

**Cynulliad Cenedlaethol Cymru**

**Pwyllgor Archwilio**

**The National Assembly for Wales**

**Audit Committee**

**Caffael Meddyginiaethau Gofal Sylfaenol**

**The Procurement of Primary Care Medicines**

**Cwestiynau 1-106**

**Questions 1-106**

**Dydd Iau 27 Mawrth 2003**

**Thursday 27 March 2003**

*Aelodau o'r Cynulliad yn bresennol: Dafydd Wigley (Cadeirydd), Eleanor Burnham, Alun Cairns, Janet Davies, Jocelyn Davies, Janice Gregory, Alison Halford, Ann Jones.*

*Swyddogion yn bresennol: Syr John Bourn, Archwilydd Cyffredinol Cymru; Frank Grogan, Swyddfa Archwilio Genedlaethol Cymru; David Powell, Swyddog Cydymffurfio Cynulliad Cenedlaethol Cymru.*

*Tystion: Ann Lloyd, Cyfarwyddwr GIG Cymru; Carolyn Poulter, Pennaeth y Gangen Gwasanaethau Fferyllol, Is-adran Iechyd Sylfaenol a Chymunedol, Cynulliad Cenedlaethol Cymru.*

*Assembly Members present: Dafydd Wigley (Chair), Eleanor Burnham, Alun Cairns, Janet Davies, Jocelyn Davies, Janice Gregory, Alison Halford, Ann Jones.*

*Officials present: Sir John Bourn, Auditor General for Wales; Frank Grogan, National Audit Office Wales; David Powell, National Assembly for Wales Compliance Officer.*

*Witnesses: Ann Lloyd, Director, NHS Wales; Carolyn Poulter, Head of Pharmaceutical Services Branch, Primary and Community Health Division, National Assembly for Wales.*

*Dechreuodd y cyfarfod am 9.10 a.m.*

*The meeting began at 9.10 a.m.*

[1] **Dafydd Wigley:** Galwaf y Pwyllgor i drefn.

For the benefit of visitors, you may be aware that we work in a bilingual capacity. Members and witnesses can speak in either language, and simultaneous translation is available through the headphones. The headphones may also be helpful to those who are hard of hearing. Please ask the attendants if you want help with that.

Croesawaf bawb i'r cyfarfod hwn. Hwn yw fy nghyfarfod olaf fel Cadeirydd, a chaf gyfle i gyfeirio at hynny yn nes ymlaen. Croesawaf y tystion, Aelodau a'r cyhoedd i'r cyfarfod hwn. Atgoffaf bawb o'r angen i ddiffodd unrhyw ffonau symudol, blipwyr ac offer technegol arall a allai amharu ar y system ddarlledu.

Nid wyf wedi derbyn unrhyw ymddiheuriadau. A oes unrhyw ddatganiadau o fuddiant?

[1] **Dafydd Wigley:** I call the Committee to order.

Er gwybodaeth i ymwelwyr, efallai eich bod yn ymwybodol ein bod yn gweithio yn ddwyieithog. Gall aelodau a thystion siarad yn y naill iaith, ac mae cyfieithu ar y pryd ar gael drwy'r clustffonau. Gall y clustffonau hefyd fod yn ddefnyddiol i bobl trwm eu clyw. Gofynnwch i'r staff os ydych angen cymorth gyda hynny.

I welcome everyone to this meeting. This is my last meeting as Chair, and I will have an opportunity to refer to that later on. I welcome witnesses, Members and the public to this meeting. I remind everyone of the need to switch off any mobile phones, beepers and other technical equipment that could interfere with the broadcasting system.

I have not received any apologies. Are there any declarations of interest?

[2] **Janet Davies:** Yes, Chair. This is not a registerable interest but, because of the hearing that we have this morning, I think that I should declare that I hold some shares in two pharmaceutical companies, GlaxoSmithKline and British Biotech.

[3] **Dafydd Wigley:** Okay, that has been noted. I am grateful to you for making that declaration.

I hope that we can break for coffee at about 10.45 a.m., and I hope that we will have cleared our first evidence session by then. We will see how well we are progressing.

Cyn imi wahodd y tystion i gyflwyno’u hunain, hoffwn ddweud un neu ddau o eiriau o ran cefndir cyn bwrw i mewn i’r agenda fanwl. Gobeithiaf y bydd yr esboniad sy’n dilyn o gymorth i ymwelwyr ac i rai sy’n dilyn ein trafodaethau ar y teledu adref, a all fod yn anodd ar brydiau. Y prif eitem ar ein agenda heddiw yw sesiwn cymryd tystiolaeth ar adroddiad a baratowyd gan Swyddfa Archwilio Genedlaethol Cymru, ‘Caffael Meddyginiaethau Gofal Sylfaenol’. Mae’n adroddiad eithaf cymhleth, oherwydd mae system y gwasanaeth iechyd gwladol o ddarparu meddyginiaethau a chyffuriau yn gymhleth ac mae’r dull o benderfynu ar y pris a delir amdanynt yn fwy cymhleth fyth. Yr ydym, felly, yn ddiolchgar iawn i swyddogion y Swyddfa Archwilio Genedlaethol ac i Archwilydd Cyffredinol Cymru, Syr John Bourn, am eu gwaith ymchwil manwl dros fisoedd lawer, sydd wedi esgor ar yr adroddiad sydd ger ein bron heddiw. Mae’r adroddiad wedi’i gytuno o ran ffeithiau gan swyddogion y swyddfa archwilio ar y naill law a chan weision sifil y gwasanaeth iechyd gwladol yng Nghymru ar y llaw arall.

[2] **Janet Davies:** Oes, Gadeirydd. Nid yw hwn yn fuddiant cofrestradwy ond, oherwydd y gwrandawriad sydd gennym y bore yma, credaf y dylwn ddatgan fy mod yn berchen ar rai cyfranddaliadau mewn dau gwmni fferyllol, GlaxoSmithKline a British Biotech.

[3] **Dafydd Wigley:** O’r gorau, mae hynny wedi ei nodi. Yr wyf yn ddiolchgar ichi am wneud y datganiad hwnnw.

Yr wyf yn gobeithio y gallwn gael egwyl am goffi tua 10.45 a.m., ac yr wyf yn gobeithio y byddwn wedi cyrraedd diwedd ein sesiwn dystiolaeth gyntaf erbyn hynny. Cawn weld sut gynnydd yr ydym yn ei wneud.

Before I invite the witnesses to introduce themselves, I would like to say one or two words in terms of the background before we move on to the detailed agenda. I hope that the following explanation will be of help to visitors and to those who are following our discussions on the television at home, which can be difficult at times. The main item on our agenda today is the evidence-taking session on a report prepared by the National Audit Office Wales, ‘The Procurement of Primary Care Medicines’. The report is quite complex, because the national health service’s system of providing medicines and drugs is complex and the method of deciding on the price is even more complex. We are, therefore, very grateful to National Audit Office officials and to the Auditor General for Wales, Sir John Bourn, for their detailed research work over many months, which has led to the drawing up of the report that is before us. The facts included in the report have been agreed upon by audit office officials on the one hand, and by civil servants of the national health service in Wales on the other.

Ein prif dystion, y byddaf yn gofyn wrthynt gyflwyno’u hunain mewn eiliad, yw penaethiaid y gwasanaeth iechyd gwladol yng Nghymru. Hwysydd, felly, yn gyfrifol am y meysydd hyn o safbwynt cynnal gwasanaeth a hefyd o safbwynt gweithredu o fewn cyllideb a sicrhau gwerth gorau am arian cyhoeddus. Mae swm sylweddol o arian yn y fantol. Mae meddyginiaethau yn cynrychioli 15 y cant o gost y gwasanaeth iechyd gwladol yng Nghymru, ac mae hynny’n gyfystyr â thros £400 miliwn y flwyddyn. Pe baem mewn sefyllfa i arbed 10 y cant o’r gost honno hyd yn oed, naill ai drwy sicrhau prisiau mwy ffafriol neu drwy ddefnydd mwy effeithiol o gyffuriau, byddai hynny’n arbed £40 miliwn y gellid ei ddefnyddio i gyflogi mwy o ddoctoriaid, nyrsys neu therapyddion. Mae’n amlwg felly bod hwn yn fater difrifol.

Mae’r adroddiad yn tynnu sylw at £97 miliwn o wariant y gellid efallai ei arbed—pwysleisiaf y gair ‘efallai’ oherwydd dyna fydd testun rhai o’r cwestiynau y byddwn yn eu holi. Mae’r adroddiad yn rhybuddio y byddai rhai peryglon o newid y drefn a rhai anawsterau wrth geisio gwireddu arbedion.

Y cwestiynau y byddwn ni, fel Pwyllgor, eisiau eu holi felly fydd rhai i ganfod faint o arian, mewn gwirionedd, y gellid ei arbed, a ydyw’n ymarferol sicrhau’r arbedion hynny a sut fath o amserlen sydd ar gyfer hyn. Yn sgîl y gwrandawriad, byddwn yn cyhoeddi adroddiad ac ynddo argymhellion i Lywodraeth Cymru yn seiliedig ar y dystiolaeth.

Symudwn ymlaen felly at y cwestiynau, a gwahoddaf ein dystion i gyflwyno’u hunain.

**Ms Lloyd:** I am Ann Lloyd, the director of NHS Wales.

Our main witnesses, whom I will ask to introduce themselves in a second, head the national health service in Wales. They are the ones, therefore, who are responsible for these areas in terms of maintaining service and also in terms of operating within budget and ensuring best value for public money. A significant amount of money is at stake. Medicines form 15 per cent of the cost of the national health service in Wales, and that is equivalent to over £400 million a year. Were we in a position to save even 10 per cent of that cost, either by ensuring more favourable prices or by the more effective use of drugs, that would save £40 million that could be used to employ more doctors, nurses or therapists. It is evident therefore that this is a serious matter.

The report draws attention to £97 million of expenditure that could perhaps be saved—I emphasise the word ‘perhaps’ because that will be the subject of some of the questions that we will ask. The report warns that there would be some risks in changing the system and some difficulties in trying to realise savings.

The questions that we, as a Committee, will want to ask therefore will be ones to determine how much money could, in reality, be saved, whether achieving those savings is practicable, and what kind of timetable exists for this. As a result of the hearing, we will publish a report that will include recommendations to the Government of Wales based on the evidence.

We will therefore move on to the questions, and I invite our witnesses to introduce themselves.

**Ms Lloyd:** Fi yw Ann Lloyd, cyfarwyddwr GIG Cymru.

**Ms Poulter:** I am Carolyn Poulter, the head of the pharmaceutical services branch in the Assembly. I am also a registered pharmacist.

[4] **Dafydd Wigley:** Diolch yn fawr. Agoraf y sesiwn drwy ofyn cwestiwn wrthy ch i, Ann Lloyd. Mae'r gyfundrefn a'r trefniadau ar gyfer caffael meddyginiaethau gofal sylfaenol yn ymddangos yn eithriadol o gymhleth. Am ba reswm y mae hynny?

**Ms Lloyd:** I think that that is because we are dealing with 1,000 individual contractors who are all buying medicines on our behalf to either prescribe or dispense to individual patients. These are independent and that, I think, is the greatest difference between the primary care sector and the secondary care sector, in that the secondary care prescribers are employees of the national health service and the general practitioners and pharmacists out in the community are not. Also, there seems to have been, as you quite rightly said, some extremely complex negotiations around how drugs for the primary care service are procured and the systems of discounts and reimbursements and the way in which, if pharmacists dispense at an increasing rate in terms of value, then their profit margins are reduced. There seems to have been, in the prescribing formulary—the drug tariff—an extraordinarily complex set of inter-related circumstances, which therefore guide the price that we are paying for drugs. The Auditor General, I think quite rightly, points out how complicated all this is and the risks of changing it, although I am wholehearted in a desire to ensure that we get value for money and, where we can possibly do so, reduce the costs of prescribing, which are going up exponentially year by year. It has certainly caused quite a difficult problem for us in the NHS, particularly this year, where the percentage has increased to about 12 per cent above last year's rates in terms

**Ms Poulter:** Fi yw Carolyn Poulter, pennaeth y gangen gwasanaethau fferyllol yn y Cynulliad. Yr wyf hefyd yn fferyllydd cofrestredig.

[4] **Dafydd Wigley:** Thank you. I will open the session by asking a question to you, Ann Lloyd. The system and the arrangements for procuring primary care medicines appear to be extremely complex. What is the reason for that?

**Ms Lloyd:** Credaf fod hynny oherwydd ein bod yn delio â 1,000 o gontractwyr unigol sydd i gyd yn prynu meddyginiaethau ar ein rhan naill ai i'w rhagnodi neu'u dosbarthu i gleifion unigol. Mae'r rhain yn annibynnol a dyna, yn fy marn i, yw'r gwahaniaeth mwyaf rhwng y sector gofal sylfaenol a'r sector gofal eilaidd, sef bod y rhagnodwyr gofal eilaidd yn cael eu cyflogi gan y gwasanaeth iechyd gwladol ond nid yw hyn yn wir am y meddygon teulu a'r fferyllwyr yn y gymuned. Hefyd, mae'n ymddangos y bu, fel y dywedasoch yn hollol gywir, rhai negodiadau tu hwnt o gymhleth am sut caiff cyffuriau ar gyfer y gwasanaeth gofal sylfaenol eu caffael a'r systemau gostyngiadau ac ad-daliadau a'r modd y mae elw fferyllwyr yn lleihau os ydynt yn dosbarthu ar raddfa gynyddol o safbwynt gwerth. Mae'n ymddangos y bu, yn y cyffurlyfr rhagnodi—rhestr brisiau'r cyffuriau—gyfres eithriadol o gymhleth o amgylchiadau rhyngberthynol, sydd felly'n arwain y pris yr ydym yn ei dalu am gyffuriau. Mae'r Archwilydd Cyffredinol, yn llygad ei le yn fy marn i, yn nodi pa mor gymhleth yw hyn i gyd a'r peryglon o newid y drefn, er fy mod i'n frwd fy nymuniad i sicrhau ein bod yn cael gwerth am arian a, lle mae'n bosibl inni wneud hynny, lleihau costau rhagnodi, sy'n codi'n gynt flwyddyn ar ôl blwyddyn. Mae'n sicr wedi achosi problem eithaf anodd i ni yn y GIG, yn enwedig eleni, lle mae'r ganran wedi codi i tua 12 y cant yn uwch na chyfraddau y llynedd o safbwynt gwerth, ac yr

of value, and we only generally give 9 per cent uplift per year to health authorities. That has caused a big problem for us all to manage. Nevertheless, I think that we need to weigh the risks that the Auditor General has very carefully pointed out to us in trying to use really good practice, which we are trying to do in Wales, and weigh the checks, balances, risks and advantages to us in trying to get more stabilisation and more central control on the prescribing and dispensing of primary care drugs.

[5] **Dafydd Wigley:** In underlining, quite rightly, the complexity and the risks that may be associated with change, would you accept that there is still scope for improving procurement arrangements in Wales?

**Ms Lloyd:** Yes, I do. I think that when we all read this report very carefully, there are obvious areas of good practice that are pointed out to us by the Auditor General and which we indeed have been pursuing. I think that, with the advent of more local control through the local health boards—and you have seen what some of the local health groups have already been doing in terms of formularies and persuasion, in trying to get better deals and in the substitution of generics from the doctors' prescribing practice—there is much more that we can do to spread that good practice and to test the local health boards on how they have adopted the helpful approach outlined in this report.

[6] **Dafydd Wigley:** I am grateful for that. Eleanor?

ydym ond yn rhoi cynnydd o 9 y cant y flwyddyn i awdurdodau iechyd yn gyffredinol. Mae hynny wedi achosi problem fawr i ni oll i'w rheoli. Serch hynny, credaf fod angen inni bwysu a mesur y risgiau mae'r Archwilydd Cyffredinol wedi eu hamlygu inni yn ofalus o geisio defnyddio arferion da iawn, yr ydym yn ceisio ei wneud yng Nghymru, a phwysu a mesur y gwiriadau, mantolenni, peryglon a manteision i ni o geisio cael mwy o sefydlogrwydd a mwy o reolaeth ganolog dros y gwaith o ragnodi a dosbarthu cyffuriau gofal sylfaenol.

[5] **Dafydd Wigley:** O danlinellu, yn hollol gywir, y cymhlethdod a'r peryglon a allai fod yn gysylltiedig â newid, a fydddech yn derbyn bod lle o hyd i wella trefniadau caffael yng Nghymru?

**Ms Lloyd:** Ydw, yr ydwyf. Credaf pan fyddwn oll yn darllen yr adroddiad hwn yn ofalus iawn, mae meysydd amlwg o arferion da y mae'r Archwilydd Cyffredinol wedi eu dwyn i'n sylw ac yr ydym yn wir wedi bod ar eu trywydd. Credaf, gyda dyfodiad mwy o reolaeth leol drwy'r byrddau iechyd lleol—ac yr ydych wedi gweld beth mae rhai o'r grwpiau iechyd lleol eisoes wedi bod yn ei wneud o ran cyffurlyfrau a pherswâd, wrth geisio cael bargeinion gwell ac wrth amnewid cyffuriau generig o arferion rhagnodi meddygon—mae llawer mwy y gallwn ei wneud i ledaenu arferion da ac i brofi'r byrddau iechyd lleol ar sut maent wedi mabwysiadu'r dull defnyddiol sy'n cael ei amlinellu yn yr adroddiad hwn.

[6] **Dafydd Wigley:** Yr wyf yn ddiolchgar am hynny. Eleanor?

[7] **Eleanor Burnham:** Paragraph 2.16 states that the Assembly does not have powers to change the pharmaceutical price regulation scheme, otherwise known as PPRS—I am only saying that in case anyone is listening and wondering what all these acronyms are—but that it may be able to influence the actions of the Department of Health. What influence do you have with the Department of Health so as to ensure that this PPRS is a good deal for Wales?

**Ms Lloyd:** We have a very close and positive working relationship with the Department of Health, because this is a universal issue and the Department of Health is operating on behalf of all the countries in the United Kingdom. It is felt better that that is the way it is done, because we then have much more leverage and much more purchasing power and ability to influence the decision universally on the pharmaceutical companies. It makes sure that we are not disadvantaged, because we are relatively small compared with England, and even Scotland, in terms of their purchasing power. So, we have continued to work very closely with the department and we are full partners in all the reviews that are being undertaken at the moment into this area.

[8] **Eleanor Burnham:** But, from our knowledge, there is obviously a lot more ill health in Wales and perhaps specific illnesses, particularly in the Valleys, ensuing from the post-industrial period. Do you see any way in which your influence could be strengthened so that, perhaps, if there are specific needs in Wales, they could be addressed to a greater extent?

**Ms Lloyd:** I think that we should not be south-east England centric. There are lots of areas of considerable ill health in England as well.

