration field.

[329] So, the profile, I think, if we look back a couple of years ago, was probably not as high profile, but certainly with the work of the last year to 18 months and now with a medical director in place, I can confirm that that receives one of the highest profiles across the health board.

[330] **Nick Ramsay:** It's one thing to have it happening at the board level and at the institutional level. What about the doctors and the nurses themselves? How are they having ownership of the issue of medicine management? Suzanne Scott-Thomas.

[331] **Ms Scott-Thomas:** Just to say, I think Judith alluded to the fact that we report at all levels throughout the health board, and that is the same with Cwm Taf. We have various layers where we engage and interact. So, for instance, we have our primary care advisers, who will go and work with each GP practice and provide reports to them on their individual practice prescribing, not just on a cost but on a quality basis as well. So, that happens on a regular basis. Then we will have what we call in Cwm Taf our 'clinical business meetings', which happen on a monthly basis, where the directorates meet with execs and their business partners. Our teams are regarded as a partner within that structure, and we will report their medicines usage, also their quality of prescribing, and some of the indicators, perhaps, around their anti-microbial prescribing—that all gets reported into their clinical business meetings at that level.

[332] And then we'll have a monthly report into our core governance meeting—the clinical governance meeting, an exception report that can include things like our progress with the development and implementation of our electronic discharge advice letter, or our 'Trusted to Care' action plan et cetera, and that will go all the way up to the board. So, it is quite wide and at all levels, I would say, for medicines management.

[333] **Nick Ramsay**: Great. Karen Gully, did you want to come in?

[334] **Dr Gully**: Well, just to add that Powys, obviously, is quite a small health board, but we've got very active engagement with our GPs—there is very much a GP-led element to that. So, a GP chairs our drug and therapeutics committee, so that's where, on a quarterly basis, we look at the national indicators. But also, in terms of our collaborative cluster working, there's a lot of emphasis on multidisciplinary working, so, the whole process of not just prescribing and administering but then, actually, the patient's journey onwards as to how the medicines are used most effectively and waste is minimised.

[335] **Nick Ramsay**: And what are the reporting lines of the chief pharmacists in the health boards? Allison Williams.

[336] **Ms Williams**: To the executive director, and through the executive director to the chief executive. So, they're at a very senior management level in all of the health boards. And we've checked with colleagues before coming in today, and that's common across all of the health boards that the reporting is directly to an executive director.

[337] **Nick Ramsay**: Rory Farrelly.

[338] **Professor Farrelly**: I was just actually going to agree with Allison—I was nodding my head in agreement.

[339] **Nick Ramsay**: Okay. The next question is from Rhianon Passmore.

[340] **Rhianon Passmore**: Thank you, Chair. This is really a question around the scope that remains to reduce the cost of medicines, and your opinions, really, about the most important issues to tackle—there is mention of the auditor general's targeted localised action plans—and if you have a view on that. I don't think we need everybody to comment, but if one of the

organisations would like to take the lead.

[341] **Nick Ramsay**: Carol Shillabeer.

[342] **Ms Shillabeer**: I'm happy to do so. So, Karen just gave a flavour of Powys, which is perhaps a little bit different to some of the other health boards. But where we've been able to make progress, over the last, certainly, three or four years, is working really closely with general practitioners around variation in prescribing in primary care. Clearly, that has been our big focus. We spend about £25 million a year on primary care medicines. I think we've been pretty successful in engaging those clinicians in the discussion, not just about quality improvement, but cost improvement, and people seeing that as two sides of the same coin and working on that. So, clinical variation is really important, the issues about whether somebody needs medicines in the first place, really focusing on prudent prescribing—I know you've been hearing quite a bit about that, so a level on that. That's not to say that we don't think we've got places to go, because we have, but, the fruits of the labour, hopefully, you've been able to pick up in the report that we've been able to make real progress, really through our primary care colleagues and with them.

[343] I think one of our areas that we've been looking at is use of medicines in our community hospitals, so we've put more investment in there, and we were successful in getting invest-to-save funding in order that we reconcile medicines in community hospitals—an important opportunity when people come into hospital and are on five, six, seven, even 10 meds—to be able to have a look at where we might make those improvements and reduce meds and increase adherence to regimes.

[344] **Rhianon Passmore**: And, so, briefly, if I just tag on the end of my question there, and repeat it again, in regard to localised targeted action plans in terms of medicine wasted, what are your plans there?

[345] **Ms Shillabeer**: Broadly, in terms of community pharmacists, we've got a range of schemes with community pharmacists. We have an annual plan for improvement in medicines management that is held by our team—a small, but perfectly formed, team. So, the actions in there are quite wide-ranging. Community pharmacists have a scheme. I always get the name of—. The medicines usage review scheme—

[346] **Rhianon Passmore**: Do you do a no-dispensing scheme?

[347] **Dr Gully**: It covers that aspect. So, yes.

[348] **Ms Shillabeer**: It's similar.

[349] **Rhianon Passmore**: Okay. So, that would be your lead. Could I ask the same to the others, but, obviously, can we keep it slightly briefer, if that's possible? But thank you.

[350] **Ms Vincent**: Just to say, from a more strategic perspective, the chief pharmacists were written to by Andrew Evans at the back end of last year, asking us to produce action plans in six key areas, one of which was efficiency and productivity, and he may well have alluded to that in the evidence they gave to you back in March. We are, as a peer group, working very closely with the other exec peer groups to identify, for primary care, prescribing areas where we would not recommend—very similar to NHS England. So, there is a paper that has been produced that we are looking at as to how we will produce that into NHS Wales—it's targeting five areas in primary care, five areas in secondary care—in terms of low value, where we wouldn't expect prescribing to happen—so, following NHS England. So, we are, at a strategic level, planning, and then that translates into the more local level, where we've all got very clear action plans that are—

[351] **Rhianon Passmore**: And that includes no-dispensing schemes.

[352] **Ms Vincent**: We don't run a no-dispensing scheme currently. There are going to be changes to the community pharmacy contract, which takes it away from an item-based remuneration, over a five-year period, to a more quality based—

[353] **Rhianon Passmore**: Is that locally with you, or nationally?

[354] **Ms Vincent**: That's a national—that's national.

[355] **Rhianon Passmore**: Okay. Good. And if I could just ask yourselves.

[356] **Ms Scott-Thomas**: I do have a local action plan for quality and cost-effective prescribing. That's fed into our integrated mid-term plan on an annual basis. It includes a wide variety of interventions and action. It's not down to just one sort of big intervention. We have a number of interventions that have been ongoing for a number of years that we still carry on as well.

So, it really is a multi-factorial intervention at all levels, and some of them are integrated, so it's something that we will do perhaps in secondary care to affect primary care prescribing. It's quite complex actually to keep all the balls up in the air at one time. I could itemise a lot of them, but—

15:45

[357] **Rhianon Passmore:** No, that's fine. So, just really also, then, to the no-dispensing scheme that I've mentioned, and keep mentioning—is there anything that you are leading on in that regard?

[358] **Ms Scott-Thomas:** We've had a no-dispensing scheme for a number of years.

