



# **Cynulliad Cenedlaethol Cymru** **The National Assembly for Wales**

## **Y Pwyllgor Iechyd a Gofal Cymdeithasol** **The Health and Social Care Committee**

**Dydd Mercher, 28 Medi 2011**  
**Wednesday, 28 September 2011**

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These proceedings are reported in the language in which they were spoken in the committee.  
In addition, an English translation of Welsh speeches is included

**Aelodau'r pwyllgor yn bresennol**  
**Committee members in attendance**

Mick Antoni	Llafur Labour
Mark Drakeford	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Rebecca Evans	Llafur Labour
Vaughan Gething	Llafur Labour
William Graham	Ceidwadwyr Cymreig Welsh Conservatives
Elin Jones	Plaid Cymru The Party of Wales
Darren Millar	Ceidwadwyr Cymreig Welsh Conservatives
Lynne Neagle	Llafur Labour
Lindsay Whittle	Plaid Cymru The Party of Wales
Kirsty Williams	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

**Eraill yn bresennol**  
**Others in attendance**

Ian Cowan	Cadeirydd, Fferylliaeth Gymunedol Cymru Chair, Community Pharmacy Wales
Mair Davies	Cadeirydd, Bwrdd Fferylliaeth Cymru Chair, Pharmacy Board Wales
Paul Gimson	Cyfawrwyddwr dros Gymru, Cymdeithas Fferyllol Frenhinol Director for Wales, Royal Pharmaceutical Society
Russell Goodway	Prif Weithredwr, Fferylliaeth Gymunedol Cymru Chief Executive, Community Pharmacy Wales
Chris James	Is-gadeirydd, Fferylliaeth Gymunedol Cymru Vice-chair, Community Pharmacy Wales

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

Steve Boyce	Y Gwasanaeth Ymchwil Research Service
Llinos Dafydd	Clerc Clerk
Catherine Hunt	Dirprwy Glerc Deputy Clerk

*Dechreuodd y cyfarfod am 9.30 a.m.*  
*The meeting began at 9.30 a.m.*

## **Cyflwyniad, Ymddiheuriadau a Dirprwyon Introduction, Apologies and Substitutions**

[1] **Mark Drakeford:** Bore da a chroeso i'r cyfarfod hwn o'r Pwyllgor Iechyd a Gofal Cymdeithasol. Nid wyf am fynd drwy'r holl gyhoeddiadau a wnawn fel arfer. Dywedaf yn unig ein bod yn gweithredu'n ddwyieithog a gall unrhyw un siarad yn Gymraeg neu'n Saesneg. A yw'r clustffonau i gyd yn gweithio? Gwelaf eu bod.

**Mark Drakeford:** Good morning and welcome to this meeting of the Health and Social Care Committee. I will not go through all the usual announcements, apart from to say that we operate bilingually, and anyone is welcome to speak in Welsh or English. Are all the headsets working? I see that they are.

### **Ymchwiliad i'r Cyfraniad a Wneir gan Fferyllfeydd Cymunedol i Wasanaethau Iechyd yng Nghymru—Tystiolaeth gan y Gymdeithas Fferyllol Frenhinol Inquiry into the Contribution of Community Pharmacy to Health Services in Wales—Evidence from the Royal Pharmaceutical Society**

[2] **Mark Drakeford:** Croesawaf Mair Davies, cadeirydd y Gymdeithas Fferyllol Frenhinol yng Nghymru, a Paul Gimson, y cyfarwyddwr. Gofynnaf ichi wneud datganiad byr ar y dechrau i gyflwyno'ch tystiolaeth. Bydd Aelodau wedyn yn gofyn eu cwestiynau. Cyn inni gyrraedd y diwedd, dof yn ôl atoch rhag ofn bod unrhyw beth na chawsom gyfle i siarad amdano neu yr hoffech ei bwysleisio, er mwyn sicrhau bod yr Aelodau wedi clywed popeth sydd gennych i'w ddweud.