[7] **Eleanor Burnham:** Mae paragraff 2.16 yn nodi nad oes gan y Cynulliad bwerau i newid y cynllun rheoleiddio prisiau fferyllol, PPRS fel y'i gelwir—yr wyf ond yn dweud hynny rhag ofn fod rhywun yn gwrando ac yn pendroni beth yw'r holl acronymau hyn—ond y gallai efallai ddylanwadu ar gamau gweithredu yr Adran Iechyd. Pa ddylanwad sydd gennych yn yr Adran Iechyd i sicrhau bod y PPRS hwn yn gytundeb da i Gymru?

**Ms Lloyd:** Mae gennym berthynas waith dda ac agos iawn gyda'r Adran Iechyd, oherwydd mae hwn yn fater cyffredinol ac mae'r Adran Iechyd yn gweithredu ar ran holl wledydd y Deyrnas Unedig. Teimlir ei bod yn well mai dyna'r modd y caiff ei wneud, oherwydd wedyn mae gennym lawer mwy o ddylanwad a llawer mwy o rym prynu a gallu i ddylanwadu ar y penderfyniad yn gyffredinol ar y cwmnïau fferyllol. Mae'n sicrhau nad ydym o dan anfantais, oherwydd yr ydym yn gymharol fach o'n cymharu â Lloegr, a hyd yn oed yr Alban, o ran eu grym prynu. Felly, yr ydym wedi parhau i weithio'n agos iawn gyda'r adran ac yr ydym yn bartneriaid llawn yn yr holl adolygiadau sy'n cael eu cynnal ar hyn o bryd yn y maes hwn.

[8] **Eleanor Burnham:** Ond, o'n gwybodaeth ni, mae'n amlwg bod llawer mwy o afiechyd yng Nghymru ac efallai afiechydon penodol, yn enwedig yn y Cymoedd, yn deillio o'r cyfnod ôl-ddiwydiannol. A ydych yn gweld unrhyw fodd y gellid cynyddu'ch dylanwad fel, efallai, os oes anghenion penodol yng Nghymru, y gellid mynd i'r afael â hwy i raddau ehangach?

**Ms Lloyd:** Credaf na ddylem ganolbwyntio ar dde-ddwyrain Lloegr. Mae llawer o ardaloedd o afiechyd sylweddol yn Lloegr hefyd.

[9] **Eleanor Burnham:** But they might be different types of illnesses.

**Ms Lloyd:** They are not necessarily different types of illnesses. Illnesses borne out of an industrial heritage are fairly prevalent in England as well. Nevertheless, we have very good health needs assessment data in Wales, as they do in Scotland, and we work very closely with colleagues in Scotland too to ensure that the full requirements of our population are borne in mind in any negotiations undertaken by the Department of Health.

[10] **Dafydd Wigley:** I turn now to the part of the report that deals with the potential for reducing the cost of medicine procurement by adopting a different tariff for drugs and by various degrees of more centralised purchasing. The savings indicated in paragraph 3.8 suggest that centralised contracts are worth pursuing. Do you plan to take this option forward and, if you are to centralise contracts in order to get more leverage over the prices, would it be at a district level or at an all-Wales level?

**Ms Lloyd:** I think, basically, that, yes, of course we will pursue the piloting of central contracts for primary care. We are very happy to consider that. There are a number of arguments for centralised purchasing and local purchasing and those have been rehearsed. The all-Wales medicines strategy group, which has recently been established, arising from the task and finish group that first highlighted this issue of primary care prescribing, will be giving us advice and guidance and looking very thoroughly at the types of pilot schemes that we can pursue within the next six months. The local health board pilot schemes that we could pursue are unlikely to destabilise the national arrangements. However, we might have an increased risk in terms of

[9] **Eleanor Burnham:** Ond efallai eu bod yn fathau gwahanol o afiechydon.

**Ms Lloyd:** Nid ydynt o reidrwydd yn fathau gwahanol o afiechydon. Mae afiechydon sy'n deillio o orffennol diwydiannol yn eithaf cyffredin yn Lloegr hefyd. Serch hynny, mae gennym ddata asesu anghenion iechyd da iawn yng Nghymru, fel sydd ganddynt yn yr Alban, ac yr ydym yn cydweithio'n agos iawn â chydweithwyr yn yr Alban hefyd i sicrhau bod gofynion llawn ein poblogaeth yn cael eu hystyried mewn unrhyw drafodaethau sy'n cael eu cynnal gan yr Adran Iechyd.

[10] **Dafydd Wigley:** Trof yn awr at y rhan o'r adroddiad sy'n ymwneud â'r potensial i leihau'r gost o gaffael meddyginiaeth drwy fabwysiadu rhestr brisiau wahanol ar gyfer cyffuriau a thrwy wahanol raddau o brynu mwy canolog. Mae'r arbedion a nodir ym mharagraff 3.8 yn awgrymu ei bod hi'n werth mynd ar drywydd contractau canolog. A ydych yn bwriadu datblygu'r opsiwn hwn ac, os ydych am ganoli contractau er mwyn cael mwy o ddylanwad ar y prisiau, a fyddai hyn ar lefel dosbarth neu ar lefel Cymru gyfan?

**Ms Lloyd:** Credaf, yn y bôn, y byddwn, wrth gwrs, yn mynd ar drywydd cynnal cynllun peilot o'r contractau canolog ar gyfer gofal sylfaenol. Yr ydym yn fodlon iawn ystyried hynny. Mae nifer o ddadleuon dros brynu canolog a phrynu lleol ac mae'r rheini wedi cael eu lleisio. Bydd grwp strategaeth meddyginiaethau Cymru gyfan, a sefydlwyd yn ddiweddar, yn deillio o'r grwp gorchwyl a gorffen a dynnodd sylw at y mater hwn o ragnodi gofal sylfaenol yn y lle cyntaf, yn rhoi cyngor a chanllawiau inni ac yn edrych yn ofalus iawn ar y mathau o gynlluniau peilot y gallwn eu mabwysiadu yn y chwe mis nesaf. Mae cynlluniau peilot y byrddau iechyd lleol y galleu eu mabwysiadu yn annhebygol o ddadsefydlogi'r trefniadau cenedlaethol. Fodd

supply, which I think is important, because one of the big problems in terms of suppliers is that if you put all your eggs in one basket and suddenly the person goes out of business, then the production of the drug might have ceased elsewhere and you really are placing yourself in a vulnerable position. We have to evaluate the balance of risk throughout that sort of thing. However, it really could influence local prescribing behaviour and, if we are targeting areas of particular ill health where the drugs budget is extremely high, then a more localised approach could be the best way forward. However, we need time to establish those organisations and to grow the behaviour, which will ensure that local formularies are effective and are owned by the GPs and others. So, that, on one side, is the local issue. In terms of the more centralised contracting pilot schemes, I think that we would have to be careful about what we chose to try to negotiate on a centralised basis because it is highly complex to negotiate some of these purchases. It has not been so bad in the secondary care sector where you are really only looking at approximately 500 items. The number is 14,000 in primary care.<sup>[i]</sup> So, in order not to disperse our energies, and to really get the savings that we would hope to achieve, I think that we would have to limit the centralised purchasing pilot scheme to a few of the most regularly used drugs, those that are probably suitable for generic prescribing. We would have to be careful that there is a suitable generic substitute available to us. We—Carolyn, particularly, and Carwen Wynne Howells, our chief pharmacist—have put this test to the all-Wales medicines strategy group to come forward with a proposal to us so that we can start to undertake pilot schemes with the agreement of the contracting community.<sup>[ii]</sup>

bynag, efallai fod mwy o berygl i ni o ran cyflenwad, sy'n bwysig yn fy marn i, oherwydd un o'r problemau mawr o ran cyflenwyr yw os ydych yn rhoi'ch wyau i gyd yn yr un fasedg ac yn sydyn bod busnes yr unigolyn hwnnw'n methu, yna mae'n bosibl fod y gwaith o gynhyrchu'r cyffur wedi dod i ben yn rhywle arall a'ch bod yn rhoi'ch hun mewn sefyllfa wan. Rhaid inni werthuso cybwysedd y risg drwy gydol y math hwnnw o beth. Fodd bynnag, gallai'n wir ddylanwadu ar ymddygiad rhagnodi lleol ac, os ydym yn targedu meysydd o afiechyd penodol lle mae'r gyllideb gyffuriau yn hynod uchel, yna mae'n bosibl mai dull mwy lleol fyddai'r ffordd orau ymlaen. Fodd bynnag, mae angen amser arnom i sefydlu'r sefydliadau hynny ac i ddatblygu'r ymddygiad, a fydd yn sicrhau bod cyffurlyfrau lleol yn effeithiol a'u bod yn eiddo i feddygon teulu ac eraill. Felly, dyna, ar un ochr, yw'r ddatl leol. O safbwynt y cynlluniau peilot contractio mwy canolog, credaf y byddai'n rhaid inni fod yn ofalus ynglyn â'r hyn y byddem yn ei ddewis i geisio negodi yn ganolog oherwydd mae'n gymhleth iawn negodi rhai o'r pryniadau hyn. Nid yw wedi bod cynddrwg yn y sector gofal eilaidd lle'r ydych ond yn edrych ar tua 500 o eitemau mewn gwirionedd. Mae'r nifer yn 14,000 mewn gofal sylfaenol.<sup>[i]</sup> Felly, er mwyn peidio â gwasgaru ein hymdrechion, ac i gael yr arbedion y byddem yn gobeithio eu sicrhau mewn gwirionedd, credaf y byddai'n rhaid inni gyfyngu ar y cynllun peilot prynu canolog i rai o'r cyffuriau a ddefnyddir yn fwyaf rheolaidd, y rheini sydd yn ôl pob tebyg yn addas ar gyfer rhagnodi generig. Byddai'n rhaid inni fod yn ofalus bod cyffur amgen generig addas ar gael i ni. Yr ydym—Carolyn, yn enwedig, a Carwen Wynne Howells, ein prif fferylllydd—wedi rhoi'r prawf hwn i'r grwp strategaeth meddyginiaethau Cymru gyfan i gyflwyno cynnig i ni fel y gallwn ddechrau cynnal cynlluniau peilot gyda chaniatâd y gymuned contractio.<sup>[ii]</sup>

[11] **Dafydd Wigley:** That is very encouraging. If I understand correctly, you are saying that over the next six months or so, you will be developing a number of pilot schemes, not just one, and that there will be some local ones and some central ones.

**Ms Lloyd:** We will be developing the methodology on which we will run those pilot schemes.

[12] **Dafydd Wigley:** Yes, and then, after, say, a six-month period of doing that, the pilot schemes could be rolled out. With regard to the local ones, do you see the local health groups actually taking the lead in negotiations where there are pilot schemes on a local level, or not? Will they have the clout, the leverage and the expertise to do that?

**Ms Lloyd:** I think that anybody would have difficulty in negotiating with major pharmaceutical companies on their own. I think that even the full force of the National Assembly will require some very specialist advice to help it with these negotiations because the pharmaceutical companies have to be able to see that there is something in it for them as well, and also to ensure that we do not destabilise the arrangements that we also have with secondary care. Some of those arrangements are almost loss leaders, and we would have to make sure that the balance was held. So, we would need some expert advice for a central or a local pilot scheme.

[13] **Dafydd Wigley:** Alun, you want to come in on this. You are not going to ask a question that is to be asked later on are you?

[11] **Dafydd Wigley:** Mae hynny'n galonogol iawn. Os deallaf yn iawn, yr ydych yn dweud y byddwch, dros y chwe mis nesaf yn fras, yn datblygu nifer o gynlluniau peilot, nid un yn unig, ac y bydd rhai lleol a rhai canolog.

**Ms Lloyd:** Byddwn yn datblygu'r fethodoleg y byddwn yn ei defnyddio i gynnal y cynlluniau peilot hynny.

[12] **Dafydd Wigley:** Iawn, ac yna, ar ôl, dywedwch, cyfnod chwe mis o wneud hynny, gellid cyflwyno'r cynlluniau peilot. O ran y rhai lleol, a ydych yn rhagweld y bydd y grwpiau iechyd lleol mewn gwirionedd yn arwain y negodiadau lle mae cynlluniau peilot yn lleol, ai peidio? A fydd ganddynt y grym, y dylanwad a'r arbenigedd i wneud hynny?

**Ms Lloyd:** Credaf y byddai unrhyw un yn cael anhawster negodi gyda chwmnïau fferyllol mawr ar ei ben ei hun. Credaf y bydd angen rhywfaint o gyngor arbenigol iawn hyd yn oed ar holl rym y Cynulliad Cenedlaethol i'w gynorthwyo gyda'r negodiadau hyn oherwydd mae'r cwmnïau fferyllol wedi llwyddo i weld bod rhywfaint o fudd yn hyn iddynt hwythau hefyd, a hefyd i sicrhau nad ydym yn dadsefydlogi'r trefniadau sydd gennym hefyd gyda gofal eilaidd. Mae rhai o'r trefniadau hynny bron yn rhai ar golled, a byddai'n rhaid inni sicrhau bod y cydbwysedd yn cael ei gynnal. Felly, byddai angen rhywfaint o gyngor arbenigol arnom ar gyfer cynllun peilot canolog neu leol.

[13] **Dafydd Wigley:** Alun, yr ydych am ddod i mewn yn y fan hon. Nid ydych yn mynd i ofyn cwestiwn sy'n mynd i gael ei ofyn yn nes ymlaen ydych chi?

[14] **Alun Cairns:** I hope not. I will be brief, Cadeirydd. Ms Lloyd, in terms of changing the methodology for these pilot schemes, or in developing it—particularly for those pilot schemes relating to the health boards, where they can strike local arrangements—can you advise us as to whether you would include the cost implications of buying in the expertise for the local health boards, because, with the greatest respect, bearing in mind that they are such new bodies, I hardly think that that hard-headed negotiating expertise would already exist within them?

**Ms Lloyd:** Yes, of course you would, because all pilot schemes must be evaluated against their full cost. Whenever we embark on pilot schemes of this or any nature in my department, we always ensure that the costs of establishing and evaluating the pilot scheme are included. I think that the issue surrounding the local health boards and where they may have a greater influence at the end of the day—and this is subject to my speculation—is that they may have a closer involvement in changing behaviour, which is absolutely fundamental to the success of any pilot scheme, be it a central or a local pilot scheme.

[15] **Dafydd Wigley:** Eleanor, do you want to ask a brief question on this?

[16] **Eleanor Burnham:** We are also, are we not, Ms Lloyd, dealing with the issue—you talk about stabilisation and not destabilising the scenario—of community pharmacists, who are extremely worried now that they are going to be in a very weakened position and that they may literally be vacuumed up by the buying power of supermarkets if they are allowed to come on-stream? That could destabilise the situation.

[14] **Alun Cairns:** Nac ydwyf gobeithio. Byddaf yn fyr, Gadeirydd. Ms Lloyd, o ran newid y fethodoleg ar gyfer y cynlluniau peilot hyn, neu ei datblygu—yn enwedig ar gyfer y cynlluniau peilot hynny sy'n ymwneud â'r byrddau iechyd, lle gallant wneud trefniadau lleol—a allwch ddweud wrthym a fydddech yn cynnwys y goblygiadau cost o brynu'r arbenigedd ar gyfer y byrddau iechyd lleol, oherwydd, gyda phob parch, o ystyried eu bod yn gyrff mor newydd, nid oes bosibl y byddai'r arbenigedd negodi craff hynny eisoes yn bodoli ganddynt yn fewnol?

**Ms Lloyd:** Byddech, wrth gwrs, oherwydd rhaid gwerthuso pob cynllun peilot yn erbyn eu cost lawn. Pryd bynnag yr ydym yn cychwyn ar gynlluniau peilot o'r math hwn neu o unrhyw fath yn fy adran i, yr ydym bob amser yn sicrhau bod costau sefydlu a gwerthuso'r cynllun peilot yn cael eu cynnwys. Credaf mai'r mater ynglyn â'r byrddau iechyd lleol a lle mae'n bosibl iddynt gael mwy o ddylanwad yn y pen draw—ac mae hyn yn amodol ar fy nhybiaeth i—yw efallai y byddant yn ymwneud yn agosach â newid ymddygiad, sy'n hollol hanfodol i lwyddiant pob cynllun peilot, boed yn gynllun peilot canolog neu leol.

[15] **Dafydd Wigley:** Eleanor, a ydych am ofyn cwestiwn byr am hyn?

[16] **Eleanor Burnham:** Yr ydym hefyd, onid ydym, Ms Lloyd, yn delio â mater—soniwch am sefydlogi a pheidio â dadsefydlogi'r sefyllfa—fferyllwyr cymuned, sy'n pryderu'n fawr bellach eu bod yn mynd i fod mewn sefyllfa lawer gwannach ac y cânt efallai, yn llythrennol, eu llyncu gan rym prynu'r archfarchnadoedd os y caniateir iddynt ymuno? Gallai hynny ddadsefydlogi'r sefyllfa.

**Ms Lloyd:** Well, as you know, the Minister made a statement about that issue yesterday. However, basically, what we would have to do in all these pilot schemes is have a thorough understanding of all the risks and the advantages and test those thoroughly. The report helpfully outlines the issues of the rural nature of some of this practice, and the risks surrounding destabilising, particularly in the rural areas.

[17] **Dafydd Wigley:** We may come back to that later. Ann?

[18] **Ann Jones:** We are still on paragraph 3.8. That paragraph, and figure 6 in particular, indicates that a few high-volume items account for the bulk of what could be a calculated saving. The report refers to them as the 'top 10'. The savings indicated in figure 6 seem to indicate that the NHS is currently not getting a good deal on some of these top 10 items. I will not attempt to tell you what the items are—I am sure that they have given this question to me on purpose. I apologise to those of you who do not have the report, but I suggest that you try to find a copy, because I will not even attempt to pronounce them. Do you think that it is a fair assessment in the auditor's report that almost £23 million in savings could be made on those top 10 drugs?

**Ms Lloyd:** Could I ask Carolyn to answer this, because she knows the detail of these particular drugs?

[19] **Dafydd Wigley:** Yes. Carolyn?

**Ms Lloyd:** Wel, fel y gwyddoch, gwnaeth y Gweinidog ddatganiad am y mater hwnnw ddoe. Fodd bynnag, yn y bôn, yr hyn y byddai'n rhaid i ni ei wneud yn yr holl gynlluniau peilot hyn yw cael dealltwriaeth drylwyr o'r holl risgiau a'r manteision a phrofi'r rheini'n drylwyr. Mae'r adroddiad yn ddefnyddiol yn amlinellu'r materion o natur wledig rhywfaint o'r arfer hwn, a'r risgiau sy'n gysylltiedig â dadsefydlogi, yn enwedig yn yr ardaloedd gwledig.

[17] **Dafydd Wigley:** Efallai y deawn yn ôl at hynny nes ymlaen. Ann?