[359] **Rhianon Passmore:** Okay. And, just briefly then, if I may, and if I go on to my second question, in regard to the approaches of the autonomous local health boards to these matters, would you say that you're all using similar frameworks, or a similar framework, when it comes to medicine management, or are you all reinventing the wheel?

[360] **Ms Williams:** Could I—? I think—

[361] **Nick Ramsay:** Allison Williams.

[362] **Ms Williams:** Where there are common benefits, then there are some very clear, targeted common actions. Sometimes, their application is varied, because the community needs are very different. So, in some of our rural communities, the needs are very different to in some of our deprived Valleys communities. So, there's flexibility, but there is a very coherent medicines management community. The chief pharmacists work very closely together, sharing best practice, and that best practice then is taken into individual organisations, and tailored to the needs of the local population.

[363] **Nick Ramsay:** Lee Waters.

[364] **Lee Waters:** Can I just jump in on that particular? I was just struck by the materials you've all kindly sent us about your public information campaigns, and there do seem to be very striking similarities. So, I believe the Cwm Taf one is, 'Your Medicines, Your Health', and, in Abertawe Bro Morgannwg, 'Only Order What you Need', and they seem broadly similar in their messaging, and in the way they've set it out. I wonder why there's the

need for two separate, distinct campaigns, and why there isn't a more coherent, all-Wales approach taken on that?

[365] **Ms Williams:** Shall I start and give it a broad, and Suzanne can give you the detail? I think there is something about the engagement of the people who are key in delivering this in the development of the actual local approach. So, you could argue that there probably is some greater value at some levels in a national branding around some of this. And I think that's a fair comment, and something that we have to look at. However, because of the granularity in the way that some of these campaigns have been developed with local people in Cwm Taf, with the schools, and with children, we've been trying to look at how we infiltrate and get the message into the community and taken the view that, by growing the campaign from within the community, we're probably going to get greater granularity. In all honesty, there's probably room for both.

[366] **Lee Waters:** Was there a strategic judgment made that, in this case, it would be better to have locally driven campaigns, or were they just organically developed in isolation of each other?

[367] **Ms Scott-Thomas:** I think 'Your Medicines, Your Health' has probably got a bit of a longer history, and has developed locally. But, within chief pharmacists, we are actively looking at whether we can roll elements of that out across Wales, and I think we are definitely going to take those out across Wales. But there are certain developments within this campaign that are being taken forward. So, I'll refer to a teaching pack we've developed within our own schools, which has now been rolled out across all primary schools in Cwm Taf. But we are having very positive conversations with the Welsh Government, in the education, that that becomes part of the curriculum.

[368] **Lee Waters:** So, that came before the ABMU campaign. Was the ABMU campaign—did you draw on the experience and the evidence of the Cwm Taf experience, or did you start from scratch?

[369] **Ms Vincent:** This was something that we did very quickly, very locally, to promote our recovery and sustainability plan, knowing that Suzanne and Cwm Taf were actually using 'Your Medicines, Your Health' as a Pacesetter, so that the learning from that Pacesetter would then be considered by the chief pharmacists. And Suzanne has already alluded to that, in terms of actually getting the brand of your 'Your Medicines, Your Health' potentially adopted for all health boards in Wales. And then there will be some central

learning that every health board would need to implement, and then there will be the local need to address the local population and what they require. The scheme that we've done there is very much a social media campaign, so it's not had a huge amount of resource put behind it. It was just interviews, using Facebook, Twitter, to push out a message to our population locally around only ordering what they need, knowing that we were going to have the potential learning coming from 'Your Medicines, Your Health' to adopt in future, and that will form part—

[370] **Lee Waters:** My question was: did you draw on the best practice of another health board, or did you start from scratch?

[371] **Ms Vincent:** I think that they're very different campaigns. So, this is just a message, in terms of getting a very quick message out to the local population. Suzanne's is very much more structured around the schools and education. That would be adopted further down the line for ABMU.

[372] **Lee Waters:** Okay, thank you.

[373] **Nick Ramsay:** Rhianon, back to you.

[374] **Rhianon Passmore:** So, what support and guidance is provided by local health boards to prescribers? Also, in regard to chief pharmacists, their role, how routinely does it identify and disseminate good practice across health boards?

[375] **Dr Gully:** Shall I start, particularly from a primary care perspective, because that's our particular focus? So, our prescribing advisers will meet with practices and agree areas for focus. So, that's a combination of consistent professional advice from our expert network, but also the local context of the practice. So, that's where we then agree three priorities for the year, based on that professional advice, and then the practice works through those.

[376] Then, also, in terms of professional networking—so, our prescribing therapeutics group reviews the indicators [correction: national indicators] and the evidence behind those, and so there are other opportunities there. And then we provide protected learning time, where prescribing is often an issue, both because of the clinical issues in terms of new medicines, new pathways, risks, and, then, obviously, the cost element as well.

[377] So, there is a package of those [correction: support]. Online learning, obviously, is very popular for GPs, because that can be done in their own time. We have national work on that, so that's consistent.

[378] **Rhianon Passmore:** How effective is it in terms of your perception of how that advice is taken up by prescribers or your strategic push into it?

[379] **Dr Gully:** Well, certainly from a Powys perspective, our performance against the national indicators has always been very, very good, and we put that down to very strong GP engagement in that work. We still see some variation, but what that does is allow us to focus on individual areas of practice.

[380] **Rhianon Passmore:** Okay. I'd like to ask the same question—

[381] **Ms Williams:** I think it's really important that we recognise some of the significant changes that have happened in the last couple of years and the move to increased numbers of pharmacists in primary care. This was a very positive initiative that came out of the cluster funding that was given to primary care. It started off with small numbers of pharmacists being employed to work within the GP practices as part of the integrated primary care team, alongside a historical model of having prescribing advisers who have always gone into primary care. In fact, the value has been so highly recognised that primary care are now investing their own practice money in pharmacists, who are the experts in the primary care team at driving not just cost but value in prescribing. I think it's really important that we consider, in the round, the value, which is quality and cost.

[382] **Rhianon Passmore:** As a localised thing, at a local level, that's deemed to be of importance. How is that being structured from above?

[383] **Ms Williams:** What happened—when the cluster money was given to the health board, we were very clear, working with our primary care cluster leads, that we wanted to talk about how the health board could facilitate these improvements, which is why we initially employed the first four cluster pharmacists, one for each of our four clusters, to work with them. Through that resource, we're now up to 12 within 18 months. So, the real value of that—alongside, as I say, the prescribing adviser service, which has always been there—is really showing how the primary care value that's placed on this is driving through.

[384] **Rhianon Passmore:** And I accept that, but my point, really, would be—you're doing that locally, it's great, and you're using your budget for that—is that being driven from above? I don't know whether you want to pick that particular point up. And also the other part of my question, which nobody's really answered yet, is in terms of your view around the chief pharmacists' ability to disseminate good practice. So, I don't know whether you want to—.