**Mark Drakeford:** I welcome Mair Davies, the chair of the society in Wales, and Paul Gimson, its director. I ask you to make a brief statement at the start to present your evidence. Members will then ask questions. Just before the end, I will come back to you to see whether there is anything that we have not had an opportunity to talk about or that you would like to emphasise, to make sure that Members have heard everything that you have to say.

[3] Thank you very much for being here this morning. We now have a few minutes at the start for you to introduce your written evidence, which all Members have had a chance to read.

[4] **Ms Davies:** Thank you for inviting Paul and me, as representatives of the Royal Pharmaceutical Society, to the meeting. The RPS is the professional body for pharmacists in Wales and throughout Great Britain. We are the only body that represents pharmacists in all sectors of pharmacy: hospitals, the community, primary care, industry and academia. That is the perspective that we bring today. The RPS promotes and protects the health and wellbeing of the public through leadership and the development of the pharmacy profession. In case some of you have a long history with regard to the RPS, I remind you that we handed over all regulatory activities to the General Pharmaceutical Council exactly one year ago—in fact, exactly one year ago yesterday. Our role now includes the advancement of science and practice in pharmacy. Pharmacists are the experts in medicine, and it is therefore crucial that they are at the forefront of medicines management, are included and integrated into NHS healthcare teams, and work in partnership and collaboration with patients and all other health and social care professionals.

[5] **Rebecca Evans:** Good morning. In your evidence you say that pharmacy

[6] 'provides a role in pharmaceutical care and public health delivery to a cohort of people who had previously been difficult to reach'.

[7] 'Difficult to reach' is a difficult term that is employed inconsistently by different organisations. Could you expand on what you mean by 'difficult to reach' and why you think that pharmacists can reach those people when other parts of the health service cannot?

[8] **Mr Gimson:** One thing that we are talking about there is the fact that one benefit of community pharmacy is its accessibility and its place in the community. It sees a cohort of people who might not necessarily access other parts of the health service. A pharmacy has footfall. We were thinking about public health matters, because community pharmacy has an opportunity to access hard-to-reach sectors of the population. Men, for example, have a reputation for not accessing health services, but most will visit a pharmacy two or three times a year. So, one thing that we are talking about is the opportunistic angle of promoting health that pharmacies offer.

[9] **Rebecca Evans:** What other groups does 'difficult to reach' refer to? Would it include people in rural areas, those with disabilities and so on?

[10] **Mr Gibson:** It is the whole gamut. It includes patients in rural communities who might have difficulty accessing other parts of the health service; it can also include patients in disadvantaged communities, because, obviously, you do not need an appointment to go into a pharmacy, so they may be more willing to access a pharmacy. It also includes people with chronic conditions, who might not be accessing other parts of the health service regularly but who visit a pharmacy regularly to get their medicines. It is based around that principle of accessibility and openness.

[11] **Rebecca Evans:** So, there is not an evidence base for this as such; it is based more on the location and footfall.

[12] **Mr Gimson:** There is some evidence around. I do not have the details to hand, but I know that work has been done on men's health. One example that pops into my head is research that was done in the north-west. Forgive me, because that is from memory; I can provide more information should you need it. However, it was a scheme that specifically targeted men in their fifties, I think. When those men popped in for their toiletries they were targeted for health checks, such as cardiovascular checks, and were given lifestyle advice and so on. More and more work is being done on accessibility in rural communities. An announcement was made a few weeks ago during rural health week about pilot projects in rural communities that are starting to generate evidence; so there is a growing evidence base.

[13] **Rebecca Evans:** Do you feel that pharmacies are equipped to deal with the additional problems that some hard-to-reach people might present with, such as housing problems or domestic violence?

[14] **Mr Gimson:** They see that cohort of patients for their prescriptions, so they are dealing with them on a daily basis in any case.