[18] **Ann Jones:** Yr ydym yn dal ar baragraff 3.8. Mae'r paragraff hwnnw, a ffigur 6 yn arbennig, yn nodi bod rhai eitemau swm uchel yn cyfrif am y rhan fwyaf o beth allai fod yn arbediad amcangyfrifedig. Cyfeiria'r adroddiad atynt fel y '10 uchaf'. Mae'n ymddangos bod yr arbedion a nodir yn ffigur 6 yn nodi nad yw'r GIG yn cael cytundeb da ar hyn o bryd ar rai o'r 10 eitem uchaf hyn. Ni cheisiaf ddweud wrthyhych beth yw'r eitemau hyn—yr wyf yn siwr eu bod wedi rhoi'r cwestiwn hwn imi yn fwriadol. Ymddiheuraf i'r rheini ohonoch nad oes gennych yr adroddiad, ond awgrymaf eich bod yn ceisio dod o hyd i gopi, oherwydd ni wnaif i hyd yn oed ceisio eu hynganu. A gredwch ei fod yn asesiad teg yn adroddiad yr archwilydd y gellid arbed bron i £23 miliwn ar y 10 cyffur uchaf hynny?

**Ms Lloyd:** A allwn i ofyn i Carolyn ateb hwn, oherwydd mae hi'n gwybod manylion y cyffuriau penodol hyn?

[19] **Dafydd Wigley:** Gallwch. Carolyn?

**Ms Poulter:** The pharmaceutical industry would be keen to point out that discounting to secondary care is purely discretionary on its part. It reflects the fact that the expenditure on drugs in secondary care is far smaller than that in primary care. It is also based on the assumption that one hospital prescription or recommendation will generate some 15 prescriptions in primary care, so there is an incentive to encourage secondary care to prescribe a particular company's drugs. Under the PPRS, the industry's overall profits are controlled, rather than the prices of the actual drugs. So, there is room for cross-subsidisation, if you like, between prices. So, the overall cost to the NHS should not be any greater because the theory is that if the pharmaceutical industry gives a discount to secondary care, it will not lose out in terms of profit, by shifting the price to primary care. It has been suggested that discounting rates in secondary care are falling following some legal challenges and also due to the introduction of the unified budget, whereby people are far more aware of the influence of secondary care prescribing on primary care, and so there is a move by hospitals to move away from this loss-leader situation. Obviously, the pharmaceutical industry needs to recoup its development costs before the expiry of a patent.

The drugs that are highlighted in this report account for some 10 per cent of the primary care drugs spend in 2002. Half of those drugs that are mentioned are within the top 10 of primary care expenditure, so, obviously, there is greater scope for the pharmaceutical industry to provide discounts on that because of the vast numbers of drugs that are prescribed.

**Ms Poulter:** Byddai'r diwydiant fferyllol yn awyddus i bwysleisio bod rhoi gostyngiadau i ofal eilaidd yn hollol ddewisol ar ei ran ef. Mae'n adlewyrchu'r ffaith bod y gwariant ar gyffuriau mewn gofal eilaidd llawer yn is nag y mae mewn gofal sylfaenol. Mae hefyd yn seiliedig ar y dybiaeth y bydd un argymhelliad neu bresgripsiwn ysbyty yn arwain at ryw 15 presgripsiwn mewn gofal sylfaenol, felly mae cymhelliad i annog gofal eilaidd i ragnodi cyffuriau cwmni penodol. Dan y PPRS, rheolir elw cyffredinol y diwydiant, yn hytrach na phrisiau'r cyffuriau eu hunain. Felly, mae lle i groes-gymorthdal, os hoffwch chi, rhwng prisiau. Felly, ni ddylai'r gost gyffredinol i'r GIG fod tamaid yn uwch oherwydd y ddamcaniaeth yw, os yw'r diwydiant fferyllol yn rhoi gostyngiad i ofal eilaidd, ni fydd ar ei golled o ran elw, drwy symud y pris i ofal sylfaenol. Awgrymwyd bod cyfraddau gostyngiadau mewn gofal eilaidd yn disgyn yn dilyn ambell her cyfreithiol a hefyd oherwydd cyflwyno'r gyllideb unedig, sy'n golygu bod pobl yn llawer mwy ymwybodol o ddylanwad rhagnodi gofal eilaidd ar ofal sylfaenol, ac felly mae ysbytai yn gwneud ymgais i symud i ffwrdd o'r sefyllfa 'ar golled' hon. Yn amlwg, mae angen i'r diwydiant fferyllol adennill ei gostau datblygu cyn bod patent yn dod i ben.

Mae'r cyffuriau sydd wedi'u hamlygu yn yr adroddiad hwn yn cyfrif am ryw 10 y cant o'r hyn a wariwyd ar gyffuriau mewn gofal sylfaenol yn 2002. Mae hanner y cyffuriau hynny sy'n cael eu crybwyll yn y 10 uchaf o wariant gofal sylfaenol, felly, yn amlwg, mae mwy o gyfle i'r diwydiant fferyllol ddarparu gostyngiadau ar hynny oherwydd y niferoedd helaeth o gyffuriau sy'n cael eu rhagnodi.

Obviously, attempts to extend centralised purchasing may lead to a scrapping of these discounts to secondary care so, while there is potential perhaps to make savings, the report does it make it very clear that there are risks involved, and we could actually lose this benefit to the NHS.

[20] **Dafydd Wigley:** Before Ann goes on to the next bit, may I come in and press you a bit further on that? Given the Napp case, where a company was fined £2 million, I think, for loss-leading, is there not already a move away from that? Do companies not realise that, if there was a question of serious loss-leading and distortion, they could be open to prosecution?

**Ms Poulter:** Absolutely, and that is why discounts to secondary care have been reduced and the all-Wales drugs contracting committee, which forms centralised contracts, is actually making a positive move to avoid drugs that are obviously loss-leaders, where there is an obvious difference between primary and secondary care.

[21] **Dafydd Wigley:** So this is a valid base here, these that are listed? They are not distorted by loss-leading at this point in time?

**Ms Poulter:** No, I do not believe so. There may be an element of that.

[22] **Dafydd Wigley:** That is helpful.

Yn amlwg, mae'n bosibl y gallai ymdrechion i ehangu prynu canolog arwain at ddiddymu'r gostyngiadau hyn i ofal eilaidd felly, tra bod potensial efallai i wneud arbedion, mae'r adroddiad yn ei gwneud yn glir iawn bod risgiau ynghlwm wrth hyn, ac y gallem mewn gwirionedd golli'r budd hwn i'r GIG.

[20] **Dafydd Wigley:** Cyn i Ann fynd ymlaen i'r rhan nesaf, a gaf fi ddod i mewn a'ch holi ymhellach am hynny? O gofio achos Napp, lle cafodd cwmni ddirwy o £2 miliwn, yr wyf yn credu, am werthu 'ar golled', onid oes eisoes symudiad i ffwrdd oddi wrth hynny? Onid yw cwmnïau'n sylweddoli, os oedd cwestiwn o werthu ar golled neu gamarwain difrifol, y gallent fod yn agored i gael eu herlyn?

**Ms Poulter:** Yn bendant, a dyna pham mae gostyngiadau i ofal eilaidd wedi eu lleihau ac mae pwyllgor contractio cyffuriau Cymru gyfan, sy'n ffurfio contractau canolog, mewn gwirionedd yn cymryd cam cadarnhaol i osgoi cyffuriau sydd yn amlwg yn rhai ar golled, lle mae gwahaniaeth amlwg rhwng gofal sylfaenol ac eilaidd.

[21] **Dafydd Wigley:** Felly mae hon yn sail ddilys yn y fan hon, y rhain sydd wedi eu rhestru? Nid ydynt yn cael eu gwyrddroi drwy werthu ar golled ar hyn o bryd?

**Ms Poulter:** Na, ni chredaf hynny. Efallai fod elfen o hynny.

[22] **Dafydd Wigley:** Mae hynny'n ddefnyddiol.

[23] **Ann Jones:** Ms Lloyd, you did refer to negotiating with the pharmaceutical industry and you did say that it takes—I think you said—the might of the Assembly. I was going to ask you about that but I think that you have acknowledged that there would be difficulties there, so how do you intend to build up in any way the expertise within the national health service to actually take on a successful and meaningful negotiation with pharmaceutical companies?

**Ms Lloyd:** Well, there is some expertise anyway in the all-Wales group that has been negotiating the secondary care drugs, so we can build on the experience that it has had, but all negotiation has to be undertaken with care because you only usually get one chance at it, and we would obviously build on the lessons that it has learned. It will have contacts with the drugs companies anyway, and their representatives. I think that we have to test this steadily and try to pick our targets very carefully, so that we are not wasting the chances that we do have. That, again, is part of the evaluation of the risk of undertaking further negotiation with the pharmaceutical companies, or anybody else for that matter.

[24] **Dafydd Wigley:** May I now turn to issues of prescribing and medicines management? I refer to part 4 of the report, which describes a range of initiatives that could reduce expenditure on medicines in Wales. Part 4 of the report indicates that there may be significant savings made for the Assembly through better prescribing and better medicines management. The report also indicates that these are not new ideas. Why, then, has progress in securing these savings been rather slow?

[23] **Ann Jones:** Ms Lloyd, cyfeiriasoch at negodi gyda'r diwydiant fferyllol gan ddweud ei bod hi'n cymryd—credaf ichi ddweud—nerth y Cynulliad. Yr oeddwn yn mynd i'ch holi am hynny ond credaf i chi gydnabod y byddai anawsterau yn y fan honno, felly sut yr ydych yn bwriadu datblygu mewn unrhyw fodd yr arbenigedd o fewn y gwasanaeth iechyd gwladol i gynnal negodiad llwyddiannus ac ystyrlon gyda chwmnïau fferyllol?

**Ms Lloyd:** Wel, mae rhywfaint o arbenigedd beth bynnag yn y grwp Cymru gyfan a fu'n negodi'r cyffuriau gofal eilaidd, felly gallwn adeiladu ar y profiad a gafodd, ond rhaid cynnal yr holl negodi gyda gofal oherwydd un cyfle'n unig y cewch, a byddem yn amlwg yn adeiladu ar y gwersi y mae wedi eu dysgu. Bydd ganddo gysylltiadau â'r cwmnïau cyffuriau beth bynnag, a'u cynrychiolwyr. Credaf fod yn rhaid i ni brofi hyn yn raddol a cheisio dewis ein targedau'n ofalus iawn, fel nad ydym yn gwastraffu'r cyfleoedd sydd gennym. Mae hynny, unwaith eto, yn rhan o'r gwerthusiad o'r risg o negodi ymhellach gyda'r cwmnïau fferyllol, neu gydag unrhyw un arall o ran hynny.

[24] **Dafydd Wigley:** A gaf fi yn awr droi at faterion rhagnodi a rheoli meddyginiaethau? Cyfeirïaf at ran 4 yr adroddiad, sy'n disgrifio amrywiaeth o fentrau a allai leihau gwariant ar feddyginiaethau yng Nghymru. Mae rhan 4 yr adroddiad yn nodi y gallai'r Cynulliad wneud arbedion sylweddol drwy ragnodi gwell a rheoli meddyginiaethau'n well. Mae'r adroddiad hefyd yn nodi nad syniadau newydd yw'r rhain. Pam, felly, y bu'r cynnydd yn y gwaith o sicrhau'r arbedion hyn braidd yn araf?

**Ms Lloyd:** I do not think that we have been doing nothing; we have been making steady progress. There is a balance here—medicines management has been good practice for many years, and that is why you have seen the growth of formularies and the seeking of alternatives and generics whenever possible. The use of generics has grown quite considerably in the past five years, so that has been good. The establishment of things like the information centre on the efficacy of drugs and substitutions has been available in Wales for some time now. Also, there has been a growth over the past few years of these relationships and partnerships between secondary and primary care, where you look at the whole pathway of the patient's illness and disease and there is an agreement between the two partners about the right drug regime that is necessary for the patient. There was a tremendous amount of criticism from primary care, some three or four years ago, when some extremely expensive new drugs were being prescribed in the secondary care service which were really escalating the costs in primary care, where they did not have the negotiated basis of secondary care. So I think that there has been quite a change in the way in which people have started to look at drugs and their management. All the health authorities, and now the local health boards, will have pharmacy advisers. They have made quite a difference to the way in which GPs have been giving out drugs.

**Ms Lloyd:** Ni chredaf ein bod wedi bod yn gwneud dim; yr ydym wedi bod yn gwneud cynnydd graddol. Mae cydbwysedd yn y fan hon—mae rheoli meddyginiaethau wedi bod yn arfer da ers sawl blwyddyn, a dyna pam yr ydych wedi gweld twf cyffurlyfrau a'r arfer o chwilio am feddyginiaethau amgen a generig pryd bynnag y bo hynny'n bosibl. Mae'r defnydd o feddyginiaethau generig wedi tyfu'n eithaf sylweddol yn y pum mlynedd diwethaf, felly mae hynny wedi bod yn dda. Mae sefydlu pethau fel y ganolfan wybodaeth am effeithiolrwydd cyffuriau ac amnewidiadau wedi bod ar gael yng Nghymru ers cryn amser bellach. Yn ogystal, bu twf yn y blynyddoedd diwethaf yn y cysylltiadau a'r partneriaethau hyn rhwng gofal eilaidd a sylfaenol, lle'r ydych yn edrych ar lwybr salwch a chlefyd y claf yn gyflawn ac mae'r ddau bartner yn gytûn am y drefn gyffuriau gywir sydd ei hangen ar y claf. Cafwyd llawer iawn o feirniadaeth gan ofal sylfaenol, rhyw dair neu bedair blynedd yn ôl, pan yr oedd rhai cyffuriau newydd hynod o ddrud yn cael eu rhagnodi yn y gwasanaeth gofal eilaidd a oedd mewn gwirionedd yn cynyddu'r costau mewn gofal sylfaenol, lle nad oeddynt wedi negodi yn yr un modd â gofal eilaidd. Felly credaf fod cryn newid wedi bod yn y modd y mae pobl wedi dechrau edrych ar gyffuriau a'u rheolaeth. Bydd cynghorwyr fferyllfa gan yr holl awdurdodau iechyd, a bellach y byrddau iechyd lleol. Maent wedi gwneud tipyn o wahaniaeth i'r modd y mae meddygon teulu wedi bod yn dosbarthu cyffuriau.

However, there is still room for improvement. There is always room for improvement. That is why I am very keen indeed to ensure that, on a more local basis, we can manage and performance manage the work that is done to try to drive down primary care dispensing values. We are also faced with the fact that costs are escalating in prescribing generally—not because people are not being careful and cautious, but because we are getting new drugs in the market that have never been available to us before and which are beneficial to patients. They are not cheap, but they are very beneficial and you only get the cost release at the end of the day. That might be four or five years down the track, when we prevent admission to hospital because of better drugs management in the community.

So it is not fair, I think, to say that nothing has been done, but we need to make sure that it is universal. I think that that is where my concerns are—that we are not being smart enough at the moment to ensure that everyone is following the best practice and that they are tested against that, and that we do not at all times look for generic substitution for really good medicines management.

[25] **Dafydd Wigley:** Eleanor, did you want to come in on this?

[26] **Eleanor Burnham:** On this point, are you happy that GPs are fully aware of all the implications of drug prescribing? I say this without being patronising. It seems to me that pharmacists have far more knowledge and perhaps we are not using them sufficiently, particularly when it comes to multiple prescribing to older people, to use the technical term.

Fodd bynnag, mae lle i wella o hyd. Mae bob amser lle i wella. Dyna pam yr wyf yn awyddus iawn yn wir i sicrhau y gallwn reoli a rheoli perfformiad y gwaith a wneir i geisio gostwng gwerthoedd dosbarthu gofal sylfaenol yn fwy lleol. Yr ydym hefyd yn wynebu'r ffaith bod costau yn cynyddu ym maes rhagnodi yn gyffredinol—nid oherwydd nad yw pobl yn ofalus ac yn bwylllog, ond oherwydd ein bod yn cael cyffuriau newydd yn y farchnad na fuont erioed ar gael i ni o'r blaen ac sy'n llesol i gleifion. Nid ydynt yn rhad, ond maent yn llesol iawn ac yr ydych ond yn cael y gost ryddhau yn y pen draw. Efallai y bydd hynny bedair neu bum mlynedd yn ddiweddarach, pan yr ydym yn osgoi cyfnod mewn ysbyty oherwydd bod cyffuriau'n cael eu rheoli'n well yn y gymuned.

Felly, ni chredaf ei bod yn deg dweud nad oes unrhyw beth wedi ei wneud, ond mae angen i ni sicrhau ei fod yn digwydd ym mhob man. Credaf mai dyna ble mae fy mhryderon—nad ydym yn ddigon clyfar ar hyn o bryd i sicrhau bod pawb yn dilyn yr arferion gorau a'u bod yn cael eu profi yn erbyn hynny, ac nad ydym bob amser yn chwilio am amnewidiad generig er mwyn cael rheolaeth dda iawn o feddyginiaethau.

[25] **Dafydd Wigley:** Eleanor, a ydych am ddweud rhywbeth am hyn?

[26] **Eleanor Burnham:** Ar y pwynt hwn, a ydych yn hapus bod meddygon teulu yn gwbl ymwybodol o holl oblygiadau rhagnodi cyffuriau? Dywedaf hyn heb fod yn nawddoglyd. Mae'n ymddangos i mi fod gan fferyllwyr lawer mwy o wybodaeth ac efallai nad ydym yn gwneud defnydd digonol ohonynt, yn enwedig pan ddaw hi i ragnodi mwy nag un cyffur i bobl hyn, i ddefnyddio'r term technegol.

**Ms Lloyd:** I think that pharmacists are rather an undervalued species. I think that, with better partnership with pharmacists—they are the experts in drugs after all. It is their profession to understand drug interactions, and I think that far more can be made of the pharmaceutical intelligence that is available within Wales. Hopefully, with the focus now being placed on primary healthcare teams that involve pharmacists fully, we might start to see some changed behaviour. Pharmacists have a great deal to offer, particularly where you are dealing with a complex illness which requires a cocktail of medications. They can also give advice on substitution. We need to encourage all our GPs. Many of them work hand in glove with their pharmacists, but we need to ensure that that good practice is spread throughout Wales.

[27] **Dafydd Wigley:** I know that Janet wants to follow on with some questions relating to pharmacists, but before that may I ask whether there is anything further that the Assembly can do to overcome some of the barriers to getting the savings that you say are there? Some progress has been made towards them; there is more that can be made perhaps. Is there anything that the Assembly can do?