[385] **Ms Williams:** In terms of driving from above, that very much came from the health board, from the board. That was driven from above. That's something that's not unique to Cwm Taf, that's something that's being driven across all of the health boards. The uptake will be slightly different, but, as a strategic driver, that is common across the whole of Wales, and we are seeing the benefits of that. I'm sure our chief pharmacist will give you the view about that.

[386] **Nick Ramsay:** Just to be clear on that, then, that is something that you would see across all of Wales, across all the health boards. It's not just something that one health board or two health boards are driving.

[387] **Ms Williams:** No, we're seeing employed prescribing pharmacists who are independent prescribers now across the whole of Wales as part of the primary care team. That's in addition to expanding roles for community pharmacy and the prescribing adviser service.

[388] **Nick Ramsay:** Carol Shillabeer, did you want to come in first, before Suzanne Scott-Thomas?

[389] **Ms Shillabeer:** Yes, please, if I could, because I think your question was about support and guidance to prescribers. We naturally talk about doctors as prescribers, but there are independent prescribers who aren't doctors. I think more and more this is an area we have to focus on to ensure non-medical or independent prescribers who aren't doctors do get the support and guidance that they need to feel confident to prescribe. We've got very good relationships with universities that deliver that programme for us and there's a very good and quite strict mentorship arrangement in place for new prescribers that come forward. But there is more—just speaking locally, really—for us to do in supporting those prescribers and making sure they continue to feel confident, because as we change different models of care we're not relying so much just on doctors prescribing. There's a whole host of people who can.

[390] **Rhianon Passmore:** So, is it your role to disseminate that good practice to local health boards so that it is a commonality rather than an isolated highlight?

[391] **Ms Shillabeer:** Absolutely. There's a couple of things. There's the value of the chief pharmacists group. My own observation is it's a strong and coherent group. There's something for us then about implementing that locally and, actually, that's a partnership between pharmacists, nurses, doctors and other therapists and health scientists where it's relevant. So, this isn't just a pharmacist giving advice—

[392] **Rhianon Passmore:** Do you think local health boards, then, are actively playing their part in allowing you to roll out this programme in terms of—?

[393] **Ms Shillabeer:** Yes, I think health boards are seeing medicines management as an absolutely critical part of the whole service provision, be it primary, secondary or tertiary care. I think the profile's going up and up and the expansion of prescribing means it's an absolutely core function. On your question about the chief pharmacists, I think those roles are becoming stronger and stronger around the health board leadership table as well. That's my own perspective, anyway.

[394] **Rhianon Passmore:** Okay. Have you got a comment on this?

[395] **Ms Vincent:** The chief pharmacists—

[396] **Nick Ramsay:** Suzanne Scott-Thomas is desperate to come in. Can I just call Suzanne first? You've been waiting quite a while. Then I'll bring you in—sorry, Judith.

[397] **Ms Scott-Thomas:** I just wanted to say that in terms of strategic leadership, we have a vision for pharmacy in Wales called 'Your Care, Your Medicines', which is very much a collaborative between the profession of pharmacy in the health boards, the chief pharmacists, the chief pharmaceutical officer and the Royal Pharmaceutical Society. So, we talk with one voice in Wales. The use of pharmacists working with GPs in GP practices was recognised very early on as something that could add to GP practice as well as helping to stabilise GP practices in a time of GP shortages. We worked together to produce a document called 'Models of Care', which described what pharmacists could do in GP practices. That was taken forward with the prudent prescribing group as well as RPS. So, on a strategic level, it very

much was led as one voice across Wales. The health boards then all reacted to that in a very positive way, as Allison said, and the board put that into action and implemented it through the primary care clusters structures and money. So, I think, across Wales at the moment, we have over 100 pharmacists working in GP practices with GPs and, I think, as you say, there's been very valued and positive progress.

[398] **Nick Ramsay:** Now, Judith Vincent.

[399] **Ms Vincent:** My final comment, really, because I'm not going to go over that ground, is that the chief pharmacists are working very much as a collaborative group now. So, we are meeting via either teleconference or personally at least twice a month. So, we are addressing Andrew's request for the six key areas to have time-bound action plans. They will shortly be produced alongside a public awareness campaign around what it is we're trying to do. That will be disseminated through all of the health boards. I think now the chief pharmacists are in a very, very different place and working very differently to the way they worked in previous lives.

[400] **Nick Ramsay:** Lee Waters.

[401] **Lee Waters:** Can I just return to what Suzanne Scott-Thomas just said about there being 100 pharmacists employed to work in a primary setting? Are those salaried pharmacists or are they independent practitioners?

[402] **Ms Scott-Thomas:** The majority of them are employed by the health boards on behalf of the clusters and I think there's quite a lot to be gained from that because they're part of the medicines management team. So, key messages can be taken out to them in a very integrated way. We also are responsible for their line management. So, GPs don't have to line manage them. We do their performance development reviews. So, that helps to take the time and the burden away from GPs.

16:00

[403] **Lee Waters:** Sure. I'm interested in this emerging model that we have of increasingly health board employed GPs and pharmacists in areas where it's difficult to recruit. Certainly, it would cover my constituency and I guess part of your health board as well. We heard in the previous session today from the pharmacists themselves and we discussed the perverse incentive there is for pharmacists sometimes to be doing things that wouldn't

necessarily be the most efficient use of resources. I just wonder how much we should explore this different model of working where we have directly employed pharmacists, which could cut through this.

[404] **Ms Williams:** Could I try and answer that? The evidence suggests to us that there's room in the system for a mixed economy. The independent contractor model has served us very well in many ways, but as we become more sophisticated in terms of the outcomes that we're looking for through independent contractor contracts, and as was alluded to earlier, moving from a numbers-based incentive scheme to a quality outcomes-based incentive scheme, that will undoubtedly strengthen the independent contractor model in community pharmacy. I'm sure you've taken evidence about the common ailments schemes and the opportunities that those give within the community pharmacy arena. But actually looking at directly employed pharmacists working as part of the primary and secondary care system, as Suzanne has described, is a real strength. It's a strength, actually, that's probably unique to Wales because of our integrated healthcare system. We would consider that to be a real advantage. You're going to undoubtedly see more and more of that.

[405] **Lee Waters:** Could I just take us into a slightly different direction on this, as it's related to this subject?

[406] **Nick Ramsay:** Hang on a minute. Neil Hamilton, did you want to come in on this at all? And then I'll bring you back.

[407] **Neil Hamilton:** I wanted to come in on medicine wastage and the extent to which we could reduce the cost of the drugs bill in this respect. I was very impressed to see in the Cwm Taf evidence that your wastage is very, very low: 0.085 per cent of the medicines budget and way down the list amongst all the health boards in England and Wales. So, what scope do you think there is generally for continued progress in this respect—in your own health board and, by extension, others who are not perhaps doing quite so well as you are?

[408] **Ms Scott-Thomas:** I think there is still scope. Medicines waste is perhaps an indicator of a number of issues. When medicines are prescribed, there are three parts to that: there's the patient, there's the prescriber and there's the supply system. So, I think we need a systematic strategy to tackle each of those elements.