[15] **Ms Davies:** It is already part of the contract, in a way, in that you have to signpost people, but it depends on the amount of signposting advice given by local health boards. However, if the facility exists, there is no reason why you could not signpost people to it. You would not be able to solve the problem, and you would not be expected to, but you could signpost them to the right place.

[16] **Rebecca Evans:** Are you satisfied with the signposting advice from the local health boards?

[17] **Ms Davies:** It is an issue for the contractor as to whether they are satisfied with what

they are given. It is up to the LHBs to provide the signposting.

[18] **Mick Antoniw:** Turning to increased bureaucracy, in section 5.2.1 of your paper you refer to regulatory burdens, increasing bureaucracy and the burden of paperwork within community pharmacy. Bearing in mind that you are a growing service in an area that is beginning to overlap with what has traditionally been done by general practitioners, and one of the first things that organisations do when they start receiving money from public bodies is complain about the burden of bureaucracy and so on, is that not somewhat irresponsible?

[19] **Mr Gimson:** That reflects feedback from many of our members. I do not have hard facts and figures to back it up, but it is fed back to us on such a regular basis that I felt that we should include it in the evidence. We are not saying that there is no need for paperwork; rather we are saying that paperwork is coming in from all angles at the moment, from the local health boards, the Government, and campaigns. The problem is that a lot of it is not in an electronic format and is not joined up. This is not a push against the need for good recording; we support record keeping, because for the evaluation of health services there needs to be good recording of outcomes. This is not a push against bureaucracy per se, rather it is a statement that it is all over the place, not joined up, and is not in an electronic format.

[20] **Mick Antoniw:** It is not based on evidence, then.

[21] **Ms Davies:** To expand a little on the subject, one of the issues at present is that a lot of the paperwork needs to be completed by the pharmacist. Looking at the skill mix in a community pharmacy would be useful. If we look at GP surgeries 10 or 15 years ago, GPs were doing a lot, but they now have a system in which there is a practice manager. That has not been looked at in community pharmacy. On the skill mix, in the last two months, in excess of 20,000 registered pharmacy technicians have come in, which is going to have an impact on community pharmacy. However, the funding and support stream for that initiative is perhaps not there yet and is not underpinning it.

[22] **Mick Antoniw:** Does that lead to a concern about consistency in quality? You talk about expanding roles and responsibilities, but how do you gauge quality and are there continuing training obligations? How do you envisage maintaining consistency in quality across community pharmacies?

[23] **Ms Davies:** There are two points. Community pharmacies have to work within a clinical governance framework. As far as individual pharmacists are concerned, they are registered with the General Pharmaceutical Council and have to work within their competency and continue their professional development.

[24] **Mick Antoniw:** How is that evaluated?

[25] **Ms Davies:** Which one?

[26] **Mick Antoniw:** The continuing training and competency aspects.

[27] **Ms Davies:** That is for the GPHC, and it is looking at a revalidation scheme.

[28] **Mick Antoniw:** I have one final point that follows on from that. Moving into the expanded area of responsibilities leaves you increasingly open and vulnerable to professional negligence compensation claims; you are moving into a very complex area. Is this an area where you envisage the professional indemnity insurance to be something that should be borne by the individual pharmacist, or are you looking towards a form of collective pooling, as applies to some of the health boards.

[29] **Mr Gimson:** At the moment, there is a professional obligation on the pharmacists to ensure that they are covered by indemnity insurance. Sometimes that is met by the individual, and it is always met by the contractor. So, I am not quite sure that I follow the question, but practicing pharmacists are all currently covered by indemnity insurance for the professional activities that they do.

[30] **Mick Antoniw:** The cost is likely to escalate quite substantially the more areas you move into. It leaves you more vulnerable. Where does that fit in with your assessment of the costing of it? Does it become a composite medical protection matter, or is it something that you should see as a pure business insurance issue?