**Ms Lloyd:** Oh, yes. I think that, through the performance management system that we will have up and running from 1 April, now that it has finally been piloted, and which we will run with the local health boards, we can test the advances that are being made in the localities in terms of better medicines management, the control of prescribing costs and the roll-out of new products and at the same time be running these pilots to try to ensure that the procurement is as slick, efficient and cost-effective as possible. I think that that is the best way to do it, as part of the management of a whole community's health and to keep a really quite strict eye on it, because we

**Ms Lloyd:** Credaf fod fferyllwyr yn bobl sy'n cael eu tanbrisio. Credaf, gyda gwell partneriaeth gyda fferyllwyr—hwy yw'r arbenigwyr ar gyffuriau wedi'r cyfan. Eu proffesiwn yw deall adweithiau rhwng cyffuriau, a chredaf y gellid gwneud llawer mwy â'r deallusrwydd fferyllol sydd ar gael yng Nghymru. Y gobaith yw, gyda'r pwyslais bellach ar dimau gofal iechyd sylfaenol sy'n cynnwys fferyllwyr yn llawn, efallai y dechreuwn weld rhywfaint o newid mewn ymddygiad. Mae gan fferyllwyr lawer i'w gynnig, yn enwedig lle'r ydych yn delio ag afiechydon cymhleth sydd angen cyfuniad o feddyginiaethau. Gallant hefyd roi cyngor ar amnewid. Mae angen i ni annog ein meddygon teulu i gyd. Mae llawer ohonynt yn gweithio law yn llaw â'u fferyllwyr, ond mae angen i ni sicrhau y lledaenir arferion da ledled Cymru.

[27] **Dafydd Wigley:** Gwn fod Janet am barhau â rhai cwestiynau yn ymwneud â fferyllwyr, ond cyn hynny, a gaf fi ofyn a oes rhywbeth arall y gall y Cynulliad ei wneud i oresgyn rhai o'r rhwystrau rhag sicrhau'r yr arbedion y dywedwch sydd yna? Mae rhywfaint o gynnydd wedi ei wneud tuag atynt; efallai fod mwy y gellir ei wneud. A oes rhywbeth y gall y Cynulliad ei wneud?

**Ms Lloyd:** O, oes. Credaf, drwy'r system rheoli perfformiad y bydd gennym ar waith o 1 Ebrill, gan ei bod bellach wedi bod drwy gynllun peilot o'r diwedd, ac y byddwn yn ei gweithredu gyda'r byrddau iechyd lleol, y gallwn brofi'r cynnydd sy'n cael ei wneud yn yr ardaloedd lleol o ran rheolaeth well o feddyginiaethau, rheoli costau rhagnodi a chyflwyno cynhyrchion newydd ac ar yr un pryd cynnal y cynlluniau peilot hyn i geisio sicrhau bod caffael mor hwylus, effeithlon a chost effeithiol â phosibl. Credaf mai dyna yw'r ffordd orau o'i wneud, fel rhan o'r gwaith o reoli iechyd cymuned gyfan ac i gadw llygad barcud arno, oherwydd rhaid i ni allu sicrhau bod y

have to be able to ensure that the prescribing budgets are used for advancement and not as a consequence of not managing value for money really well.

[28] **Dafydd Wigley:** Indeed. Janet?

[29] **Janet Davies:** Could I first of all get a definition clear in my mind? We talk about community pharmacists. By 'community pharmacists' do you include the supermarket pharmacies or are you thinking purely of the small individual pharmacy shops?

**Ms Poulter:** Generally, you regard community pharmacists as pharmacists who work in the community and who dispense GP prescriptions, so that would include supermarkets. All pharmacists have the same basic qualification, they are registered with the Royal Pharmaceutical Society, and will provide pharmaceutical services to the same standard.

[30] **Janet Davies:** Thank you for that, because I think that most of us have had letters concerning issues relating to that. I just wanted to clarify it in my own mind before I went any further. I turn to paragraph 4.7, which describes pharmacists' concerns that moving from a reimbursement system could threaten the viability of their services. What, Ms Lloyd, is your assessment of the concerns of community pharmacists regarding impaired services as a result of changes in procurement?

**Ms Lloyd:** I will ask Carolyn to answer that, if I may, because she understands the intricacies of the discounts and the profits margins and so on that are run by the community pharmacists.

cyllidebau rhagnodi yn cael eu defnyddio er cynnydd ac nid o ganlyniad i beidio â rheoli gwerth am arian yn dda iawn.

[28] **Dafydd Wigley:** Yn wir. Janet?

[29] **Janet Davies:** A allaf yn gyntaf gael diffiniad yn glir yn fy meddwl? Siaradwn am fferyllwyr cymuned. Wrth sôn am 'fferyllwyr cymuned' a ydych yn cynnwys y fferyllfeydd mewn archfarchnadoedd neu a ydych yn cyfeirio at siopau fferyllfa unigol bach yn unig?

**Ms Poulter:** Yn gyffredinol, yr ydych yn ystyried fferyllwyr cymuned fel fferyllwyr sy'n gweithio yn y gymuned ac sy'n dosbarthu presgripsiynau meddygon teulu, felly byddai hynny'n cynnwys archfarchnadoedd. Mae gan bob fferylllydd yr un cymwysterau sylfaenol, maent wedi eu cofrestru gyda'r Gymdeithas Fferyllol Frenhinol, a byddant yn darparu gwasanaethau fferyllol i'r un safon.

[30] **Janet Davies:** Diolch am hynny, oherwydd credaf fod y mwyafrif ohonom wedi cael llythyrau am faterion yn gysylltiedig â hynny. Yr oeddwn am ei wneud yn glir yn fy meddwl fy hun cyn i mi fynd dim pellach. Trof at baragraff 4.7, sy'n disgrifio pryderon fferyllwyr y gallai symud o system ad-dalu fygwth dichonadwyedd eu gwasanaethau. Beth, Ms Lloyd, yw eich asesiad o bryderon fferyllwyr cymuned ynglyn â gwasanaethau diffygiol o ganlyniad i newidiadau mewn caffael?

**Ms Lloyd:** Gofynnaf i Carolyn ateb hynny, os caf fi, oherwydd mae hi'n deall cymhlethdodau'r gostyngiadau a'r meintiau elw ac ati sy'n cael eu cynnal gan y fferyllwyr cymuned.

**Ms Poulter:** As you alluded to, this report has similar connotations to the Office of Fair Trading report, 'The Control of Entry Regulations and Retail Pharmacy Services in the UK', in that changes could affect pharmacists' profit margins. We do not have the information as to the viability of certain pharmacies, but, certainly, some pharmacies, perhaps in rural areas, will have smaller profit margins than others. So, really, as Ms Lloyd said earlier, the point to note is that we assess the risks of making any changes to procurement. We will assess them very carefully, and work with stakeholders when working up pilot schemes.

[31] **Janet Davies:** Thank you. I think that my last question has been answered already to quite an extent, but you may wish to clarify it a bit further. There is the problem of the risk of centralised services impairing pharmacy services. You mentioned at one point having too many eggs in one basket. Is there anything that you would like to say to further that point?

**Ms Lloyd:** Well, I think that I would just like to reiterate that, in making any change of this nature, the pilot schemes must evaluate the risks really effectively. The last thing that anybody wishes to do is to destabilise a whole system, which will stop people being able to access the drug regimes that are required to keep them well and healthy. There is also the whole issue of dispensing GPs, particularly in rural areas, and the community pharmacists, particularly in rural areas, or where the communities rely very heavily on them. We must ensure that we weigh those risks very carefully indeed before we make any wholesale change, because it is really important that we maintain these services for people in these communities.

**Ms Poulter:** Fel y crybwyllasoch, mae gan yr adroddiad hwn oblygiadau tebyg i adroddiad y Swyddfa Masnachu Teg, 'The Control of Entry Regulations and Retail Pharmacy Services in the UK', i'r perwyl y gallai newidiadau effeithio ar feintiau elw fferyllwyr. Nid oes gennym y wybodaeth ynglyn â dichonadwyedd fferyllfeydd penodol, ond, yn sicr, bydd gan rai fferyllfeydd, efallai mewn ardaloedd gwledig, feintiau elw llai nag eraill. Felly, mewn gwirionedd, fel y dywedodd Ms Lloyd yn gynharach, y pwynt i'w nodi yw ein bod yn asesu'r risgiau sy'n gysylltiedig â gwneud unrhyw newidiadau i gaffael. Byddwn yn eu hasesu'n ofalus iawn, ac yn gweithio gyda rhanddeiliaid tra'n gwella cynlluniau peilot.

[31] **Janet Davies:** Diolch. Credaf fod fy nghwestiwn olaf eisoes wedi cael ei ateb i raddau helaeth, ond efallai yr hoffech ei egluro ychydig ymhellach. Mae'r broblem o'r risg y gallai gwasanaethau wedi eu canoli amharu ar wasanaethau fferyllol. Soniasoch ar un adeg am gael gormod o wyau yn yr un fasedg. A oes rhywbeth yr hoffech ei ddweud i ymhelaethu ar y pwynt hwnnw?

**Ms Lloyd:** Wel, credaf fy mod ond am ailadrodd, o wneud unrhyw newid o'r math hwn, bod yn rhaid i'r cynlluniau peilot werthuso'r risgiau yn effeithiol iawn. Y peth diwethaf mae unrhyw un am ei wneud yw dadsefydlogi'r system gyfan, a fydd yn rhwystro pobl rhag gallu cael mynediad i'r cyffuriau angenrheidiol i'w cadw'n fyw ac yn iach. Mae hefyd y mater o feddygon teulu yn dosbarthu, yn enwedig mewn ardaloedd gwledig, a'r fferyllwyr cymuned, yn enwedig mewn ardaloedd gwledig, neu lle mae'r cymunedau'n dibynnu'n drwm iawn arnynt. Rhaid i ni sicrhau ein bod yn pwysu a mesur y risgiau hynny yn ofalus iawn yn wir cyn i ni wneud unrhyw newid mawr, oherwydd mae'n bwysig iawn ein bod yn cynnal y gwasanaethau

[32] **Dafydd Wigley:** Have you finished, Janet?

[33] **Janet Davies:** I was just going to say that I am certainly very well aware that, quite often, it seems as though the service is quite strained on the ground when you have to actually wait for the drugs until the afternoon or the following day. Therefore, I think that it is something that we must be very aware of.

[34] **Dafydd Wigley:** It is a balance, is it not? Alison, do you want to come in on this?

[35] **Alison Halford:** Yes, on a very quick point. First of all, I think that it is very useful that Janet has asked for a definition of community pharmacists. Surely, it covers and embraces everybody. What is a non-community pharmacist, may I ask?

**Ms Lloyd:** A hospital one.

[36] **Alison Halford:** Oh, it is a hospital one. Community to me means small chemists in rural areas and things like that. However, I am very pleased that you indicated in what you have just said that you are supporting what I consider to be a community pharmacist, which is possibly not a supermarket. My particular area depends on small pharmacists in little towns and villages and so on, so what you said was very comforting.

[37] **Dafydd Wigley:** Before we move on to the GP aspect, which I think that Alun will take on, may I just ask whether you believe there is any scope for the essential small pharmacy scheme coming in as a safety net if there were some perceived loss of income from changes arising from this study?

hyn ar gyfer pobl yn y cymunedau hyn.

[32] **Dafydd Wigley:** A ydych wedi gorffen, Janet?

[33] **Janet Davies:** Yr oeddwn ar fin dweud fy mod yn sicr yn ymwybodol iawn, yn aml iawn, ei bod hi'n ymddangos bod y gwasanaeth dan dipyn o straen ar lawr gwlad pan fo'n rhaid i chi aros am y cyffuriau tan y prynhawn neu drannoeth. Felly, credaf ei fod yn rhywbeth y mae'n rhaid i ni fod yn ymwybodol iawn ohono.

[34] **Dafydd Wigley:** Onid cydbwysedd ydyw? Alison, a ydych am gyfrannu at hyn?

[35] **Alison Halford:** Ydw, ar bwynt cyflym iawn. Yn gyntaf oll, credaf ei bod yn ddefnyddiol iawn bod Janet wedi gofyn am ddiffiniad o fferyllwyr cymuned. Yn ddiau, y mae'n cynnwys ac yn cwmpasu pawb. A gaf fi ofyn beth yw fferyllydd nad yw'n fferyllydd cymuned?

**Ms Lloyd:** Fferyllydd ysbyty.

[36] **Alison Halford:** O, fferyllydd ysbyty ydyw. Mae cymuned i mi yn golygu fferyllfeydd bach mewn ardaloedd gwledig a phethau felly. Fodd bynnag, yr wyf yn falch i chi nodi yn yr hyn yr ydych newydd ei ddweud eich bod yn cefnogi yr hyn yr ystyriaf yn fferyllydd cymuned, nad yw'n archfarchnad o bosibl. Mae fy ardal benodol i yn dibynnu ar fferyllfeydd bach mewn pentrefi a threfi bach ac ati, felly yr oedd yr hyn a ddywedasoeh yn gysur mawr.

[37] **Dafydd Wigley:** Cyn i ni symud ymlaen at fater y meddyg teulu, a fydd dan ofal Alun yr wyf yn credu, a gaf fi ofyn a ydych yn credu bod unrhyw bosibilrwydd y gallai'r cynllun fferyllfa fach hanfodol fod yn rhwyd achub pe bai rhywfaint o golled incwm cydnabyddedig yn sgîl newidiadau yn deillio o'r astudiaeth hon?

**Ms Lloyd:** I think that that is something that we would have to consider very carefully. There are issues around the terms and conditions on which pharmacists are employed at the moment and the independent contractor nature of their status. I think that we just have to ensure that we take that into consideration—

[38] **Dafydd Wigley:** Am I not right in saying that we in the Assembly have powers to vary that scheme? If that is the case, that might be one way forward. Is that something that you would consider?

**Ms Lloyd:** Yes.

[39] **Alun Cairns:** Ms Lloyd, I want to refer to paragraph 4.9, which sets out the concerns of dispensing GPs that moving from a reimbursement system could act as a disincentive to GPs taking up practice in rural areas. What is your assessment of that, and would you also couple that to letting us know whether there is a shortage of GPs in rural areas?

**Ms Lloyd:** As you know, we have a shortage of GPs right across Wales, particularly in some of the Valleys communities and some of the rural areas. That is why a considerable amount of effort is going into increasing training and inducing people to come to Wales to take up practices. In terms of the dispensing general practitioners, these are largely prevalent in the rural areas and their terms and conditions are being considered slightly separately from the GP contract; they are not included yet as a particular issue in that GP contract that is being negotiated at the moment. They are being regarded as a separate case, which would be an addition to the GP contract, because it is recognised that there is vulnerability in making any radical changes around their status and our ability to be able to maintain those people within the rural

**Ms Lloyd:** Credaf fod hynny yn rhywbeth y byddai'n rhaid i ni ei ystyried yn ofalus iawn. Mae materion ynghylch yr amodau a'r telerau sy'n sail i gyflogi fferyllwyr ar hyn o bryd a natur contractwr annibynnol eu statws. Credaf fod angen i ni ond sicrhau ein bod yn ystyried hynny—

[38] **Dafydd Wigley:** Onid ydwyf yn gywir i ddweud bod gennym ni yn y Cynulliad bwerau i amrywio'r cynllun hwnnw? Os mai dyna'r achos, efallai fod hynny'n un ffordd ymlaen. A yw hynny'n rhywbeth y byddech yn ei ystyried?

**Ms Lloyd:** Ydyw.

[39] **Alun Cairns:** Ms Lloyd, yr wyf am gyfeirio at baragraff 4.9, sy'n nodi pryderon meddygon teulu sy'n dosbarthu y gallai symud i ffwrdd o system ad-dalu fod yn rhwystr i feddygon teulu rhag cymryd practis mewn ardaloedd gwledig. Beth yw'ch asesiad o hynny, ac a fyddech hefyd yn cyplysu hynny â dweud wrthym a oes prinder meddygon teulu mewn ardaloedd gwledig?

**Ms Lloyd:** Fel y gwyddoch, mae gennym brinder meddygon teulu ledled Cymru, yn enwedig yn rhai o gymunedau'r Cymoedd a rhai o'r ardaloedd gwledig. Dyna pam mae cryn dipyn o ymdrech yn cael ei roi i'r gwaith o gynyddu hyfforddiant ac annog pobl i ddod i Gymru i gymryd practis. O ran meddygon teulu sy'n dosbarthu, mae'r rhain, i raddau helaeth, yn gyffredin yn yr ardaloedd gwledig ac mae eu hamodau a'u telerau yn cael eu hystyried ychydig ar wahân i'r contract meddyg teulu; nid ydynt wedi eu cynnwys hyd yn hyn fel mater penodol yn y contract meddyg teulu hwnnw sy'n cael ei negodi ar hyn o bryd. Maent yn cael eu hystyried fel achos ar wahân, a fyddai'n ychwanegol i'r contract meddyg teulu, oherwydd cydnabyddir bod gwendid o wneud unrhyw newidiadau radical i'w statws a'n gallu ni i

communities. So, it is very important.

[40] **Alun Cairns:** So, building on that—and in the response to Dafydd Wigley a little earlier where the essential small pharmacy scheme was highlighted, you recognised that there might be a need to look at that, certainly because of the difficulties for what we would usually call community pharmacies, particularly in rural areas—can you reassure the Committee by saying that a similar sort of scheme might well be explored in relation to the dispensing GPs because of the vulnerability of the rural areas particularly?

**Ms Lloyd:** The dispensing GPs are recognised as a special case within the GP negotiations that the NHS Confederation is undertaking on behalf of the four Governments at the moment. We await to see the sort of responses that we get between the general practitioner committee and confederation.

[41] **Alun Cairns:** I am looking for a reassurance that, if a scheme might be considered for the community pharmacies in rural areas, the dispensing GPs will not be forgotten.

**Ms Lloyd:** They certainly will not be forgotten because we have already highlighted to the confederation and the GPC that this is an issue for us.

gynnal y bobl hynny yn y cymunedau gwledig. Felly, mae'n bwysig iawn.

[40] **Alun Cairns:** Felly, gan adeiladu ar hynny—ac mewn ymateb i Dafydd Wigley ychydig yn gynharach lle amlygwyd y cynllun fferyllfa fach hanfodol, bu i chi gydnabod efallai fod angen edrych ar hwnnw, yn sicr oherwydd yr anawsterau ar gyfer yr hyn y byddem fel arfer yn eu galw'n fferyllfeydd cymuned, yn enwedig mewn ardaloedd gwledig—a allwch chi sicrhau'r Pwyllgor drwy ddweud y gellid ystyried cynllun tebyg ar gyfer meddygon teulu sy'n dosbarthu, oherwydd sefyllfa wan yr ardaloedd gwledig yn enwedig?

**Ms Lloyd:** Mae'r meddygon teulu sy'n dosbarthu yn cael eu cydnabod fel achos arbennig yn y negodiadau meddygon teulu y mae'r Conffederasiwn GIG yn eu cynnal ar ran y bedair Llywodraeth ar hyn o bryd. Yr ydym yn aros i weld pa fath o ymatebion a gawn rhwng y pwyllgor meddygon teulu a'r conffederasiwn.