[409] 'Your Medicines, Your Health' is very much targeted towards the patient and the public in getting them to take more responsibility for the medicines that they use, and when they visit their GP and recognising that if they have a cupboard full of medicines they need to do something about it. There is also not just a financial cost to that, but there's a cost to their health if they're not taking their medicines as prescribed. Perhaps their GP doesn't know about it and will prescribe more if it's not having the desired effect. So, there's that element.

[410] Then, there's the element of the prescriber and them having the best available evidence and guidance to make the right decisions for that patient, together with the patient. It should very much be a co-production, making sure that that decision is made together. Because if it's not, then the patient is unlikely to take the medicines as prescribed. Then, there's the supply system, which I'm sure you've heard quite a lot a about today around how that could be improved. That's not to say it can't, because I think it could. But we know in Cwm Taf we have over 7.5 million prescriptions written every year. That's vast. So, we need to make sure that whatever we put in place has to be a systematic approach to it and has to be able to be easily adopted by everybody across the health board to be effective. So, I think there is room for improvement and we are trying to target each area.

[411] **Neil Hamilton**: That's very interesting. To what extent do you think that there is a problem with repeat prescribing? It depends on how often patients have a review of their medicine needs. Sometime, this could go perhaps for 12 months without any further review and in that period, the patient need might have varied very significantly. There's a problem in that the patient may be taking medicines they no longer need, and, secondly, they might be piling up in a cupboard if they're not taking them.

[412] **Ms Scott-Thomas**: I think we have a real opportunity in Wales at the moment. We have taken a very brave decision, perhaps, to change the community pharmacy contract, but I think the right decision. We are able to divert the energies of community pharmacy away from just the supply systems to more patient-facing and clinical services. And I think that all of us—the chief pharmacists and the health board—are developing plans of how we can maximise that input into the patient-facing services. It is about medicines waste, but it is also about making sure that with our investment in medicines, we get maximum—not 'use'; I can't think of the word—that we maximise that investment into medicines and patients get the best out of them. And I think that community pharmacy is key to that going forward. So

we will be actively developing plans for better services, be it better medicines use reviews, chronic disease management services, discharge medicine reviews, access into the GP record—they are all enablers then to make sure that the patient is seen. Because the patient is seen by the community pharmacy probably on a monthly basis, whereas they don't see the GP that often. So I think the opportunities are there; we just need to make sure that we are doing the best we can to get the best out of that change in contract.

[413] **Nick Ramsay:** Karen Gully, did you want to come in on that as well?

[414] **Dr Gully:** I just wanted to give an example in terms of Suzanne's previous comments around what we've done nationally. So, in the GP contract in Wales, we've had what's called a national clinical priority around frailty and polypharmacy—multiple drugs. That's taken clinicians out of the day-to-day volume of practice [correction: prescriptions] to actually look at prescribing for more vulnerable patients who may be harmed by over-medicalisation, and to look at those things, and to take those issues into the clusters where they now have pharmaceutical colleagues who can actually carry on that discussion. So, that was a national drive to give time for those professional conversations to be actively held at cluster level, and then clusters have an action plan that's bespoke for their areas. So, lining up those initiatives is just an example.

[415] **Nick Ramsay:** I think Judith Vincent wanted to make a brief comment as well.

[416] **Ms Vincent:** Just one comment, really, on the cluster pharmacists. Actually, they are becoming very prudent in terms of managing how repeat prescribing is happening. They are undertaking a large amount of the reauthorisations on behalf of GPs, and have been shown to actually deprescribe—so, actually stop medicines that aren't needed. They're four times more likely—that's certainly our local experience—to stop a medicine than in previous reviews. So, I think these cluster pharmacists have got an expanding role in terms of how we manage the medicines bill in terms of getting value for it, but also stopping things that are no longer needed.

[417] **Nick Ramsay:** Neil Hamilton.

[418] **Neil Hamilton:** I'm fine.

[419] **Rhianon Passmore:** Can I just pick up on that point, if I may? In regard

to that particular point, that's not really mentioned in terms of the sort of cluster model, in terms of procurement of medicines—[*Inaudible*.] Could you elaborate a little bit more on that?

[420] **Ms Vincent:** Sorry, could you say that again?

[421] **Rhianon Passmore:** You talked about—I don't know if I heard you correctly—you talked about clusters and the purchasing.

[422] **Ms Vincent:** No, what I was saying is that it's prudent. The use of the pharmacists within the clusters to take on roles that have been historically done by GPs is proving to be prudent in that they are actual managing the reauthorisations and are four times more likely to stop a medication than if a GP had done that review. So it's actually good use of a professional's time focusing on that.

[423] **Rhianon Passmore:** Thank you.

[424] **Nick Ramsay:** Lee Waters.

[425] **Lee Waters:** There are a lot balls up in the air at the moment, if I could just grab a couple of them.

[426] **Nick Ramsay:** You usually do.

[427] **Lee Waters:** First of all, Suzanne Scott-Thomas, you mentioned the wastage issue. In your written evidence, you note that the current legislation and the regulation doesn't allow the reuse of medicines once dispensed to a patient. Do you think that should be reviewed?

[428] **Ms Scott-Thomas:** I think it can be reviewed with what's emerging in terms of innovations. They're not quite with us yet, but we will have, perhaps, 'smart packs', which can tell you whether they've been opened or not, or whether they've been stored in, say, the correct temperature. Because if they were left out today, perhaps, we'd find that they probably wouldn't be fit for purpose with the heat et cetera. So I think with emerging innovations and technology, there will come a time when we will need to review that legislation and regulation, because packs will become—we'll be able to tell whether they've been kept at the right temperature and humidity, or whether they've been tampered with. We have to be careful that we are dealing with legitimate medicines and not counterfeits, because there is a huge black

market in counterfeits, so we want to make sure that the patients get exactly what they've been prescribed.

[429] **Lee Waters**: How far away are we from those smart packs, do you think?

[430] **Ms Scott-Thomas**: The technology's emerging—probably in the next five years, I would say that we could revisit that. We've done some work around it and I think there is a will to do that, but we just need the technology to support us.

[431] **Lee Waters**: As that legislation is reviewed to keep up with developments, there's an opportunity to look at reuse of medicines and wastage more generally, presumably.

[432] **Ms Scott-Thomas**: Yes, we're always looking at ways—. It's something we do within secondary care, where we can be assured they haven't gone out of our systems—our management systems. We will recycle medicines that we've sent up to the wards and have come back that haven't left the building, for instance. Within secondary care, it's a slightly different picture.

[433] **Lee Waters**: Sure, okay. Just to move on to the second ball that I want to grab out of the air, if I may, Chair, we touched earlier on prudent prescribing, and one of the key tenets of prudence is that if harm is avoidable, we should avoid it.

[434] **Nick Ramsay**: Hang on, Lee. I don't think we're moving on to prudent prescribing just yet. I think Mike Hedges wanted to come in briefly, then I'll bring you in.

[435] **Mike Hedges**: I was going to come in on—

[436] **Nick Ramsay**: Sorry, but Mike needs to speak as well.