[31] **Ms Davies:** I think that pharmacists in the community partnership should be treated exactly like any other NHS employee, and the same as pharmacists working in secondary care.

[32] **Mick Antoniw:** Okay, thank you.

[33] **Kirsty Williams:** We had such high hopes when the contract was renegotiated. We thought that the new contract would be the beginning of a revolution in the role of community pharmacies, and that we would, for the first time, really recognise them as part of the healthcare team. Your paper suggests that the opportunities that were afforded within the renegotiated contract simply have not been met, especially if you look at the poor take-up of locally enhanced services. It simply has not happened.

[34] Your paper talks about—depressingly, again—a significant gap between national policy intent and local interpretation and implementation of that policy. So, there is consensus, and a clear Government will about what community pharmacy should be doing, yet on the ground we do not see it happening. What three things could this committee recommend the Minister do so that we do not waste the next six years? Have you got an analysis of the opportunities that have been lost? Could you give us a sense of how patient care could be enhanced if we took the contract seriously and used it to its optimum? Also, with regard to independent prescribing by pharmacist, for instance, have you got any analysis at all of what that could mean? The Government makes great play of having greater access to GPs. If we had independent prescribing in pharmacies more comprehensively, what would that mean in terms of cost savings to GPs and the opportunity to free up time for GPs to see people they should be seeing but who cannot be dealt with in another sector? Frankly, I find it depressing.

[35] **Ms Davies:** A lot of questions. [*Laughter.*]

[36] **Kirsty Williams:** I will be quiet for the rest of the session. Do you want to deal with the policy issue first, Paul?

[37] **Mr Gimson:** I am just trying to think back to the first question.

[38] **Kirsty Williams:** What has gone wrong?

[39] **Mr Gimson:** I think you said that there was disappointment considering the sense of optimism at the start of the contract that it would develop a more enhanced role. That is a fair comment, in that there is a general sense of disappointment that that overall vision has not been achieved. That is borne out in the paper. Since then, what were the original intentions have been repeated in a lot of policy statements. What we have not seen to any large degree is that turned into delivery on the ground. In terms of the reasons, I would be speculating, if I am honest. I hope that this committee will uncover why that might be the case.

[40] **Kirsty Williams:** What are the solutions? What could we do?

9.45 a.m.

[41] **Mr Gimson:** There is no clear delivery plan. One of the things we mention is the need for a strategic vision or delivery plan to accompany a lot of the statements. Within the LHB, that has led to—I do not know whether it is confusion or that it is not clear about what is its responsibility to implement. We would like to see a clear message about how these intentions will be delivered.

[42] One of the things we have identified is that, at an LHB level, there is a lack of input into the planning process that takes into account pharmaceutical care. Often, we find ourselves at the end of a process asking where the pharmacy element is in how an LHB is tackling, say, diabetes—it just has not been considered in the process. Again, we could speculate on the reasons for that, but at the moment, there are no pharmacists on the boards of LHBs. As a rule, the pharmacists employed by LHBs are not at the executive level of management. Pharmacists are placed within the health professions forum, the professional advisory committee to the LHB, but exactly what they do is still unclear. So, their role—their opportunity—to feed into health planning is unclear to us. Do you want to add anything on that, Mair?

[43] **Ms Davies:** The other place where there are no pharmacists is on the national clinical forum. There is no pharmacy input on that. That is something that we would like the committee to note and, we hope, take forward. I think that the other questions you asked were about how patient care is enhanced. I have to go outside the country for examples, but the Scottish model of community pharmacy is really the policy intent that we have been discussing here. It is all there. I have been reading about how they developed the services in Scotland. On minor ailments services, they undertook two nationwide pilot schemes. These were successful, so they rolled them out nationally. We can send you examples of pilot schemes from every LHB in Wales on all services, but the roll-out is what is missing. Even if the results are good, these are just not rolled out. That is what is missing there. The Scottish model would be a good model for us to start with, to be perfectly honest. We can send details of that to the committee if you think it would be helpful in any way.