[41] **Alun Cairns:** Yr wyf yn chwilio am sicrwydd na fydd y meddygon teulu sy'n dosbarthu yn cael eu hanghofio pe bai cynllun yn cael ei ystyried o bosibl ar gyfer y fferyllfeydd cymuned mewn ardaloedd gwledig.

**Ms Lloyd:** Yn bendant ni fyddant yn cael eu hanghofio oherwydd yr ydym eisoes wedi amlygu i'r conffederasiwn a'r pwyllgor meddygon teulu bod hwn yn fater i ni.

[42] **Alun Cairns:** Paragraph 4.13 sets out pharmaceutical industry concerns. Naturally, it would have concerns because, if the NHS wants to make some cost savings, they must come from somewhere. I suspect that the industry is likely to bear the brunt of that cost saving. What is your view on the potential impact on the pharmaceutical industry of the changes in procurement?

**Ms Lloyd:** I cannot tell you what they would be at the moment, obviously. Their profit margins might reduce. The Auditor General has helpfully outlined what the problems could be. Particularly for us, a reduction in research and development would have to be weighed very carefully because that is very important to the service as a whole. Whether or not, if Wales went on its own, they would regard it as having much effect at all on their profit margin is something that we would have to consider very carefully. However, again, we would have to take the advice in this report as part of the risk in looking at changing any way in which we procure.

[43] **Alun Cairns:** Thank you. Cadeirydd, I have one final comment, if that is okay. You mentioned the impact of research and development, but we cannot forget that research and development is a global market and I would imagine that the procurement of pharmaceuticals in Wales is a very small part of that.

**Ms Lloyd:** Yes, I note that.

[42] **Alun Cairns:** Y mae paragraff 4.13 yn nodi pryderon y diwydiant fferyllol. Yn naturiol, byddai ganddo bryderon oherwydd, os yw'r GIG am wneud rhai arbedion cost, rhaid iddynt ddod o rywle. Yr wyf yn amau mai'r diwydiant sy'n debygol o ddwyn baich yr arbed cost hwnnw. Beth yw'ch barn ar effaith bosibl y newidiadau mewn caffael ar y diwydiant fferyllol?

**Ms Lloyd:** Ni allaf ddweud wrthy ch beth fyddent ar hyn o bryd, mae'n amlwg. Gallai eu meintiau elw leihau. Mae'r Archwilydd Cyffredinol wedi amlinellu'n ddefnyddiol y problemau a allai godi. Yn enwedig ar ein cyfer ni, byddai'n rhaid pwysu a mesur lleihad mewn ymchwil a datblygu yn ofalus iawn oherwydd mae hynny'n bwysig iawn i'r gwasanaeth yn ei gyfanrwydd. Pe bai Cymru'n mynd ar ei phen ei hun, mae a fyddent yn ystyried ei fod yn cael llawer o effaith ar eu maint elw ai peidio yn rhywbeth y byddai'n rhaid i ni ei ystyried yn ofalus iawn. Fodd bynnag, unwaith eto, byddai'n rhaid i ni gymryd y cyngor yn yr adroddiad hwn fel rhan o'r risg o edrych ar newid unrhyw fodd yr ydym yn caffael.

[43] **Alun Cairns:** Diolch. Gadeirydd, mae gennyf un sylw olaf, os yw hynny'n iawn. Soniasoch am effaith ymchwil a datblygu, ond ni allwn anghofio bod ymchwil a datblygu yn farchnad fyd-eang a byddwn yn dychmygu bod caffael meddyginiaethau yng Nghymru yn rhan fach iawn ohoni.

**Ms Lloyd:** Ydyw, yr wyf yn nodi hynny.

[44] **Dafydd Wigley:** Yes, indeed. In terms of profitability, I think that a return on capital of 21 per cent is what is regarded as a norm, and it is only when a company exceeds its target profit by 40 per cent that any question of repaying comes in. So, there is a reasonable level of profitability there, is there not?

**Ms Lloyd:** Yes.

[45] **Dafydd Wigley:** In that context, if we were to go down this road in Wales, clearly the implications are not too serious, as has been suggested, in terms of research and development, unless our changes in Wales lead to similar changes elsewhere. May I ask you, are you coming under any pressure centrally, from London, to avoid going down a road such as this because of the knock-on effect?

**Ms Lloyd:** No, not at the moment. There is the Department of Health's review into generics going on at the moment, of which we are a part. This is not an issue on which I, personally, or any of my staff have been put under pressure. This is a genuine report from the Auditor General, who scrutinises both of us, and we are required to take forward the suggestions that he has made, bearing in mind the risks, which he has rightly pointed out, which might surround it. I am sure that our English colleagues would like to see how we get on about it. However, there is no pressure.

[46] **Dafydd Wigley:** Yes, indeed. That is very positive.

[47] **Eleanor Burnham:** May I come in on this?

[48] **Dafydd Wigley:** Very briefly, Eleanor.

[44] **Dafydd Wigley:** Ydyw, yn wir. O ran proffidioldeb, credaf mai elw ar gyfalaf o 21 y cant yw'r hyn a ystyrir yn arferol, a dim ond pan fo cwmni yn mynd y tu hwnt i'w elw darged gan 40 y cant y mae unrhyw gwestiwn o ad-dalu'n codi. Felly, mae lefel resymol o broffidioldeb yno, onid oes?

**Ms Lloyd:** Oes.

[45] **Dafydd Wigley:** Yn y cyd-destun hwnnw, os byddem yn dilyn y ffordd hon yng Nghymru, mae'n amlwg nad yw'r goblygiadau yn rhy ddifrifol, fel sydd wedi ei awgrymu, o ran ymchwil a datblygu, oni bai fod ein newidiadau yng Nghymru yn arwain at newidiadau tebyg yn rhywle arall. A gaf fi ofyn i chi, a ydych dan unrhyw bwysau yn ganolog, o Lundain, i osgoi dilyn trywydd tebyg oherwydd y sgîl-effaith?

**Ms Lloyd:** Na, ddim ar hyn o bryd. Mae adolygiad yr Adran Iechyd ar feddyginiaethau generig yn cael ei gynnal ar hyn o bryd, ac yr ydym yn rhan ohono. Nid yw hwn yn fater yr wyf i, yn bersonol, nac unrhyw aelod o fy staff wedi cael ein rhoi o dan bwysau yn ei gylch. Mae hwn yn adroddiad dilys gan yr Archwilydd Cyffredinol, sy'n archwilio'r ddau ohonom, ac mae'n ofynnol i ni ddatblygu'r awgrymiadau mae ef wedi eu gwneud, gan gofio'r risgiau, y mae ef yn gywir wedi eu nodi, a allai fod yn gysylltiedig â hwy. Yr wyf yn siwr y byddai ein cydweithwyr yn Lloegr yn hoffi gweld sut gynnydd y gwnawn yn ei gylch. Fodd bynnag, nid oes pwysau.

[46] **Dafydd Wigley:** Byddent, yn wir. Mae hynny'n gadarnhaol iawn.

[47] **Eleanor Burnham:** A gaf fi ddod i mewn ar hyn?

[48] **Dafydd Wigley:** Yn fyr iawn, Eleanor.

[49] **Eleanor Burnham:** Is there any merit now in looking at reducing these huge prescriptive costs by perhaps piloting complementary medicine in the areas where they might be efficacious?

[50] **Dafydd Wigley:** Frankly, I think that that goes beyond this report.

[51] **Jocelyn Davies:** I think that the Member should declare an interest, because she has been an aromatherapist.

[52] **Eleanor Burnham:** Yes, sorry. I am a qualified aromatherapist.

[53] **Dafydd Wigley:** We will take that question as one that stands as a consideration. Janice?

[54] **Janice Gregory:** Thank you, Chair. Paragraph 4.19 says that Wales is slightly behind England and Scotland in terms of generic prescribing. Why is this, Ann?

**Ms Lloyd:** May Carolyn answer this? She has done some of the research into it.

[55] **Janice Gregory:** She certainly can.

**Ms Poulter:** Well, I am not sure that we do fully understand why. There are actually variations within Wales as to the generic prescribing rates. I believe that some parts of Wales are at a rate of about 62 per cent while others are at 76 per cent. I think that the important thing to remember is that we have made considerable progress in this area, increasing from 40 per cent to almost 70 per cent in the last 10 years. We do have a significant number of dispensing doctors in Wales so that could be an issue, but I have not examined the evidence for that.

[49] **Eleanor Burnham:** A oes unrhyw werth yn awr i edrych ar leihau'r costau rhagnodi enfawr hyn drwy efallai roi prawf ar feddygaeth gyflenwol yn y meysydd lle gallai fod yn effeithiol?

[50] **Dafydd Wigley:** A bod yn onest, credaf fod hynny'n mynd y tu hwnt i'r adroddiad hwn.

[51] **Jocelyn Davies:** Credaf y dylai'r Aelod ddatgan buddiant, oherwydd yr oedd hi'n aromatherapydd.

[52] **Eleanor Burnham:** Dylwn, mae'n ddrwg gennyf. Yr wyf yn aromatherapydd cymwys.

[53] **Dafydd Wigley:** Cymerwn y cwestiwn hwnnw fel mater i'w ystyried. Janice?

[54] **Janice Gregory:** Diolch, Gadeirydd. Dywed paragraff 4.19 fod Cymru ychydig ar ei hôl hi o'i chymharu â Lloegr a'r Alban o ran rhagnodi generig. Pam felly, Ann?

**Ms Lloyd:** A all Carolyn ateb hwn? Mae hi wedi gwneud peth o'r ymchwil iddo.

[55] **Janice Gregory:** Wrth gwrs y gall.

**Ms Poulter:** Wel, nid wyf yn siwr ein bod yn deall pam yn llawn. Mewn gwirionedd, mae'r cyfraddau rhagnodi generig yn amrywio o fewn Cymru. Credaf fod gan rai rhannau o Gymru gyfradd o tua 62 y cant tra bod gan eraill gyfraddau o 76 y cant. Credaf mai'r peth pwysig i'w gofio yw ein bod wedi gwneud cynnydd sylweddol yn y maes hwn, yn cynyddu o 40 y cant i bron i 70 y cant yn y 10 mlynedd diwethaf. Mae gennym nifer sylweddol o feddygon sy'n dosbarthu yng Nghymru felly gallai hynny fod yn berthnasol, ond nid wyf wedi astudio'r dystiolaeth dros hynny.

The all-Wales medicines strategy group will be monitoring this—it has developed a set of high-level prescribing indicators, and it has actually started looking at generic prescribing rates across Wales. It will start looking at the differences within Wales. It is also to benchmark—it is going to start benchmarking with north-east England, which has a similar population to Wales, and look at why there may be differences between, say, England and Wales and look at solutions.

[56] **Janice Gregory:** You have partly answered my supplementary question, which was could Wales overtake England, but you obviously have to find out why it is that we are behind England and Scotland before you can start talking about overtaking them.

[57] **Dafydd Wigley:** Before you leave that, am I right in saying that the northern region has in fact some 68 or 69 per cent of generic prescribing compared to 60 per cent in Wales? There is a 9 per cent, almost a 10 per cent, difference.

**Ms Poulter:** I thought that the Welsh level was higher than that, actually.

[58] **Dafydd Wigley:** They are the Audit Commission figures that have been presented to us. It underlines the point that you are making and I think that it adds to the validity of seeing how we can close the gap.

**Ms Poulter:** Absolutely.

[59] **Dafydd Wigley:** Sorry, Janice.

Bydd grwp strategaeth meddyginiaethau Cymru gyfan yn monitro hyn—mae wedi datblygu cyfres o ddangosyddion rhagnodi lefel-uchel, ac mewn gwirionedd mae wedi dechrau edrych ar gyfraddau rhagnodi generig ledled Cymru. Bydd yn dechrau edrych ar y gwahaniaethau o fewn Cymru. Bydd hefyd yn meincnodi—mae'n mynd i ddechrau meincnodi gyda gogledd-ddwyrain Lloegr, sydd â phoblogaeth debyg i Gymru, ac edrych ar pam efallai fod gwahaniaethau rhwng, er enghraifft, Cymru a Lloegr ac ystyried atebion.

[56] **Janice Gregory:** Yr ydych wedi ateb fy nghwestiwn atodol yn rhannol, sef a allai Cymru fynd heibio i Loegr, ond mae'n amlwg bod yn rhaid i chi ganfod pam yr ydym y tu ôl i Loegr a'r Alban cyn y gallwch ddechrau sôn am fynd heibio iddynt.

[57] **Dafydd Wigley:** Cyn i chi adael hynny, a ydwyf yn iawn i ddweud bod gan ranbarth gogledd Lloegr mewn gwirionedd gyfradd ragnodi generig o ryw 68 neu 69 y cant o gymharu â 60 y cant yng Nghymru? Mae hynny'n wahaniaeth o 9 y cant, bron i 10 y cant.

**Ms Poulter:** Yr oeddwn yn meddwl fod lefel Cymru yn uwch na hynny, a dweud y gwir.

[58] **Dafydd Wigley:** Dyna ffigurau'r Comisiwn Archwilio sydd wedi eu cyflwyno i ni. Mae'n tanlinellu'r pwynt yr ydych yn ei wneud a chredaf ei fod yn ychwanegu at ddilysrwydd gweld sut gallwn gau'r bwlch.

**Ms Poulter:** Yn bendant.

[59] **Dafydd Wigley:** Mae'n ddrwg gennyf, Janice.

[60] **Janice Gregory:** Obviously, the work is currently being undertaken, so I do not think that we can expand any further on that until the conclusions as to why are determined.

[61] **Dafydd Wigley:** Alun, did you want to come in on that before Janice moves on to the next question?

[62] **Alun Cairns:** Yes. I am concerned about an inconsistency that I have picked up from Ms Lloyd, if that is okay, Cadeirydd. Ms Lloyd, you mentioned earlier that there were some great developments at local levels in terms of negotiating—when we were pursuing questions about where the expertise lies within the local health boards to gain more generic prescriptions from GPs. If there is progress, I think that that is very good, and we need to welcome it. However, when we look at the figures for England and Wales—75 per cent in England and Scotland compared to 79 per cent in Wales—I hope that we are not being complacent.

**Ms Lloyd:** No, we are not, and I do not think that I am being inconsistent either. There has been steady progress, and—

[63] **Alun Cairns:** But we are still not at the English level, though?

**Ms Lloyd:** We are still not at the English level, but we are getting near to the English level, and some of the areas are at that comparable level.

[64] **Dafydd Wigley:** I think that the progress to which you refer probably refers to the difference between the figures that Carolyn had and mine. My figures were for 1998-99. There has been progress since then. So it is a matter of maintaining that.

[60] **Janice Gregory:** Yn amlwg, mae'r gwaith yn cael ei gynnal ar hyn o bryd, felly ni chredaf y gallwn ehangu ymhellach ar hynny nes pennu'r casgliadau ynglyn â pham y digwydd hynny.

[61] **Dafydd Wigley:** Alun, a oeddech am ddod i mewn ar hynny cyn i Janice symud ymlaen at y cwestiwn nesaf?

[62] **Alun Cairns:** Oeddwn. Yr wyf yn pryderu am anghysondeb gan Ms Lloyd yr wyf wedi sylwi arno, os yw hynny'n iawn, Gadeirydd. Ms Lloyd, soniasoch yn gynharach fod rhai datblygiadau gwych yn lleol o ran negodi—pan oeddem yn holi cwestiynau ynglyn â ble mae'r arbenigedd yn y byrddau iechyd lleol i sicrhau mwy o bresgripsiynau generig gan feddygon teulu. Os oes cynnydd, credaf fod hynny'n dda iawn, a dylem ei groesawu. Fodd bynnag, pan edrychwn ar y ffigurau ar gyfer Cymru a Lloegr—75 y cant yn Lloegr a'r Alban o gymharu â 79 y cant yng Nghymru—yr wyf yn gobeithio nad ydym yn bod yn hunanfodlon.

**Ms Lloyd:** Na, nac ydym, ac ni chredaf fy mod yn bod yn anghyson ychwaith. Bu cynnydd graddol, ac—

[63] **Alun Cairns:** Ond, er hynny, nid ydym ar lefel Lloegr o hyd?

**Ms Lloyd:** Nid ydym ar yr un lefel â Lloegr o hyd ond yr ydym yn agosáu at lefel Lloegr, ac mae rhai o'r ardaloedd ar y lefel gyffelyb honno.

[64] **Dafydd Wigley:** Credaf fod y cynnydd y cyfeiriwch ato yn ôl pob tebyg yn cyfeirio at y gwahaniaeth rhwng y ffigurau a oedd gan Caroline a'n rhai i. Yr oedd fy ffigurau i ar gyfer 1998-99. Bu cynnydd ers hynny. Felly mater o gynnal hwnnw ydyw.

[65] **Janice Gregory:** Paragraph 4.25—we are leaping around the paragraphs now—recommends that

‘the Assembly’s NHS Directorate should review the continued justification for GPs prescribing medicine that the *British National Formulary* indicates are of limited clinical value.’

What justification is there for a GP to prescribe medicines that are of limited clinical value? I hope that I am on the right track here, but, surely, when we ask patients to accept generic medicines, we would hasten to find out whether they were of limited clinical value, when it is quite difficult to get patients to accept cheaper alternatives?

**Ms Lloyd:** Could I deal with that latter point first, please? Just to clarify, generic drugs are not equivalent to drugs of limited clinical value. They are not the same thing at all. A generic is just a cheaper substitution—

[66] **Janice Gregory:** Panadol for paracetamol?

**Ms Lloyd:** Something like that, yes.

It will allow—as long as it is therapeutically the same—when drugs come off licence, that they can be manufactured by a whole variety of people. It is the licence that triggers whether something is generic or not. There are an awful lot of drugs for which there is no generic substitution either because, therapeutically, they are not equivalent, or because they are still on licence. Sorry, I meant to say patent, not licence.

[65] **Janice Gregory:** Mae paragraff 4.25—yr ydym yn neidio o amgylch y paragraffau bellach—yn argymhell

‘y dylai Cyfarwyddiaeth GIG y Cynulliad adolygu a ellir parhau i gyfiawnhau bod meddygon y teulu yn rhagnodi meddyginiaethau sydd o werth clinigol cyfyngedig yn ôl *British National Formulary*.’

Pa gyfiawnhad sydd dros feddyg teulu yn rhagnodi meddyginiaethau sydd â gwerth clinigol cyfyngedig? Gobeithio fy mod ar y trywydd cywir yn y fan hon, ond, nid oes bosibl, pan ofynnwn i gleifion dderbyn meddyginiaethau generig, y byddem yn prysuro i ganfod a oeddynt â gwerth clinigol cyfyngedig, pan fo’n eithaf anodd cael cleifion i dderbyn amnewidiadau rhatach?