[437] **Mike Hedges**: —the 'Trusted to Care' report, which ABMU will be very familiar with, and, following on from that, MARRS, which is medicines administration, recording, review, storage and disposal. What assurance can you give that there are no ongoing patient safety risks associated with medicines administration, recording, review and storage? I don't want to go into 'Trusted to Care', but it was not a particularly good report.

[438] **Professor Farrelly:** Maybe I'll start. Obviously, on the back of 'Trusted to Care', what we did do is we developed a number of what we call peer unannounced inspections across all clinical areas—across mental health, primary care, learning disabilities and secondary care—with those happening 24 hours around the clock to actually ensure that there were no events that were found in the original 'Trusted to Care' report around medicines being left in the locker in relation to patients who had cognitive impairment. We have continued that peer inspection across the last three years. We have, obviously, seen that number reduce significantly from where we were in 2014-15.

[439] We also have an ongoing programme, and we did then, of actually looking across 125 wards in relation to the storage of medicines. We have an audit programme that we actually did report up to the board at the time, which did identify a number of areas in secondary care that we did actually have to action. We did do that, and obviously I'll let Judith pick up on the MARRS stuff, but from a 'Trusted to Care' perspective, we still report all of those things through our public quality and safety committee and we have seen that improvement, and the sustainability of the improvement, around all of those issues. I will let Judith answer around the MARRS stuff.

[440] **Ms Vincent:** There are a couple of things that we do on a monthly basis. We do an audit of any missed doses, so my team is on the ward to audit every month. If there have been any missed doses, that is then reported through the patient safety thermometer into each of the units via the report I mentioned earlier of the quality and safety committee. So, we have an ongoing view of anything that's happening on the wards.

[441] There is very close working between the pharmacy teams and the nursing teams now on the wards. They look to us for support, and, in fact, we have two areas where we are piloting technician-led, or technician-supported at the moment, administration of medicines. So, they're actually working alongside the nurses to support the administration, and it is a future aspiration to move that to being technician led. So, we're looking at how we develop—again, I suppose, in the line of prudent principles—the use of the right person in doing some of that. Technicians have got extensive training in medicines, so I think that's probably where we've got the assurance.

[442] I guess in terms of some other storage, some of the things that we have also done are around automated cabinets. Again, I believe you had evidence supplied in the March meeting from the Welsh Government in terms

of what that is looking like. We have automated cabinets in all areas that do not have patients' own medication use—so, emergency departments, theatres, intensive therapy units: those sorts of areas. We'll obviously, as that evaluation bears out, look to how we could use them in the ward environment.

[443] **Nick Ramsay:** Allison Williams.

16:15

[444] **Ms Williams:** Just to add, in response to the 'Trusted to Care' report, Healthcare Inspectorate Wales undertook independent reviews across all of the health boards—every single hospital site—with action plans in response to all of those, particularly on medicine storage, at a very granular level. It was almost every room in every ward in every hospital. All of those were monitored through the sub-committees of the boards across the whole of Wales, and you'll see in the written evidence that we've provided the levels of compliance, now, that are being achieved, and the automated dispensing, as was said by colleagues earlier.

[445] **Rhianon Passmore:** Chair, can I just ask about automated dispensing? Is there a common picture across Wales in terms of local health boards' approach to the type of units that are using this non-patient-directed—?

[446] **Ms Williams:** In terms of the areas where they've been targeted first, absolutely, and that's where the first tranche of investment was put in across the whole of Wales. Now we're looking at the next level of investment, because that has to be balanced between the safety features that come with automated dispensing, but also encouraging patients, when they're in hospital, to administer their own medication under supervision, where they can, because obviously that, then, reduces the risk when they go home from hospital and improves compliance with their medication regime. So, it's a bit more of a balancing act now as we're looking into the in-patient areas.

[447] **Nick Ramsay:** That's fine. Back to Mike Hedges.

[448] **Mike Hedges:** Just one last question on medicines and medicines going out of date. Is there any system internally within a health board or throughout Wales where you've got some of the more expensive medicines coming towards the end of their date to flag that up within your own health board or flag it up to other health boards, rather than just waiting for them

to go out of date?

[449] **Ms Scott-Thomas**: We work very hard to make sure that high-cost medicines are not wasted. As you can see in our report, we have a very low wastage of medicines, and there's a lot of work that goes on to achieve that picture. There isn't an official system. We have a collaborative group across Wales of all our logistic pharmacy staff who, again, work very closely together, led by our all-Wales procurement pharmacist, and they share a lot of information and will, if they can, move medicines around to ensure that they aren't wasted. We do a lot of things, such as, where we can, vial-share. So, if there's an expensive medicine, we will work with the clinic to make sure we have a cohort of a number of patients coming in on one day so we're able to share vials, rather than opening one for each patient and taking part out et cetera. So, I don't think—. To answer your question, there's not an official sort of system. There is an unofficial system, which I think works very well.

[450] **Mike Hedges**: There's nothing wrong with unofficial systems. They quite often work a lot better than official systems. Just from a personal point of view, I think that there's huge progress being made. About 12 years ago I was a member of the Swansea NHS trust, and there were substantial problems then with very expensive medicines going out of date, so it's certainly an area where you've made substantial progress. I'm not quite sure how to phrase this question—don't you think you've made very good progress so far on this?

[451] **Nick Ramsay**: Is anyone going to say 'no'? No, you're not. Okay, back to Lee Waters. The second ball you were going to catch.

[452] **Lee Waters**: Okay, thank you very much. It's been suspended in mid-air. I just want to touch on prudent prescribing and the notion of avoiding harm, and the issue of prescribing errors. We were told that up to 50 per cent of hospital admission may involve prescribing errors, and this has made an effect where the system is creating its own demand through avoidable medicines-related admissions. Now, as I understand it, the data that captures medicines-related admissions aren't very good, and don't get enough attention, according to many people working in the field, and they could be out by a factor of 10 in the incidents that we record, compared to what the literature is telling us is likely to be there. So, what work is going on to improve those data so we can reduce medicines-related admissions?

[453] **Ms Williams**: If I could just start off, I think one of the difficulties in terms of capturing this is that we're very reliant on the information given to us by patients, because such medication errors could be about people not taking their medication at all. It could be about them taking the right medication in the wrong way. It could be about them taking the wrong medication in the right way. So, ever having a definitive mechanism by which we could capture the medicines-related changes in somebody's health status, I think, will never be perfect. We're always going to have challenges with that because we are reliant on patient-reported data, but this makes the medication review system outside of hospital the most important factor in ensuring people are taking their medications correctly. There's a difference between a medication error and a prescribing error; prescribing errors are much more easily identifiable because you have an audit trail between the medicine that an individual was prescribed or dispensed, and an original prescription. Those are, thankfully, very, very rare because of the robust checks in the system. I think the more difficult issue is compliance with the prescription in the first place, causing iatrogenic problems and therefore hospital admissions.

[454] **Nick Ramsay**: [*Inaudible.*]

[455] **Ms Williams**: Sorry, medication-related admissions.