[44] In Wales, we have a huge opportunity in the NHS, because primary and secondary care are together under one umbrella. If you could just bring pharmaceutical care under the one umbrella, with the development of clinical networks with the patient—and patient safety in particular in the middle of this—it could really make a big difference to the delivery of national health services in Wales. The big change, if pharmacists, and particularly community pharmacists, were involved, with access to clinical specialist pharmacists in hospitals is, first, in adherence to medicines. The result of good adherence to medicines is, we would hope, a huge reduction in hospital admissions. There is evidence for that. However, how do you measure people not going into hospital? It is very difficult. How do you measure patient outcomes? It is very difficult. How do you measure the fact that people are now adhering when they were not before? Would they tell anyone? These are very difficult measures for us to give you evidence for.

[45] **Kirsty Williams:** On the issue of prescribing and people being able to collect a prescription medicine from the pharmacist for relatively minor conditions, such as eye infections or other minor infections, to save them going to the GP—thereby allowing the GP to concentrate on patients who really need their input—have you carried out any assessment of what that might mean for primary care?

[46] **Mr Gimson:** We have not done an assessment, but I think that, rather than the

independent prescribing, which we have mentioned elsewhere, you are talking about the use of pharmacists to treat minor ailments and acute conditions, which has been the policy intent right from the beginning. There are lots of different models out there, but the basic premise is that certain conditions do not necessarily need to be referred to other parts of the health service, such as GP surgeries, accident and emergency departments and the sexual health service, but can be addressed by pharmacies. We already see examples of this in some local health boards; for example, in Torfaen, if you need treatment for a minor ailment—I do not know what is on its list, but say thrush or something like that—you can go to the pharmacy to have that treatment, rather than having to go to the GP.

[47] The research that has been done shows that this approach can be effective if it is done right. It does not necessarily reduce capacity or the demand on one service, but it shifts that demand from one part of the NHS to another. I suppose that what we talk about a lot of the time is how we can shift that demand closer to the community. The worry is that the Torfaen example and the one at Neath Port Talbot will close down. So, we need the proper roll-out of these services so that they can be evaluated and we can measure their effect on capacity properly. It is a no-brainer that improving access for minor ailments through pharmacies is the way forward.

[48] **Darren Millar:** I have a supplementary question to Kirsty's question. Instinctively, I would support more prescribing by community pharmacists, but the one thing that holds me back from wanting to really wade in to say that this is absolutely the right direction is the fact that pharmacists are paid on the number of prescriptions that they dispense. So, if you are given more powers to dispense, and you are effectively writing a cheque for yourself each time you dispense, there will be a financial incentive for you to do so even if it may not be necessarily sensible with regard to treatment. How can there be safeguards in the system to prevent unnecessary prescriptions being written by pharmacists if this approach is used to a greater extent in the future?

[49] **Mr Gimson:** I suppose that the answer is in the question: it is really about how the service is designed. I do not want to keep harking back to Scotland, but it has a system that is not just based on quantity, but also on capitation. You need to look at the models that are out there. I take the point that there is a perverse incentive, but I think we can rely on the professionalism of the majority of pharmacists not to do that. However, it is about the design of the service. So, the Scottish system is based on capitation, and there are other schemes that tackle this for which we can provide examples. However, this is based on the payment model for how you prescribe and what you are paid for.

[50] **Darren Millar:** So, you would advocate significant changes to the payment model to disincentive inappropriate prescribing?

[51] **Mr Gimson:** What we have said here is that we would like to see a shift over time towards a model that is based on the clinical services provided, rather than on the sheer volume of services provided, with the caveat that the volume of the work must be supported.