**Ms Lloyd:** A allaf ddelio â’r pwynt diwethaf yn gyntaf, os gwelwch yn dda? I egluro, nid yw cyffuriau generig yn gyfwerth â chyffuriau sydd â gwerth clinigol cyfyngedig. Nid ydynt yr un peth o gwbl. Amnewidiad rhatach yn unig yw meddyginiaeth enerig—

[66] **Janice Gregory:** Panadol ar gyfer paracetamol?

**Ms Lloyd:** Rhywbeth felly, ie.

Bydd yn caniatáu—cyn belled â’i fod yr un fath yn therapiwtig—pan fo trwydded cyffuriau yn dod i ben, y gallant gael eu cynhyrchu gan amrywiaeth eang o bobl. Y drwydded sy’n pennu a yw rhywbeth yn enerig ai peidio. Mae llawer iawn o gyffuriau nad oes amnewidiad generig ar eu cyfer oherwydd, yn therapiwtig, nid ydynt yn gyfwerth, neu oherwydd eu bod ar drwydded o hyd. Mae’n ddrwg gennyf, yr oeddwn yn golygu dweud patent, nid trwydded.

What is the justification for prescribing something of limited benefit? Well, to be honest, I cannot justify that at all. I think that that is the sort of issue that we have to take up with our general practice colleagues. The last time that we had what was called a blacklist—I cannot remember how many years ago that was, it was about 10 or so. About 10 years ago, we had a blacklist throughout the UK on just this sort of issue. We found to our horror that, instead of people stopping prescribing, generally, against this blacklist, there were substitutions for far more expensive items. I do not think that we quite evaluated the risk of having a blacklist at that time. However, basically, if patients go to their doctors, they want good advice and they want the right clinical regime. Although some people will be convinced that a drug, any drug, will make them much better, nevertheless, that has to be a point of discussion between the GP and his or her patient, because there is no point. Although the drugs that fall into this definition are, apparently, relatively cheap, nevertheless, there has to be better discussion about what can improve the health of individuals when they go to see their primary care practitioner.

[67] **Janice Gregory:** So, in your opinion, do you think that these drugs are cost-effective? That is my supplementary question.

Beth yw'r cyfiawnhad dros ragnodi rhywbeth sydd â budd cyfyngedig? Wel, i fod yn onest, ni allaf gyfiawnhau hynny o gwbl. Credaf mai dyna'r math o fater y mae'n rhaid i ni ei drafod â'n cydweithwyr ym maes meddygaeth deuluol. Y tro diwethaf yr oedd gennym yr hyn a alwyd yn rhestr waharddedig—ni allaf gofio faint o flynyddoedd yn ôl oedd hynny, tua 10 neu rywbeth tebyg. Tua 10 mlynedd yn ôl, yr oedd gennym restr waharddedig ledled y DU ar y math hwn o fater yn union. Yn hytrach na phobl yn rhoi'r gorau i ragnodi, yn gyffredinol, yn unol â'r rhestr waharddedig hon, bu i ni ganfod, er mawr arswyd i ni, amnewidiadau am eitemau llawer drutach. Ni chredaf i ni werthuso'n iawn y risg o gael rhestr waharddedig bryd hynny. Fodd bynnag, yn y bôn, os yw cleifion yn mynd at eu meddygon, maent eisiau cyngor da ac maent eisiau'r drefn glinigol gywir. Er y bydd rhai pobl wedi'u hargyhoeddi y bydd cyffur, unrhyw gyffur, yn gwneud iddynt deimlo yn llawer gwell, serch hynny, rhaid i hynny fod yn destun trafod rhwng y meddyg teulu a'i glaf neu a'i chlaf, oherwydd nad oes diben. Er bod y cyffuriau sy'n perthyn i'r diffiniad hwn, mae'n debyg, yn gymharol rhad, serch hynny, rhaid bod trafodaeth well am beth all wella iechyd unigolion pan fônt yn mynd i weld eu hymarferydd gofal sylfaenol.

[67] **Janice Gregory:** Felly, yn eich barn chi, a gredwch fod y cyffuriau hyn yn gost effeithiol? Dyna fy nghwestiwn atodol.

**Ms Lloyd:** I do not know whether I can answer that question. I think that it might be argued that, if patients remain happy and feel that they are getting better, it is a matter of clinical judgment for their general practitioner. If it means that they have just a small clinical improvement, and it is the clinical judgment of the GP that it is a good investment for the person concerned, then that is down to his or her clinical judgment. That does not mean that the clinical judgment cannot be tested to ensure that it is soundly based.

[68] **Jocelyn Davies:** The report points to some initiatives aimed at improving prescribing behaviour. Perhaps you would like to tell us about the progress in that area and how you are evaluating it.

**Ms Lloyd:** I would like Carolyn to answer some of this because she is doing some of the evaluation. What we have to ensure is that prescribing is safe and effective—that is the beginning and end of the issue. The Welsh Medicines Resource Centre is, as you know, a source of independent advice on prescribing, and it is now very well used indeed. I think that we still need to get out to the GPs in their surgeries what help is available from that source to help to improve their prescribing, particularly as I am sure that the health authorities previously, and now the local health boards, will have been impressing upon the independent contractors the costs of prescribing and the fact that, if the prescribing budget is overspent, then that will come out of another element of patient care.

**Ms Lloyd:** Ni wn a allaf ateb y cwestiwn hwnnw. Credaf y gellid dadlau, os yw cleifion yn parhau i fod yn hapus ac yn teimlo eu bod yn gwella, ei fod yn fater o farn glinigol eu meddyg teulu. Os yw'n golygu eu bod yn cael gwelliant clinigol bach yn unig, a bod y meddyg teulu o'r farn glinigol ei fod yn fuddsoddiad da ar gyfer yr unigolyn dan sylw, yna ei farn glinigol ef neu hi sy'n cyfrif. Nid yw hynny'n golygu na ellir profi barn glinigol i sicrhau bod iddi sail gadarn.

[68] **Jocelyn Davies:** Mae'r adroddiad yn cyfeirio at rai mentrau sydd â'r nod o wella ymddygiad rhagnodi. Efallai yr hoffech ddweud wrthym am y cynnydd yn y maes hwnnw a sut yr ydych yn ei werthuso.

**Ms Lloyd:** Hoffwn i Carolyn ateb peth o hyn oherwydd ei bod yn gwneud rhywfaint o'r gwerthuso. Yr hyn y mae'n rhaid i ni ei sicrhau yw bod rhagnodi yn ddiogel ac yn effeithiol—dyna swm a sylwedd y mater. Mae Canolfan Adnoddau Moddion Cymru, fel y gwyddoch, yn ffynhonnell o gyngor annibynnol ar ragnodi, ac mae bellach yn cael llawer iawn o ddefnydd. Credaf fod dal angen i ni gyfleu i'r meddygon teulu yn eu meddygfeydd y cymorth sydd ar gael o'r ffynhonnell honno i gynorthwyo i wella'u rhagnodi, yn enwedig gan fy mod yn siwr bod yr awdurdodau lleol yn flaenrol, a'r byrddau iechyd lleol bellach, wedi bod yn pwysleisio i'r contractwyr annibynnol gostau rhagnodi a'r ffaith, os oes gorrario ar y gyllideb ragnodi, yna y bydd hynny'n cael ei dynnu o elfen arall o ofal cleifion.

The development of local formularies is proving to be most effective. We now have to test whether or not local formularies are universally available throughout Wales. However, they have certainly made good progress, particularly in those areas where we are now seeing more salaried GPs, because there is a greater ability to start to have that dialogue.

There are prescribing incentive schemes and I would like Carolyn to discuss those and whether or not we have found that they really are going to make a difference to us. The prescribing advisers have been available through health authorities for at least 10 years. They are there to test the dispensing and the prescribing habits throughout the community and they have made considerable progress. They have also highlighted to GPs the changing drug regimes that are on the horizon so that they get a better understanding of what is about to come through. We also have a computer software system in existence that can be easily accessed by the prescribers. Would you like to talk about incentives, Carolyn?

**Ms Poulter:** Yes. Most local health groups have developed their own prescribing incentive schemes. They have been developed with the GPs. They will involve prescribing targets linked to certain prescribing indicators: for example, generic prescribing or, say, the use of drugs of limited clinical value, if you like. If the GPs meet the targets that are set within these prescribing incentive schemes, then I know that some local health groups have arrangements for the GPs to gain some of the financial savings that they have made—they will get some money back to spend on patient care. Therefore incentives such as that are in existence. The all-Wales prescribing advisory group that is soon to be set up will review all the prescribing incentive schemes that are in existence and evaluate whether they are

Mae datblygu cyffurlyfrau lleol yn profi'n effeithiol iawn. Mae'n rhaid i ni bellach brofi ai yw cyffurlyfrau lleol ar gael yn gyffredinol ledled Cymru ai peidio. Fodd bynnag, maent yn sicr wedi gwneud cynnydd da, yn enwedig yn yr ardaloedd hynny lle'r ydym bellach yn gweld mwy o feddygon teulu cyflogedig, oherwydd bod mwy o allu i gynnal y deialog hwnnw.

Mae cynlluniau cymhellion rhagnodi a byddwn yn hoffi galw ar Carolyn i drafod y rheini ac a ydym wedi canfod eu bod mewn gwirionedd yn mynd i wneud gwahaniaeth i ni ai peidio. Mae'r ymgynghorwyr rhagnodi wedi bod ar gael drwy awdurdodau iechyd am o leiaf 10 mlynedd. Maent yno i brofi'r arferion dosbarthu a rhagnodi ledled y gymuned ac maent wedi gwneud cynnydd sylweddol. Maent hefyd wedi dwyn sylw meddygon teulu at y newidiadau i'r trefniadau cyffuriau sydd ar y gorwel fel eu bod yn cael gwell dealltwriaeth o'r hyn sydd ar fin dod i'r fei. Mae gennym hefyd system meddalwedd gyfrifadurol mewn bodolaeth y gall y rhagnodwyr gael mynediad hawdd iddi. A hoffech chi siarad am gymhellion, Carolyn?

**Ms Poulter:** Hoffwn. Mae'r mwyafrif o grwpiau iechyd lleol wedi datblygu eu cynlluniau cymhellion rhagnodi eu hunain. Maent wedi eu datblygu gyda'r meddygon teulu. Byddant yn cynnwys targedau rhagnodi sy'n gysylltiedig â dangosyddion rhagnodi penodol: er enghraifft, rhagnodi generig neu, o bosibl, defnyddio cyffuriau sydd â gwerth clinigol cyfyngedig, os hoffwch chi. Os yw'r meddygon teulu yn cwrdd â'r targedau a osodir yn y cynlluniau cymhellion rhagnodi hyn, yna gwn fod gan rai grwpiau iechyd lleol drefniadau i'r meddygon teulu gael rhywfaint o'r arbedion ariannol maent wedi eu gwneud—byddant yn cael peth arian yn ôl i wario ar ofal cleifion. Felly mae cymhellion tebyg mewn bodolaeth. Bydd y grwp cynghori ar ragnodi Cymru gyfan, sydd i'w sefydlu'n fuan,

providing good value for money. In terms of the feeling on the ground, the prescribing advisers tell me that they are very well received by the GPs and that they have had a considerable impact on improving both the quality and cost-effectiveness of prescribing.

[69] **Jocelyn Davies:** It may be considerable, but is it sufficient?

**Ms Poulter:** That will be for the all-Wales prescribing advisory group to evaluate. Anything would be—

[70] **Jocelyn Davies:** What barriers are there? The potential savings are enormous and, as you say, could then be spent on initiatives other than drugs.

**Ms Poulter:** The savings are there. The ones that are highlighted in the report are significant, but when you consider them against the total drug spend they are relatively small. However, obviously, any saving is good and, as I say, the all-Wales prescribing advisory group will evaluate the effect. However, the local health groups feel that they are very good value and that they have demonstrated improvements in prescribing in both quality as well as cost-effectiveness. They are continuing those schemes, which is evidence of the fact that they must be working. We need to evaluate them more formally.

[71] **Jocelyn Davies:** No doubt we will look at that when they have been evaluated, Chair.

[72] **Dafydd Wigley:** No doubt.

yn adolygu'r holl gynlluniau cymhellion rhagnodi sy'n bodoli ac yn gwerthuso a ydynt yn cynnig gwerth da am arian. O ran y farn ar lawr gwlad, dywed y cynghorwyr rhagnodi wrthyf eu bod yn cael derbyniad da iawn gan feddygon teulu a'u bod wedi cael effaith sylweddol ar wella ansawdd rhagnodi a pha mor gost effeithiol ydyw.

[69] **Jocelyn Davies:** Efallai ei fod yn sylweddol, ond a yw'n ddigonol?

**Ms Poulter:** Bydd hynny i'w werthuso gan y grwp cynghori ar ragnodi Cymru gyfan. Byddai unrhyw beth yn—

[70] **Jocelyn Davies:** Pa rwystrau sydd? Mae'r arbedion posibl yn enfawr ac, fel y dywedwch, gellid eu gwario wedyn ar fentrau heblaw cyffuriau.

**Ms Poulter:** Mae'r arbedion yno. Mae'r rhai sydd wedi eu crybwyll yn yr adroddiad yn sylweddol, ond maent yn gymharol fach pa fo'ch yn eu hystyried yn erbyn y cyfanswm sy'n cael ei wario ar gyffuriau. Fodd bynnag, yn amlwg, mae unrhyw arbediad yn dda ac, fel y dywedaf, bydd y grwp cynghori ar ragnodi Cymru gyfan yn gwerthuso'r effaith. Fodd bynnag, mae'r grwpiau iechyd lleol yn teimlo eu bod yn werth da iawn a'u bod wedi dangos gwelliannau mewn rhagnodi o ran ansawdd a pha mor gost effeithiol ydyw. Maent yn parhau â'r cynlluniau hynny, sy'n dystiolaeth o'r ffaith bod yn rhaid eu bod yn gweithio. Mae angen i ni eu gwerthuso'n fwy ffurfiol.

[71] **Jocelyn Davies:** Mae'n siwr y byddwn yn edrych ar hynny pan fyddant wedi cael eu gwerthuso, Gadeirydd.

[72] **Dafydd Wigley:** Mae'n siwr.

[73] **Jocelyn Davies:** The report states that over £15 million-worth of drugs every year is just wasted, because patients do not take them or throw them away or whatever. What progress is being made in improving medicines management?

**Ms Lloyd:** Well, this is a very tricky issue, because it is very much about culture, and patient behaviour as well. Certainly, we are looking very closely indeed at the repeat prescription regimes and I think that pharmacists can really play a major part, with their GP colleagues, in looking at that. Often, patients will behave in such a way—and I am sure that we have all done it—as to not finish the course, and, particularly if it is a course of antibiotics, you do not finish it because you feel better, so that is a waste. I think that we need to improve the information that we give to patients about the use of their drugs. Some patients cannot take a particular drug that is prescribed for them, so it is really important that, again, a discussion goes on between the general practitioner and the patient. However, we have plans afoot at the moment to work with the pharmaceutical companies to try to ensure that medicines management is brought to the forefront. We have to ensure—and I think that the basis of it is repeat prescriptions—that there is a much better system, whereby if a prescription is to be repeated, there is a review of the requirement for that particular set of drugs. We also have to ensure that the professional services are available to the GPs and to the patients to allow that to take place, because we have to try to ensure that waste is absolutely limited.

[73] **Jocelyn Davies:** Mae'r adroddiad yn nodi bod gwerth dros £15 miliwn o gyffuriau bob blwyddyn yn cael eu gwastraffu, oherwydd nad yw cleifion yn eu cymryd neu'n eu taflu neu beth bynnag. Pa gynnydd sy'n cael ei wneud yn y gwaith o wella'r rheolaeth o feddyginiaethau?

**Ms Lloyd:** Wel, mae hwn yn fater lletchwith iawn, oherwydd mae'n ymwneud llawer â diwylliant, ac ymddygiad cleifion hefyd. Yn sicr, yr ydym yn edrych yn ofalus iawn ar y trefniadau ail-bresgripsiwn a chredaf y gall fferyllwyr chwarae rhan bwysig iawn, gyda'u cydweithwyr ym maes meddygaeth deuluol, wrth edrych ar hynny. Yn aml, bydd cleifion yn ymddwyn yn y fath fodd—ac yr wyf yn siwr ein bod ni bob un wedi ei wneud—fel nad ydynt yn gorffen y cwrs, ac, yn enwedig os mai cwrs o wrthfotigau yw, nid ydych yn ei orffen oherwydd eich bod yn teimlo'n well, felly mae hynny'n wastraff. Credaf fod angen i ni wella'r wybodaeth y rhown i gleifion am y defnydd o'u cyffuriau. Ni all rhai cleifion gymryd cyffur penodol sy'n cael ei ragnodi iddynt, felly mae'n bwysig iawn, unwaith eto, bod trafodaeth rhwng y meddyg teulu a'r claf. Fodd bynnag, mae gennym gynlluniau ar droed ar hyn o bryd i weithio gyda chwmnïau fferyllol i geisio sicrhau bod blaenoriaeth yn cael ei rhoi i reoli meddyginiaethau. Rhaid i ni sicrhau—a chredaf mai sail hyn yw ail-bresgripsiynau—bod system lawer gwell, lle os yw presgripsiwn yn mynd i gael ei ail-ragnodi, bod adolygiad o'r gofyniad am y set benodol honno o gyffuriau. Rhaid i ni hefyd sicrhau bod y gwasanaethau proffesiynol ar gael i'r meddygon teulu a'r cleifion i alluogi hynny i ddigwydd, oherwydd rhaid i ni geisio sicrhau bod cyn lleied o wastraff â phosibl.

There has been a huge discussion going on about prescription packs and whether or not if something is prescribed for 28 days and there are 30 tablets in a pack that is a waste. Well, it may or may not be. Most pharmacists will manage that quite carefully, but, again, that is set against the risk of having two odd tablets in a pack in the box, and do you actually have the name of the drug on the pack that is left? So, we have to be careful in terms of quality and risk, but there is much more that can be done on an individual basis and there is a big drive going on at the moment about repeat prescriptions and their proper management.

[74] **Jocelyn Davies:** So repeat prescriptions, you think, are the main cause of that waste. What about the patients who may not want to have generics and who may waste them? Have you any evidence that that is a significant factor?

**Ms Poulter:** I have no evidence that it is a significant factor. It is down to communication between the GP and the patient, and also between the community pharmacist and the patient, to ensure that the patient understands that, although the tablets might look different, they are actually the same, are produced to the same standard and will do the same job.

[75] **Eleanor Burnham:** Can I just press you briefly for an example of a medicine of limited clinical value? Who is it that determines what is of good or limited clinical value?