[456] **Nick Ramsay**: Can't be an expert on all medical terms—

[457] **Ms Williams**: My apologies.

[458] **Nick Ramsay**: That's all right. Sorry, back to you, Lee.

[459] **Lee Waters**: Sorry. I appreciate the data are problematic, both Cwm Taf and Abertawe Bro Morgannwg are university health boards. To what extent are you working with the academic community on this? As I understand it, in Cardiff University we have one of the world's leaders in patient safety, Dr Andrew Carson-Stevens. And so far as I understand—I don't know Dr Carson-Stevens—the involvement of these world-leading practitioners in the NHS in Wales is limited. We did have some assurances through the 1000 Lives campaign—they did deliver some symposiums, but that doesn't seem to go anywhere near capturing the potential for them to be working with Welsh health boards on improving these data.

[460] **Ms Vincent**: Forgive me, I don't know the exact detail, but I can

certainly bring it back to you. But there has been a meeting recently facilitated by Professor Routledge with some of these experts to set up a patient safety-orientated group—

[461] **Lee Waters:** Great.

[462] **Ms Vincent:** —and I believe he is the gentleman you've referred to who is engaged in that. I don't have sufficient detail at the tip of my tongue or in my notes, I'm sorry, but we can certainly bring that back in terms of some of the detail, unless you know a bit more Suzanne.

[463] **Ms Scott-Thomas:** No, I was just going to add on to that, that in Betsi there is a Bevan exemplar pharmacist working up there doing this very work on medicines-related admissions, and we're waiting for that work to come to fruition. So, I think there is a quite a lot of work ongoing, which is recognising that the information we need on which to act is probably not there yet in Wales.

[464] **Ms Vincent:** And we also have a consultant pharmacist whose focus is, at an all-Wales level, patient safety. So, I do need to go back to Professor Routledge and find out a bit more about that group. I certainly know that Lynnette was involved in that first meeting. So, I think there is movement.

[465] **Lee Waters:** That sounds very encouraging. The point I was looking for some assurance on is: as the university health boards in particular, were you making the most of these academic linkages?

[466] **Ms Vincent:** Yes.

[467] **Lee Waters:** Okay, thank you.

[468] **Nick Ramsay:** Okay. Mohammad Asghar.

[469] **Mohammad Asghar:** Thank you. [*Inaudible.*]—very interesting to the whole panel. You know we spend more than £660 million on medicine in Wales; 1 per cent saving means we can have another 300 nurses and 100 doctors. So, safety, prudence and also saving are very essential in this area. I heard just now from Suzanne regarding tampering and counterfeit medicine, which was just mentioned. Sorry, Chair, I just want to just satisfy this for my own sake: so, when a patient was given a medicine and took it back to the chemist—'Look, I don't need that, take it back'—and what they do is put it in

the bin. So, surely, every medicine is sealed, there is a sticker there, which clearly states who it was given to, and when it was given, and by whom it was given. And do you still believe that person—some sort of counterfeit or anything like that?

[470] **Ms Scott Thomas**: I think the counterfeiters these days are very clever. So, we need to be guarded against that. We have coming in—I can't remember the timescales, but it's in the next year or so—a system for electronically auditing every pack that's delivered to community pharmacy from the manufacturers, and that will have its own unique barcode et cetera. So, there is a way of reducing counterfeit medicines into the system. But as regards medicines coming back, counterfeit is one issue. We also need to ensure that those medicines have been stored appropriately—

[471] **Mohammad Asghar**: And tampering you mentioned—

[472] **Ms Scott Thomas**: Yes. So, we make sure that when they're stored in our care that they are stored within the limited temperatures and, perhaps, humidities, and some of them may need fridge storage, et cetera—things like insulins. So, we need to make sure that they have had the appropriate storage throughout their lifetime out of our hands, and that's what I'm saying: perhaps there are, coming, 'smart labels', as we call them, which can, say, I don't know, turn red if they've gone out of the temperature control for some time, so we can detect when they are safe to use. We're not there yet, but I think there will be a time when we can move into that area.

[473] **Mohammad Asghar**: Thank you. My question now is on medicines administration, recording, review and storage—called MARRS—and whether witnesses think that there are still problems in MARRS, despite the profile given to this by 'Trusted to Care' and the subsequent development of MARRS policy, and what assurance you can provide that there are no ongoing patient safety risks associated with this policy.

[474] **Nick Ramsay**: I think, actually, Oscar, that question has pretty much been covered. I don't know if there's anything you want to add to your previous answer—

[475] **Mohammad Asghar**: The first one—

[476] **Nick Ramsay**: The question you've just asked. I don't know if there's anything you'd want to add to that. It's obviously an area of concern for

committee members.

[477] **Ms Scott-Thomas:** We have developed a cross-Wales medication safety dashboard, where we audit the data on a monthly basis, and each ward can look at their medicine safety profile and see whether they have got areas where, perhaps, they have not administered medicines that are appropriate, or missed a couple of doses, and they can look at that—we will look at that. So, we can look at it on a ward level and on a directorate level and on a health board level, and that gives us assurance and gives us a real-time view of areas where we need to go in and address and address them quickly, perhaps. That would provide you with that assurance.

[478] **Mohammad Asghar:** Thanks a lot. Whether the plan for a two-year timescale to complete the review of compliance with the MARRS policy is too long, given the potential patient safety concerns associated with the incomplete recording of information on drug charts.

[479] **Ms Scott-Thomas:** The two-year review is something that, perhaps, we haven't taken much notice of, because we do it on a monthly basis. So, to comply with the medication safety dashboard, we do our audits on a rolling basis every month, so we have a good view of what hasn't been completed on each drug chart, and again, we can see that and target it. So, we don't wait two years; this is something that happens on a regular basis.

[480] **Mohammad Asghar:** The Welsh Government responded to indicate that the pharmaceutical officer for Wales will be working with NHS bodies to complete a review of the use of automated ward vending machines, which is what the next question is: whether the planned review of the use of automated ward vending machines has been undertaken, and if so, what the review has identified.

[481] **Ms Williams:** I think that's back to the point I was making earlier in terms of ward based—at the moment the jury is out in terms of us getting this balance between the automated dispensing of medicines on the ward, versus encouraging people to have their own medicines and take responsibility for their own medicines. So, that is something that we're going to have to come to a view on, having reviewed all of the options around that, probably within the next 12 months. But what we've done is we've targeted the high-risk areas, and the areas where implementation would be quickest and most effective, and that has been achieved across all of the health boards.

[482] **Mohammad Asghar**: Thank you.

[483] **Nick Ramsay**: Neil McEvoy.

[484] **Neil McEvoy**: My one is about Government and making medicines available outside of the national appraisal process. What are the implications for health bodies when that happens?

[485] **Ms Williams**: Shall I make a start, there? We have a number of processes, as you know, and you will have taken evidence on them. One is the NICE guidelines—the national process—and the other is the AWMSG, the All Wales Medicines Strategy Group, where the evaluations are undertaken. And more recently, there has also been a mechanism so that we're getting more consistency in the IPFR—the individual patient funding requests review for medicines. And on the whole, this serves us very well, because it enables us to quickly get a robust—clinically robust—but consistent view, so that we can avoid postcode lottery decisions across Wales, which are not good for patients.

16:30

[486] On the whole, it has served us well in the sense that this has enabled us, in a very small number of cases, to make a medicine available before the entire NICE process has been gone through. But, generally, that's because there is very strong clinical evidence that making that available for patients sooner would have life-enhancing or life-extending benefits for them, and it's not really counter-indicated with the NICE appraisal process. But, the key for us is making the right decisions and having consistency across Wales.

[487] **Nick Ramsay**: Carol Shillabeer.

[488] **Ms Shillabeer**: Thanks very much. Just a point to note, really, as I agree with everything that Allison said. Powys is a health board that straddles the Wales-England border, and there have been times when—particularly in England, there was the cancer drugs fund—some of our population move between the English and Welsh systems, where there has been real challenge around whether drugs are available to people in Wales or in England. So, it's just to underline, really, the importance of NICE and AWMSG communicating and working closely together. In England, the cancer drugs fund is now closed, so we haven't got so much of a live issue, but just for you to be

aware that there have been issues cross-border in the past.

[489] **Neil McEvoy:** So, what kind of engagement is there when those matters arise and decisions are taken outside the process? Is there a protocol for engaging or—? What happens?

[490] **Ms Shillabeer:** Well, just on the cross-border rather than the issue of appraisals of medicines that come out of sync, I think, is what you're saying: we've got a relationship with our providers across the border in England and we've also got something called 'the individual patient funding review panel', which, I think, Karen chairs for us now. So, there are (a) communication mechanisms between clinicians across the border, and then (b) another avenue by which patients and clinicians have to put forward a case for a specific drug, largely based on exceptionality. We could spend the rest of the evening talking about exceptionality, but there are different routes for those drugs that may not be commonly and widely available, which we have utilised for patients.

[491] **Ms Williams:** If I could just add there, Wales is also extremely successful at working with industry around clinical trials, particularly for patients for cancer drugs. So, where it is appropriate, where it is safe, where there is strong patient and clinical engagement, we also ensure that our patients have access to medicines through that route if it's appropriate, while things are going, sometimes, through the approvals process. So, we do everything that we can to make the appropriate medications available to our patients where we can.

[492] **Neil McEvoy:** I remember that patients had to campaign strongly and fiercely for a bowel cancer drug not so long ago.

[493] **Ms Williams:** I think one of the big challenges is that on some of the cancer drugs that are used because the evidence base is very strong for one particular cancer, there are trials looking at how they might have a similar efficacy in treating another cancer. The difficulty that we have is that until that evidence is really clear, they won't go through the AWMSG or the NICE process. Understandably, particularly when patients have exhausted other treatment opportunities, they will want to avail themselves of that, and then we've got to get the balance right between clinical trial, so that we can prove efficacy, and making that drug available. That's often not cost based; that's often efficacy-of-treatment based.

[494] **Nick Ramsay:** Judith Vincent, did you have anything to add to that?

[495] **Ms Vincent:** I think the number of occasions that it happened were very small. It was a couple of years ago now, and since that time there are a couple of things that have come into play. Obviously, there's the new treatment fund, which does make drugs available for patients in a much quicker time frame in Wales than had been doing previously. Where decisions need to be made for cohorts of patients where we're not expecting guidance, the chief execs now have the 'One Wales' process where they receive evidence from AWMSG and AWTTC and a cohesive decision across Wales is made via the chief execs route. So, I think that was a point in time, and I think we've now got far more robust processes that will not cause an impact onto the service, that have been put in place to address the issue.

[496] **Nick Ramsay:** Good. Rhianon Passmore, do you have any questions on electronic prescribing?

[497] **Rhianon Passmore:** I do. Bear with me two seconds. In regard to the Welsh hospital electronic prescribing and medicines administration project, what progress has been made in your view? Who'd like to take it first?

[498] **Ms Vincent:** I think significant progress has been made. I can speak personally from an ABMU prospective. We were very fortunate in that we had the one hospital pharmacy system across all of our sites. That was actually electronic prescribing fit. So, we've been fortunate this year that a business case has been supported by our executive team, and has gone through the NWIS approval processes, and we have a business case approved to test for Wales the benefit of electronic prescribing, ahead of the procurement and the implementation of EPMA in the other sites, in two of our hospital sites this year, and that was approved through the £10 million digital strategy. We will be implementing electronic prescribing into Neath—hopefully we will start in November of this year, with completion by the end of the financial year—and moving into the Princess of Wales Hospital in 2018. So that is looking at not only the patient benefit, but providing the learning for Wales, in terms of, as that business case moves forward, what needs to be thought of as implementation needs to happen across Wales.

[499] **Ms Scott-Thomas:** Just to add to that, we are part of the rest of Wales that is using what's known as the EDS pharmacy system for procurement and supply, but the new electronic prescribing system, whose business case is going through NWIS at the moment, would replace that very old system. And

it would hopefully be a joint system for the pharmacy system and electronic prescribing. Within Cwm Taf, we have also fully implemented the electronic discharge advice letter, which means that we have electronic transfer of medicines information and discharge information directly into GP practices, and that will link to the new electronic prescribing system when that comes into force. Also, we are looking for a completely circular and integrated system that would pick up and pull the medicines information out of GP systems, populate into the electronic prescribing and then self-populate back in from when the patient is discharged. So, we're just missing the bit in the middle at the minute, within the secondary care sector, but we've never had as much movement as we've had in the last year, and progress on this electronic prescribing. We have great hopes that this will be implemented in the next year.

[500] **Nick Ramsay:** We have been waiting in Wales for a long time for this holy grail of electronic prescribing, haven't we?

[501] **Ms Scott-Thomas:** Yes, we have. And I think the pharmacy profession has been pushing the door for a long time. But, thankfully, now we have been heard, and it seems to have come up the priority list, and there are great leaps being made forward.

[502] **Rhianon Passmore:** So, can I ask in terms of what the challenges are: it's a huge project, so I don't think anybody's underestimating how big it is in terms of cultural change, in terms of staffing and working practices that have to change across a huge organisation. In terms of how you perceive those challenges, from your perspectives, what are the biggest issues that have to be still countered to move that forward? You've mentioned secondary care there.

[503] **Ms Scott-Thomas:** I think it's predominantly a change that will happen within secondary care, and it is very much about changing behaviours and changing cultures. We have a good sense of what needs to happen, having already put the electronic discharge advice letter system in. We have had to change the behaviours of clinicians, and we will have to change behaviours and the ways of working of nurses as well. That's a whole-system change; that's huge. So we know exactly the expectations that we will need to go forward to implement this on time, and safely, because it has a huge risk to it as well. We—

[504] **Rhianon Passmore:** Could you outline the risk for us?