Bu trafod helaeth am becynnau presgripsiwn ac a yw'n wastraff ai peidio os yw rhywbeth yn cael ei ragnodi am 28 diwrnod ac mae 30 tabled mewn pecyn. Wel, efallai ei fod yn wastraff neu efallai nad yw. Bydd y mwyafrif o fferyllwyr yn rheoli hynny'n eithaf ofalus, ond, eto, rhoddir hynny'n erbyn y risg o gael dwy dabled dros ben mewn pecyn yn y boc, ac a oes gennych mewn gwirionedd enw'r cyffur ar y pecyn sy'n weddill? Felly, rhaid i ni fod yn ofalus o ran ansawdd a risg, ond mae llawer mwy y gall unigolion ei wneud ac mae ymdrech fawr ar y gweill ar hyn o bryd sy'n rhoi sylw i ail-bresgripsiynau a'r rheolaeth gywir ohonynt.

[74] **Jocelyn Davies:** Felly ail-bresgripsiynau, yn eich tyb chi, yw prif achos y gwastraff hynny. Beth am gleifion nad ydynt, o bosibl, am gael cyffuriau generig ac a fydd, o bosibl, yn eu gwastraffu? A oes gennych unrhyw dystiolaeth fod hynny'n ffactor arwyddocaol?

**Ms Poulter:** Nid oes gennyf unrhyw dystiolaeth fod hynnyn ffactor arwyddocaol. Mae'n dibynnu ar y cyfathrebu rhwng y meddyg teulu a'r claf, a hefyd rhwng y fferylllydd cymuned a'r claf, i sicrhau bod y claf yn deall, er bod tabledi yn edrych yn wahanol, eu bod mewn gwirionedd yr un fath, yn cael eu cynhyrchu i'r un safon ac y byddant yn gwneud yr un fath.

[75] **Eleanor Burnham:** A gaf eich holi'n fyr am enghraifft o feddyginiaeth sydd â gwerth clinigol cyfyngedig? Pwy sy'n pennu beth sydd â gwerth clinigol da neu werth cyfyngedig?

**Ms Poulter:** I think that the classic ones are some bitters and tonics that can be prescribed for indigestion; those sort of simple indigestion remedies, perhaps. That would be an example. They are actually marked in the British national formulary, those drugs that are considered to be of limited clinical value, and I think that the decision is made based on the views of the British Medical Association and the Royal Pharmaceutical Society, but I am not actually too sure about that—

[76] **Eleanor Burnham:** Would that be influenced at all by the pharmaceutical companies so that, perhaps, it would appear that it was better to use their expensive drugs as opposed to something such as that you have just mentioned, that was relatively cheap?

**Ms Poulter:** No. In terms of those drugs that are marked as of limited clinical value, it is just based on current evidence, and often that evidence changes.

[77] **Dafydd Wigley:** Janet, do you want to come in with a brief question here? Then Ann, then Alison.

[78] **Janet Davies:** This is a rather sensitive question to ask, but is there any evidence at all as to whether wastage of drugs is more or less likely if prescriptions are free rather than paid for?

**Ms Lloyd:** No-one has done any work on that. As you know, in Wales, there is a large number of people anyway who would always have had free prescriptions. I simply cannot answer that.

**Ms Poulter:** Credaf mai'r rhai clasurol yw rhai chwerwon a thonigau y gellir eu rhagnodi ar gyfer diffyg traul: y mathau hynny o feddyginiaethau diffyg traul syml, efallai. Byddai hynny yn enghraifft. Maent wedi eu nodi mewn gwirionedd yng nghyffurlyfr cenedlaethol Prydain, y cyffuriau hynny a ystyrir i fod â gwerth clinigol cyfyngedig, a chredaf y gwneir y penderfyniad yn seiliedig ar safbwyntiau Cymdeithas Feddygol Prydain a'r Gymdeithas Fferyllol Frenhinol, ond nid wyf mewn gwirionedd yn rhy siwr ynglyn â hynny—

[76] **Eleanor Burnham:** A fyddai'r cwmnïau fferyllol yn dylanwadu ar hynny o gwbl fel, efallai, y byddai'n ymddangos ei bod yn well defnyddio'u cyffuriau drud hwy yn hytrach na rhywbeth tebyg i'r hyn yr ydych newydd sôn amdano, a oedd yn gymharol rad?

**Ms Poulter:** Na. O ran y cyffuriau hynny sydd wedi eu nodi eu bod â gwerth clinigol cyfyngedig, mae'n seiliedig ar dystiolaeth gyfredol yn unig, ac yn aml mae'r dystiolaeth honno'n newid.

[77] **Dafydd Wigley:** Janet, a ydych am ddod i mewn gyda chwestiwn byr yma? Wedyn Ann, wedyn Alison.

[78] **Janet Davies:** Mae hwn yn gwestiwn braidd yn sensitif i'w ofyn, ond a oes unrhyw dystiolaeth o gwbl ynghylch a yw gwastraffu cyffuriau yn fwy neu'n llai tebygol os yw presgripsiynau am ddim yn hytrach na bod tâl amdanynt?

**Ms Lloyd:** Nid oes neb wedi gwneud unrhyw waith ar hynny. Fel y gwyddoch, yng Nghymru, mae nifer fawr o bobl beth bynnag a fyddai wastad wedi cael presgripsiynau am ddim. Ni allaf ateb hynny, yn syml.

[79] **Dafydd Wigley:** That probably goes beyond the scope of this report, does it not? No doubt it is a consideration that the Government will have, in its broadest context. Ann, did you want to come in before we move on?

[80] **Ann Jones:** Yes. It was on the repeat prescription. You sort of highlighted that as being probably one of the major players in wastage. Should we not be looking to utilise the pharmacist in a way, certainly in hospitals, because that is where most prescribing will start? You are prescribed a drug, you come out with a pack to go home with, and then you go to your GP and it is all repeated. Could the hospital pharmacist be utilised more to cut down on some of the wastage of drugs, even in hospitals?

**Ms Poulter:** Yes, absolutely. Hospital pharmacists do review patients' medication. They have an ideal opportunity to review patients' medication while they are in bed. So, yes.

[81] **Ann Jones:** So we should develop that role? The role of the hospital pharmacist should be developed far more than it is in certain areas now?

**Ms Poulter:** I would argue that the role of the hospital pharmacist is quite well-developed, actually, far more so than that of the community pharmacist.

[82] **Ann Jones:** Okay.

[83] **Dafydd Wigley:** Is there good enough co-ordination between the hospital pharmacist and the community pharmacist?

[79] **Dafydd Wigley:** Mae hynny yn ôl pob tebyg yn mynd y tu hwnt i gwmpas yr adroddiad hwn, onid ydyw? Mae'n siwr y bydd yn ystyriaeth y bydd gan y Llywodraeth, yn ei chyddestun ehangaf. Ann, a oeddech am gyfrannu cyn i ni symud ymlaen?

[80] **Ann Jones:** Oeddwn. Yr oedd yn ymwneud ag ail-bresgripsiynau. Bu i chi fwy neu lai amlygu hwnnw fel un o'r prif ffactorau gwastraff yn ôl pob tebyg. Oni ddylem ystyried defnyddio'r fferyllydd mewn modd, yn bendant mewn ysbytai, oherwydd dyna lle fydd y rhan fwyaf o ragnodi yn dechrau? Mae cyffur yn cael ei ragnodi i chi, dewch allan gyda phecyn i fynd adref gyda chi, ac yna yr ydych yn mynd at eich meddyg teulu ac mae'r cyfan yn ailddechrau. A ellid defnyddio mwy ar y fferyllydd ysbyty i leihau rhywfaint ar y gwastraffu cyffuriau, hyd yn oed mewn ysbytai?

**Ms Poulter:** Gellid, yn bendant. Mae fferyllwyr ysbyty yn adolygu meddyginiaeth cleifion. Mae ganddynt gyfle delfrydol i adolygu meddyginiaeth cleifion tra'u bod yn y gwely. Felly, gellid.

[81] **Ann Jones:** Felly dylasem ddatblygu'r rôl honno? Dylid datblygu rôl y fferyllydd ysbyty llawer mwy nag y mae mewn rhai ardaloedd ar hyn o bryd?

**Ms Poulter:** Byddwn yn dadlau bod rôl y fferyllydd ysbyty yn eithaf datblygedig, mewn gwirionedd, llawer mwy na rôl y fferyllydd cymuned.

[82] **Ann Jones:** O'r gorau.

[83] **Dafydd Wigley:** A oes cyd-drefnu digon da rhwng y fferyllydd ysbyty a'r fferyllydd cymuned?

**Ms Poulter:** I think that it could be improved. The difficulty is that patients can go to any pharmacy that they want.

[84] **Dafydd Wigley:** Yes, of course. Alison, did you want to come in?

[85] **Alison Halford:** I am just curious. How on earth can anybody determine that £15.6 million-worth of medicine is wasted? Unless you go to someone's medicine cabinet and find half a pack of Feldene or something, how do you actually quantify waste?

**Ms Lloyd:** There have been some dump campaigns recently, and from those dump campaigns this is the sort of figure that is being highlighted. The fact that some people would choose not to dump even would lead to a margin of error. However, I think that everyone recognises that there is an issue about this.

[86] **Alison Halford:** Thank you for that. On repeat prescriptions, if you have arthritis, a condition which deteriorates, then, clearly, repeat prescriptions are going to be the order of the day. Again, how do you distinguish between those chronic cases and those people who actually have a problem and then just continue taking the pills because they think that it is going to be good for them, although they are better? How do you actually break down the dangers? You are talking about big drives on repeat prescriptions. What are you actually trying to achieve? I know that you are looking for savings.

**Ms Poulter:** Credaf y gellid ei wella. Yr anhawster yw y gall cleifion fynd i unrhyw fferyllfa y dymunant.

[84] **Dafydd Wigley:** Ie, wrth gwrs. Alison, a ydych am ddod i mewn?

[85] **Alison Halford:** Yr wyf yn chwilfrydig. Sut ar y ddaear gall unrhyw un bennu bod gwerth £15.6 miliwn o feddyginiaeth wedi'i gwastraffu? Oni bai eich bod yn mynd i gwpwrdd moddion rhywun a dod o hyd i hanner pecyn o Feldene neu rywbeth, sut yr ydych yn mesur gwastraff mewn gwirionedd?

**Ms Lloyd:** Bu rhai ymgyrchoedd dympio yn ddiweddar, a dyma'r math o ffigur sy'n cael ei amlygu o'r ymgyrchoedd dympio hynny. Mae'r ffaith y byddai rhai pobl yn dewis peidio â dympio hyd yn oed yn gadael lle i wallau. Fodd bynnag, credaf fod pawb yn cydnabod bod hwn yn fater i'w drafod.

[86] **Alison Halford:** Diolch i chi am hynny. Ynghylch ail-bresgripsiynau, os oes gennyh arthritis, cyflwr sy'n gwaethygu, yna, yn amlwg, bydd ail-bresgripsiynau yn angenrheidiol. Eto, sut yr ydych yn gwahaniaethu rhwng yr achosion cronig hynny a'r bobl hynny sy'n wirioneddol â phroblem ac sy'n parhau i gymryd y pils oherwydd eu bod yn credu eu bod yn mynd i wneud daioni iddynt, er eu bod yn well? Sut yr ydych yn goresgyn y peryglon? Yr ydych yn sôn am ymgyrchoedd mawr i fynd i'r afael ag ail-bresgripsiynau. Beth yr ydych yn ceisio ei gyflawni mewn gwirionedd? Gwn eich bod yn chwilio am arbedion.

**Ms Lloyd:** Well, not just savings; it is about effective management of the patient. Of course, people who have chronic illness will have continuing prescribing needs. However, the prescription might change over time. Really, we are pushing for very good evaluation of the patients and not just ‘so-and-so wants a repeat prescription’. I know that people are very hard-pressed—

[87] **Alison Halford:** I think that Carolyn is going to make a point on your behalf.

**Ms Lloyd:** Yes. She is going to talk about side effects.

**Ms Poulter:** It is all about regular ongoing monitoring of patient compliance, side effects and the efficacy of the drug. That is where the pharmacist really can play a major role, so that patients do not just order their repeat medicines and continue without any follow-up.

[88] **Jocelyn Davies:** May I ask a question on that?

[89] **Dafydd Wigley:** Yes, and we will then go back to Alison.

[90] **Jocelyn Davies:** Does this also involve patients who may have three or four items on repeat prescription, and continue to get the three or four items but are only taking one of them, and the other three are just getting stockpiled in the cupboard?

**Ms Lloyd:** Yes.

[91] **Dafydd Wigley:** Right. Point well made. Alison?

**Ms Lloyd:** Wel, nid arbedion yn unig; mae'n ymwneud â rheoli'r claf yn effeithiol. Wrth gwrs, bydd gan bobl sydd ag afiechyd cronig anghenion presgripsiwn parhaus. Fodd bynnag, efallai y bydd y presgripsiwn yn newid dros amser. Yn y bôn, yr ydym yn pwysu am werthusiad da iawn o gleifion ac nid 'mae angen ail-bresgripsiwn ar hwn a'r llall' yn unig. Gwn fod pobl dan bwysau mawr—

[87] **Alison Halford:** Credaf fod Carolyn yn mynd i wneud pwynt ar eich rhan.

**Ms Lloyd:** Ydyw. Mae hi'n mynd i sôn am sgîl-ffeithiau.

**Ms Poulter:** Mae'r cyfan yn ymwneud â monitro cydymffurfiaeth cleifion yn barhaus a rheolaidd, sgîl-ffeithiau ac effeithiolrwydd y cyffur. Dyna lle gall y fferylllydd mewn gwirionedd chwarae rôl bwysig, fel nad yw cleifion ond yn archebu eu meddyginiaethau dro ar ôl tro ac yn parhau heb unrhyw ddilyniant.

[88] **Jocelyn Davies:** A gaf fi ofyn cwestiwn am hynny?

[89] **Dafydd Wigley:** Cewch, ac yna awn yn ôl at Alison.

[90] **Jocelyn Davies:** A yw hyn hefyd yn cynnwys cleifion sydd o bosibl â thair neu bedair eitem ar ail-bresgripsiwn, ac yn parhau i gael y tair neu bedair eitem ond yn cymryd un ohonynt yn unig, gyda'r tri arall ond yn pentyrru yn y cwpwrdd?

**Ms Lloyd:** Ydyw.

[91] **Dafydd Wigley:** O'r gorau. Yr oedd hwinnw'n bwynt da. Alison?

[92] **Alison Halford:** I have one question on the involvement of pharmacists in medication reviews, which can help to avoid the risk of adverse reactions. Is it a good idea, and how are these widespread reviews working? Are they working?

**Ms Poulter:** Yes. Many, or most local health groups, have prescribing advisers and pharmacy technicians who work with GPs, and they will often go into a GP's practice and target patients who are on, for example, 10 prescription items or more. They invite them into the surgery to discuss their medication with them to see whether all the drugs are required, whether they are experiencing side effects and whether they are getting good benefit from their medicines. That happens now. Community pharmacists will do that to some extent; it is perhaps on an ad hoc basis, but it does occur. What we need to do is to formalise that and encourage and remunerate pharmacists for doing it.

[93] **Alison Halford:** So how can these reviews be made more widespread, and how long will we have to wait for that?

**Ms Poulter:** We have started negotiations on a new pharmacy contract, and we are looking to remunerate pharmacists for these professional services, rather than just remunerating them for dispensing high volumes of prescriptions, to demonstrate that we value this service that pharmacists provide.

[92] **Alison Halford:** Mae gennyf un cwestiwn am ran fferyllwyr yn y gwaith o adolygu meddyginiaethau, sy'n gallu cynorthwyo i osgoi'r risg o adweithio andwyol. A yw'n syniad da, a sut mae'r adolygiadau eang hyn yn gweithio? A ydynt yn gweithio?

**Ms Poulter:** Ydynt. Mae gan lawer, neu'r mwyafrif o grwpiau iechyd lleol, gynghorwyr rhagnodi a thechnegwyr fferyllfa sy'n gweithio gyda meddygon teulu, a byddant yn aml yn mynd i bractis meddyg teulu ac yn targedu cleifion sydd , er enghraifft, ar 10 eitem bresgripsiwn neu fwy. Maent yn eu gwahodd i'r feddygfa i drafod eu meddyginiaeth gyda hwy i weld a oes angen yr holl gyffuriau, a ydynt yn dioddef unrhyw sgîl-ffeithiau ac a ydynt yn cael budd da o'u meddyginiaethau. Mae hynny'n digwydd yn awr. Bydd fferyllwyr cymuned yn gwneud hynny i ryw raddau; efallai ei fod yn ad hoc, ond mae yn digwydd. Yr hyn sydd ei angen i ni ei wneud yw ffurfioli hynny ac annog a gwobrwyo fferyllwyr am ei wneud.

[93] **Alison Halford:** Felly sut y gellir gwneud yr adolygiadau hyn yn fwy cyffredin, a pha mor hir y bydd yn rhaid inni aros am hynny?

**Ms Poulter:** Yr ydym wedi dechrau negodiadau ar gontract fferyllfa newydd, ac yr ydym yn bwriadu gwobrwyo fferyllwyr am y gwasanaethau proffesiynol hyn, yn hytrach na'u gwobrwyo am ddosbarthu llawer o bresgripsiynau yn unig, i ddangos ein bod yn gwerthfawrogi'r gwasanaeth hwn y mae fferyllwyr yn ei ddarparu.

[94] **Janice Gregory:** There is obviously patient education involved in this because the repeat prescriptions that I have seen are different from how they used to be. You now have to actually tick them. So if you have a list of 10 or 15 medications on a repeat prescription, you now have to indicate the ones that you want a repeat prescription for. I quite accept that most people will just tick every box because it is easier than reading them maybe, or they just want them all. Therefore, there must be a public information campaign of some sort for the patient. I do not know whether we can expect GPs, with all the pressures that are upon them, to sit down with their patients and say, 'please do not tick every box if you do not require it'. I just wanted to make that point.

[95] **Dafydd Wigley:** Val, your question has been partly picked up, but there are other aspects to it. Can you take that on now?

[96] **Val Lloyd:** Yes, it is slightly different. I was going to refer to the fact that you mentioned pack size standardisation. I have a slightly different line of questioning on that. It does seem to be a sensible way of improving value for money. Could you tell us what has prevented this from being done sooner, and how do you intend to overcome any obstacles to moving it forward?

**Ms Lloyd:** Could I just clarify the question? Do you mean having pack size—

[97] **Val Lloyd:** Standardisation.