[505] **Ms Scott-Thomas**: Well, I think whenever medicines are involved there is a risk. Part of our job is about mitigating that risk. So, when, at the moment, a medicine is written on a chart, it has a number of checks and balances in that process. We need to make sure that that electronic process has those checks and balances within it, and that there is very good testing to make sure that they are appropriate and happen every time. NWIS are well-placed to take this forward, they—

[506] **Nick Ramsay**: It's been happening in England for quite a while, though. We took evidence that suggested that. So, they seem to be progressing with it at a faster rate. Do you think we're being a bit overcautious?

[507] **Ms Scott-Thomas**: I don't, actually. Medicines are hugely complex, but also we want to do it once for Wales. We don't want each health board going and having their own discrete system, which we could be at risk of, and I think it is the way that they've taken in England. We want one system for Wales. So, when our medical staff and nursing staff move around the hospitals, if they're experiencing different systems each time they move a hospital, that's a risk. We want them to learn once and be able to move from hospital to hospital in a safe manner. So, that's one efficiency of having a one-Wales system. The other efficiency is the reports that you can get out of that system. So, you can get a Wales view of medicines prescribing. What we have at the moment is a Wales view of what we issue to a ward and secondary care. We don't have a view at all of what is prescribed. I think that would offer us a huge amount of information that can then help us target our energies.

[508] **Nick Ramsay**: Okay. A couple of quick supplementaries. Lee Waters wanted to come in, then Mike.

[509] **Lee Waters**: We've heard a couple of times in recent months about delays to IT systems, first on hospital food and nutrition and now on medicines management. We heard in the previous session that NWIS were struggling with managing competing demands and prioritising them. I just wonder whether you, as the users of NWIS—whether or not you think that they are coping well enough with the demands placed on them, and whether or not they deliver to you the fit-for-purpose systems you need to deliver healthcare.

[510] **Ms Williams**: I think—if I kick off—that the demands that we're

constantly putting on them, as the pace of technology is moving, are increasing. I think we all have a responsibility, probably, to be prioritising some of that more clearly and more effectively, because we could genuinely be overloading them with just too much work. I think that every time we have these conversations, we end up adding more to their work plan, because there is more that we can do. So—

[511] **Lee Waters**: They are rather large, aren't they? They have the same budget as Velindre NHS Trust. We're not talking about a small room of IT nerds somewhere in Nantgarw.

[512] **Ms Williams**: No, but, if we actually look, an awful lot of that budget is also—

[513] **Nick Ramsay**: There's nothing wrong with Nantgarw.

[514] **Mike Hedges**: Or with IT nerds. [*Laughter*.]

[515] **Ms Williams**: An awful lot of that budget is actually running the systems because a lot of these systems are understandably very costly to run. If you actually look at the core resource, it's not a massive resource of people. So, they are doing a lot of very hard work, and I think there is a challenge for us nationally about the order and the priority of the ask.

[516] **Lee Waters**: So, it's a question of the inputs we're asking of them rather than their capacity to deliver. You're confident in their ability to deliver.

[517] **Ms Williams**: Well, there's capacity and there's capability. I think that, in terms of the ask and the capacity, there probably is a mismatch, because there is constantly more that we can be doing, and our clinicians particularly are very information and IT hungry. I think the capability is there. I think the issue is about us being more prudent in terms of the priorities that we set and the scale of the expectation.

[518] **Lee Waters**: Okay. Thank you.

[519] **Nick Ramsay**: An appropriate point, I think to bring in a former IT specialist—not from Nantgarw, I don't think. Mike Hedges.

[520] **Mike Hedges**: I've just been described a nerd by my friend there, Lee

Waters. Can I talk about primary care? Primary care is, again, prescriptions. You go to the doctor, he writes the prescription, he hands it to you, you physically walk away with it and go into a chemist or pharmacist of your choice. What is the problem with them doing it electronically to a pharmacist that you choose to be a regular pharmacist, so, in which case, if you have lots of medicines, then the pharmacist will know everything you're having rather than you picking and mixing the pharmacy you go to?

16:45

[521] And also it means that you can go back to the doctor and say, 'I've just received this prescription from Mike Hedges offering him this, he's also having this, and the information I've got is these two don't go very well together, are you sure you want to send both?' That, I think, would be a huge advantage, rather than just a bit of paper, go along, pick a pharmacy, and there's no understanding of what else you're taking. Now, polypharmacy worries me greatly anyway, but this idea means that at least you'd know what was happening. And, it's really, I would say, relatively straight forward. You could have an electronic form, a doctor would fill the electronic form, and he'd send it through the network to the chemist or pharmacist who would then read it and, given reasonable luck, it would be ready by the time you arrive.

[522] **Ms Williams:** I'm sure Karen may want to answer this, but, if I can give you another example, the GP practice that my family are registered with, that's exactly how it works. There is a preferred pharmacist who is just across the road from the GP practice, and everything is done electronically. If patients don't want to receive—because there is a patient choice element here—that, they can opt out and they can have a physical prescription and take it to an alternative. But, actually, the system you describe is possible, and is in place in some places in Wales already.

[523] **Dr Gully:** It's called the repeat dispensing scheme, so that's possible where there's a known pharmacy. And I think the dialogue between pharmacists and GPs or GP teams is everyday practice, so picking up the phone and having a conversation, if the pharmacist has a view about the prescription, is just normal practice. That's not unusual. It is more difficult where those relationships aren't as established, which is why we're encouraging that more collaborative approach and encouraging patients to think of their 'own' pharmacy where that's appropriate.

[524] **Nick Ramsay:** We are almost—well, we are out of time. We're two minutes past time, but that's not bad going, considering the amount of areas we've covered. Rory Farrelly, Professor, did you have anything you wanted to add on the electronic prescribing?

[525] **Professor Farrelly:** I suppose one of the things we—. Having been in Scotland for a number of years where we did them as part of a wide roll-out of electronic prescribing, both from a—and also a patient record perspective—. People shouldn't underestimate the organisational development that needs to go alongside it and, actually, it needs to be clinically led in the organisation; we're fortunate it is being clinically led for our roll-out. But people shouldn't underestimate the organisational development support that needs to go to practitioners as part of that. And that's actually where the capacity will be important. So, I think it's just important for committee members to be aware of that, based upon my experience in other countries.

[526] **Nick Ramsay:** Great, thank you. Bit of a marathon there; we've covered a lot of areas. It's been really helpful, thanks for being with us and your co-operation. Thank you all the witnesses—I won't go through you again, it'll take another 20 minutes. [*Laughter.*] We will be finalising the transcript and we'll send it to you just for you to check for any errors or omissions and just let us know. But thanks for being with us today.

16:48

Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o'r Cyfarfod
Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Meeting

Cynnig:

bod y pwyllgor yn penderfynu gwahardd y cyhoedd o weddill y cyfarfod yn unol â Rheol Sefydlog 17.42(vi).

Motion:

that the committee resolves to exclude the public from the reminder of the meeting in accordance with Standing Order 17.42(vi).

Cynigiwyd y cynnig.
Motion moved.

[527] **Nick Ramsay:** We will now go into private session, which is—move 17.42 Standing Order to go into private session.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 16:48.
The public part of the meeting ended at 16:48.