[94] **Janice Gregory:** Mae'n amlwg bod addysg cleifion yn ymwneud â hyn oherwydd mae'r ail-bresgripsiynau yr wyf wedi eu gweld yn wahanol i'r hyn yr arferent fod. Mae'n rhaid i chi eu ticio bellach. Felly os oes gennych restr o 10 neu 15 o feddyginiaethau ar ail-bresgripsiwn, bellach mae'n rhaid i chi nodi'r rhai yr ydych angen ail-bresgripsiwn ar eu cyfer. Yr wyf yn derbyn yn llwyr y bydd y mwyafrif o bobl yn ticio pob boc oherwydd mae'n haws na'u darllen efallai, neu mae eu hangen hwy i gyd arnynt. Felly, rhaid cael ymgyrch gwybodaeth gyhoeddus o ryw fath ar gyfer y claf. Ni wn a allwn ddisgwyl i feddygon teulu, gyda'r holl bwysau sydd arnynt, eistedd gyda'u cleifion a dweud, 'peidiwch â thicio pob boc os nad oes ei angen arnoch'. Yr oeddwn am wneud y pwynt hwnnw.

[95] **Dafydd Wigley:** Val, mae'ch cwestiwn wedi cael ei drafod yn rhannol, ond mae agweddau eraill arno. A allwch chi ofyn hwnnw yn awr?

[96] **Val Lloyd:** Ydyw, mae ychydig yn wahanol. Yr oeddwn yn mynd i gyfeirio at y ffaith eich bod wedi crybwyll safoni maint pecynnau. Mae gennyf gwestiynau ychydig yn wahanol am hynny. Mae'n ymddangos yn fodd synhwyrol o wella gwerth am arian. A allech ddweud wrthym beth sydd wedi rhwystro hyn rhag cael ei wneud yn gynharach, a sut yr ydych yn bwriadu goresgyn unrhyw rwystrau i'r gwaith o'i ddatblygu?

**Ms Lloyd:** A allaf wneud y cwestiwn yn glir? A ydych yn golygu cael maint pecynnau—

[97] **Val Lloyd:** Safonol.

**Ms Lloyd:** What has prevented us doing it in the past, I cannot say. There have been lots and lots of different initiatives in terms of proper dispensing, an awful lot of which were, quite rightly, driven by improved quality in the management of risk. You will have seen the initiatives, coming from the hospital sector as well, whereby people who might get confused, if they are on a number of tablets, about which day they are on and whether or not they have taken their tablets at the right time, have these sort of almost automated packs so that they are able to keep track of their medicines. All of those are really good things—not only do they improve the patient’s ability to take his or her medicines, and therefore not waste them, but they allow ourselves, the hospitals, and the GPs, to ensure that patients are taking the right medicines at the right time and not getting in a jumble about it. They are really good. In terms of the packs, one of the great advantages of them is that they have the names of what you are taking on them. That, again, is a security issue. From the hospital point of view, the downside of packs, certainly when they were first produced, was that the hospitals were going towards only, for example, giving seven days’ worth of take-home drugs and, all of a sudden, 28-day packs were appearing. That caused a problem, but there was a lot of discussion between the two sectors about how that would be managed, and it certainly ensures that patients will take the right course of drugs, because their drugs are all set out for them and they can tell when they have missed a day or a dose and so on. So, again, it is an issue of the management of risk and an improvement in quality. The downside is that you can get greater waste from it. However, in terms of dispensing, most of the pharmacists anyway will retain drugs not dispensed in a safe environment and they will be dispensed normally by that individual as part of a prescription. So, I think that, although there was a lot of controversy when it started, the

**Ms Lloyd:** Beth sydd wedi ein rhwystro rhag ei wneud yn y gorffennol, ni allaf ddweud. Bu llawer iawn o fentrau gwahanol o ran dosbarthu cywir, gyda llawer iawn ohonynt, yn hollol gywir, yn cael eu hyrwyddo gan well ansawdd yn y gwaith o reoli risg. Byddwch wedi gweld y mentrau hyn, a ddawo’r sector ysbyty hefyd, lle y bydd pobl a allai ddrysu, os ydynt yn cymryd nifer o dabledi, ynglyn â pha ddiwrnod y maent arno ac a ydynt wedi cymryd eu tabledi ar yr amser cywir ai peidio, yn cael y math o becynnau hyn sydd bron yn awtomataidd fel eu bod yn gallu cadw cyfrif o’u meddyginiaethau. Mae’r rheini i gyd yn bethau da iawn—nid yn unig maent yn gwella gallu’r claf i gymryd ei feddyginiaethau neu ei meddyginiaethau, ac felly peidio â’u gwastraffu, ond maent yn caniatáu i ni, yr ysbytai, a’r meddygon teulu, i sicrhau bod cleifion yn cymryd y meddyginiaethau cywir ar yr amser cywir ac nad ydynt yn drysu yn eu cylch. Maent yn dda iawn. O ran y pecynnau, un o’u manteision mawr yw bod enwau yr hyn yr ydych yn ei gymryd arnynt. Mae hynny, eto, yn fater diogelwch. O safbwynt yr ysbyty, anfantais y pecynnau, yn sicr pan y’u cynhyrchwyd yn y lle cyntaf, oedd bod yr ysbytai yn tueddu, er enghraifft, i roi gwerth saith niwrnod o gyffuriau yn unig i fynd adref ac, yn sydyn, yr oedd pecynnau 28-diwrnod yn ymddangos. Achosodd hynny broblem, ond bu llawer o drafod rhwng y ddau sector ynglyn â sut y byddai hynny’n cael ei reoli, ac mae’n bendant yn sicrhau y bydd cleifion yn cymryd y cwrs cywir o gyffuriau, oherwydd mae eu cyffuriau wedi eu gosod allan ar eu cyfer a gwyddant os ydynt wedi colli diwrnod neu ddos ac ati. Felly, eto, mae’n fater o reoli’r risg a gwella ansawdd. Yr anfantais yw y gallwch gael mwy o wastraff oddi wrtho. Fodd bynnag, o ran dosbarthu, bydd y mwyafrif o’r fferyllwyr beth bynnag yn cadw cyffuriau na chânt eu dosbarthu mewn amgylchedd diogel a byddant yn cael eu dosbarthu fel arfer gan yr unigolyn hwnnw fel rhan o bresgripsiwn. Felly,

system has settled down and I think that we basically feel that we are dealing with an improved quality.

[98] **Val Lloyd:** I find that very helpful, but I was actually thinking about the last sentence in paragraph 4.34:

‘It would help to reduce the barrier to substituting one medicine for another caused by differences in pack size.’

Certain items will come in packs of 30 and perhaps they will be dispensed in a 28-day course, as you mentioned earlier—cutting off two, which would then be lost. However, I am looking at it in a different way, in terms of when we can substitute one medicine for another quite properly.

**Ms Poulter:** The problem is that the packs are made for a global market—the packs of 28 and 30. There is no standardisation and, although perhaps in the UK we would prefer standardisation to pack sizes of 28, I believe that certain European countries would prefer them to be in packs of 30. Wales, as a small player, has limited influence over the pharmaceutical industry to produce a standard pack size. However, we are setting up a NHS industry forum whereby NHS staff and the pharmaceutical industry can come together and discuss such issues. We hope that we will be able to influence this in that way.

[99] **Val Lloyd:** Thank you, Chair. I think that that is all.

[100] **Dafydd Wigley:** Did you have a brief comment, Eleanor?

credaf, er y bu llawer o ddadlau pan ddechreuodd y system, mae wedi dod i drefn a chredaf ein bod yn y bôn yn teimlo ein bod yn delio ag ansawdd gwell.

[98] **Val Lloyd:** Mae hynny’n ddefnyddiol iawn i mi, ond yr oeddwn mewn gwirionedd yn meddwl am y frawddeg olaf ym mharagraff 4.34:

‘Byddai o gymorth i leihau’r rhwystr i amnewid un feddyginiaeth am un arall a achosir gan wahaniaethau ym maint pecynnau.’

Bydd rhai eitemau yn dod mewn pecynnau o 30 ac efallai y byddant yn cael eu dosbarthu mewn cwrs 28-diwrnod, fel y soniasoch yn gynharach—gan adael dau yn weddill a fyddai wedyn yn cael eu colli. Fodd bynnag, yr wyf yn edrych arno mewn modd gwahanol, o ran pryd y gallwn amnewid un feddyginiaeth am un arall yn hollol briodol.

**Ms Poulter:** Y broblem yw bod pecynnau yn cael eu gwneud ar gyfer marchnad fyd-eang—y pecynnau o 28 a 30. Nid oes safoni ac, er efallai y byddem yn ffafrio safoni i becynnau o 28 yn y DU, credaf y byddai’n well gan rai gwledydd Ewropeaidd iddynt fod mewn pecynnau o 30. Dylanwad cyfyngedig sydd gan Gymru, fel chwaraewr bach, ar y diwydiant fferyllol i gynhyrchu pecyn o faint safonol. Fodd bynnag, yr ydym yn sefydlu fforwm diwydiant y GIG lle gall staff y GIG a’r diwydiant fferyllol ddod at ei gilydd a thrafod y cyfryw faterion. Yr ydym yn gobeithio y byddwn yn gallu dylanwadu ar hyn yn y modd hwnnw.

[99] **Val Lloyd:** Diolch yn fawr, Gadeirydd. Credaf mai dyna’r cyfan.

[100] **Dafydd Wigley:** A oedd gennych sylw byr, Eleanor?

[101] **Eleanor Burnham:** I had the pleasure of going round Boots in Wrexham where they showed me their care management for nursing homes and residential homes. My concern is that Boots is in a very strong position. Do you envisage helping smaller, independent community pharmacists and, perhaps, as you said earlier, remunerating them for all the extra work that is involved in all these care management plans?

**Ms Poulter:** We will be looking at remunerating pharmacists for these additional professional services through the new pharmacy contract.

[102] **Dafydd Wigley:** That is part of the review that you are doing at the moment. Janet, did you have something that you wanted to bring in before we pull things together?

[103] **Janet Davies:** Yes. Reading the report as a whole, two things struck me in a sort of broad, overall way. One was the complexity of the issue, which has been talked about. The other was that there are quite a number of organisations that are reviewing and considering this matter. Do you feel that there is any duplication among the organisations, or do they all have a different and valid role?

**Ms Lloyd:** In discussing this with Carolyn, we think that there is no duplication because people are actually keeping in contact with each other. They all have a valid role in looking at this very complex system to ensure that we are all getting best value for money and that patient safety remains at the forefront of the discussion. So, we are sharing information among ourselves about the various aspects that are being reviewed.

[101] **Eleanor Burnham:** Cefais y pleser o fynd o amgylch Boots yn Wrecsam lle dangosant i mi eu rheolaeth ar ofal ar gyfer cartrefi nyrsio a chartrefi preswyl. Fy mhryder yw bod Boots mewn sefyllfa gref iawn. A ydych yn rhagweld cynorthwyo fferyllwyr cymuned annibynnol, llai ac, efallai, fel y dywedasoich yn gynharach, eu gwobrwyo am yr holl waith ychwanegol sy'n gysylltiedig â'r holl gynlluniau rheoli gofal hyn?

**Ms Poulter:** Byddwn yn edrych ar wobrwyo fferyllwyr am y gwasanaethau proffesiynol ychwanegol hyn drwy'r contract fferyllfa newydd.

[102] **Dafydd Wigley:** Mae hynny'n rhan o'r adolygiad yr ydych yn ei wneud ar hyn o bryd. Janet, a oedd gennych ryw beth yr oeddech am ei ddweud cyn inni gloi?

[103] **Janet Davies:** Oedd. O ddarllen yr adroddiad yn ei gyfanrwydd, cefais fy nharo gan ddau beth mewn rhyw fath o fodd cyffredinol, eang. Un oedd cymhlethdod y mater, sydd wedi cael ei drafod. Y llall oedd fod cryn nifer o sefydliadau sy'n adolygu ac yn ystyried y mater hwn. A ydych yn teimlo bod unrhyw ddyblygu ymhlith y sefydliadau, neu a oes ganddynt i gyd rôl wahanol a dilys?

**Ms Lloyd:** Wrth drafod hyn gyda Carolyn, credwn nad oes dyblygu oherwydd bod pobl mewn gwirionedd yn cadw mewn cysylltiad â'i gilydd. Mae ganddynt oll rôl ddilys yn y gwaith o edrych ar y sefyllfa dra chymhleth hon i sicrhau ein bod ni i gyd yn cael gwerth gorau am arian a bod diogelwch y claf yn parhau'n flaenoriaeth yn y drafodaeth. Felly, yr ydym yn rhannu gwybodaeth ymhlith ein hunain am y gwahanol agweddau sy'n cael eu hadolygu.

[104] **Dafydd Wigley:** Good. Incidentally, for the benefit of colleagues, I will try to fit in another item before the coffee break, if I can. However, in conclusion, I am certainly impressed, and I think that my colleagues are impressed, by the positive attitude that you are taking towards this matter, and I would like to thank you for that. However, may I ask, in approaching a very complex subject—containing as it does a significant number of vested interests and some pretty big battalions with whom the changes have to be negotiated—do you and your colleagues have the stomach for that fight? At the very least to get the pilot schemes up and running, which can, hopefully, then indicate that substantial savings could be achieved without any great loss in terms of disruption or loss of service and, in a way, it could be a trailblazer for the rest of the UK, for it to emulate progress being made in Wales. Do you have the stomach for that fight?

**Ms Lloyd:** We always have the stomach for an active discussion with our partners. I think that, if the Auditor General says that there are ways in which moneys can be saved to be reinvested in patient care, then we must explore those seriously. As he has very helpfully pointed out, there are a number of risks surrounding this and that is an issue on which the all-Wales medicines strategy group will advise us, before we launch any pilot schemes, to ensure that we protect the system. We do not want anything falling over. However, I certainly think that we should pursue many of the initiatives that are outlined in this report.

[104] **Dafydd Wigley:** Iawn. Gyda llaw, er budd cyd-Aelodau, ceisiaf gynnwys eitem arall cyn yr egwyl goffi, os gallaf. Fodd bynnag, i gloi, cefias argraff dda, a chredaf i'm cyd-Aelodau gael argraff dda, am yr agwedd gadarnhaol yr ydych yn ei chymryd ar y mater hwn, a hoffwn ddiolch i chi am hynny. Fodd bynnag, a gaf fi ofyn, o fynd i'r afael â phwnc cymhleth iawn—sy'n cynnwys fel y mae nifer sylweddol o fuddiannau a rhai lluoedd eithaf mawr y mae'n rhaid negodi'r newidiadau gyda hwy—a oes gennych chi a'ch cydweithwyr y stumog ar gyfer y frwydr honno? Yn y man lleiaf i roi'r cynlluniau peilot ar waith, a fydd wedyn, gobeithio, yn gallu nodi y gellid sicrhau arbedion sylweddol heb unrhyw golled fawr o ran amharu ar neu golli gwasanaeth ac, mewn ffordd, y gallai fod yn esiampl ar gyfer gweddill y DU, fel ei bod yn ceisio efelychu'r cynnydd sy'n cael ei wneud yng Nghymru. A oes gennych y stumog ar gyfer y frwydr honno?

**Ms Lloyd:** Mae gennym bob amser y stumog ar gyfer trafodaeth weithredol gyda'n partneriaid. Credaf, os dywed yr Archwilydd Cyffredinol fod ffyrdd y gellid arbed arian i'w ail-fuddsoddi yng ngofal cleifion, yna fod yn rhaid i ni archwilio'r rheini o ddifrif. Fel y mae wedi nodi'n ddefnyddiol, mae nifer o risgiau yn gysylltiedig â hyn ac mae hwnnw'n fater y bydd y grwp strategaeth meddyginiaethau Cymru gyfan yn ein cyngori arno, cyn inni lansio unrhyw gynlluniau peilot, i sicrhau ein bod yn diogelu'r system. Nid ydym am i unrhyw beth fynd o'i le. Fodd bynnag, yr wyf yn credu yn bendant y dylasem fynd ar drywydd llawer o'r mentrau a amlinellir yn yr adroddiad hwn.

[105] **Dafydd Wigley:** I am very grateful to you for that and for your evidence. Clearly, the writing up of a report on this will straddle the election period and it may well be that the new Committee that will be formulated in the new Assembly will want to return to some aspects of this. There may be opportunities for other interests to appear before the Committee, to make sure that there is a proper balance of evidence, before the final report is drawn up. I thank you very much for the comprehensive nature of the replies that you have given. I think that you are going to be staying on for the next item, are you not?

**Ms Lloyd:** Yes, and I have lost my headphones.

[106] **Dafydd Wigley:** In which case I will stick to English. Before we move on, as I always do, I will explain that the draft transcript will be sent to you in order for you to have an opportunity to correct any factual mistakes before it is published. It will then be published as part of the minutes of this meeting, and will appear as an attachment when we finally bring our report forward. Thanks to both Carolyn and yourself.

[105] **Dafydd Wigley:** Yr wyf yn ddiolchgar iawn i chi am hynny ac am eich tystiolaeth. Yn amlwg, bydd y gwaith o ysgrifennu adroddiad am hyn yn digwydd y naill ochr i gyfnod yr etholiad ac mae'n bosibl y bydd y Pwyllgor newydd a fydd yn cael ei greu yn y Cynulliad newydd am ddychwelyd at rai agweddau ar hyn. Efallai y bydd cyfleoedd i fuddiannau eraill ymddangos gerbron y Pwyllgor, i sicrhau bod cydbwysedd cywir o dystiolaeth, cyn llunio'r adroddiad terfynol. Diolch yn fawr iawn i chi am natur gynhwysfawr yr atebion yr ydych wedi eu rhoi. Credaf eich bod yn mynd i fod yn aros ar gyfer yr eitem nesaf, onid ydych?

**Ms Lloyd:** Ydw, ac yr wyf wedi colli fy nghlustffonau.

[106] **Dafydd Wigley:** Os felly, parhaf yn y Saesneg. Cyn inni symud ymlaen, fel y gwnaf bob tro, hoffwn egluro y bydd y trawsgrifiad drafft yn cael ei anfon atoch er mwyn i chi gael cyfle i gywiro unrhyw gamgymeriadau ffeithiol cyn ei gyhoeddi. Bydd wedyn yn cael ei gyhoeddi fel rhan o gofnodion y cyfarfod hwn, a bydd yn ymddangos fel atodiad pan fyddwn yn cyhoeddi ein hadroddiad yn y pen draw. Diolch i Carolyn ac i chi.

*Daeth y sesiwn cymryd tystiolaeth i ben am 10.27 a.m.  
The evidence-taking session ended at 10.27 a.m.*

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[i] Mae'r pwyllgor contractio cyffuriau Cymru gyfan yn negodi contractau ar gyfer rhyw 500 eitem o'r miloedd o gyffuriau sydd ar gael mewn gofal sylfaenol ac eilaidd.

The all-Wales drugs contracting committee negotiates contracts for some 500 items from the thousands of drugs that are available in primary and secondary care.

[ii] Caiff papur ei gyflwyno i'r grwp strategaeth meddyginiaethau Cymru gyfan yn ei gyfarfod ym mis Mehefin.

A paper will be presented to the all-Wales medicines strategy group at its June meeting.