[52] **William Graham:** I want to go back to one of the earlier questions about hard-to-reach groups. Some years ago, the Social Justice and Regeneration Committee of this Assembly made some recommendations, particularly with regard to the treatment of addicts. It seemed to us as a committee that it was wrong that when you go in for your treatment, you have to have it supervised by the pharmacist—to take methadone in an open shop is not a good idea. There are few pharmacies in my area that have private consultation rooms. What is your view as a society on that?

[53] **Mr Gimson:** I do not know the exact figure by heart, but I think that over 80 per cent now have a consultation room. I can get you the exact figure. I hope that that situation has



changed since then.

[54] **William Graham:** So, you are confident that 80 per cent of all pharmacies now have a consultation room?

[55] **Mr Gimson:** That may not be the exact figure, but I am confident that the majority do.

[56] **William Graham:** What about those that do not?

[57] **Mr Gimson:** If you look at the curve, you will see that it is on the increase. We will reach a point where everyone will have one.

[58] **William Graham:** Are you making that recommendation to your members?

[59] **Mr Gimson:** We would recommend that, if they wanted to provide clinical services, they must have the right facilities.

[60] **Lindsay Whittle:** I would like to ask about the consistency of local health boards' commissioning work across Wales. I do not want to be parochial, because we should not be. Are you finding that there are shortfalls, with the hard-to-reach or unhealthier areas of population not getting enhanced services? Are all the health boards commissioning fairly across Wales? My next question is on medicine use reviews. My pharmacy has a private consultation room, and I have recently had a medicine use review. Are you finding any animosity between GPs and pharmacists? When I went back to my GP to say that I had this review, and that the pharmacist suggested looking at the blood pressure tablets that I take, the GP was quite cross—

[61] **Kirsty Williams:** Perish the thought.

[62] **Lindsay Whittle:** Yes, it was all the pressure from the Liberal Democrats.

[63] They were quite cross because they were the GP surgery, not the pharmacists. I accept the advice from both, as they are professional people in medicine.

[64] **Mr Gimson:** I will answer the first question, and Mair will answer the second. Regarding consistency, the answer is 'no'; there is no consistency.

[65] **Lindsay Whittle:** Do you think that there should be?

[66] **Mr Gimson:** Yes, absolutely. One issue is that the commissioning of enhanced services is low, and, not only that, it is a patch-work. So, for example, when using the old model, some of the well-established services, such as smoking cessation, are done in about 15 or 16 of the former LHB areas—apologies, I do not know the exact number. So, it seems hard to justify why the service is in most LHBs, but not in all of them. The minor ailments service, for example, is only in one part of one LHB. So, there is a lot of inconsistency. That is why we have called consistently for better use of pharmaceutical needs assessments, so that, when LHBs plan for the healthcare needs of their population, they consider properly the pharmaceutical needs of the population. Another example is the substance misuse services that were alluded to earlier. It is a service that is based on pharmaceutical needs, but it is not necessarily needed everywhere. If there is a national framework in place, you could assess where the local need is. That is what we are calling for with pharmacists. So, when a need is identified, that service would then be provided. The simple answer is that there is no consistency.

[67] **Lindsay Whittle:** That is something that we need to highlight to the appropriate Minister, obviously.

[68] **Ms Davies:** Just to confirm, was your question about MURs about the relationship with the GP?

[69] **Lindsay Whittle:** It just seemed that there was some small feeling of animosity. They are both next door to each other and I get a good service from both.

[70] **Ms Davies:** That has been recognised. I do not know whether you are aware of the recent joint statement between the Royal College of General Practitioners and the Royal Pharmaceutical Society.

[71] **Lindsay Whittle:** No, I am not.

[72] **Ms Davies:** We could send you a copy of the statement. It contains 62 statements, so I will not go through them all today. It is about collaborative partnerships. It is about the need for all healthcare professionals, particularly GPs and community pharmacists, to work together and to develop partnerships. There needs to be facilitation at an LHB level for this to work. They also need to consider the contracts, the expertise and who should do what role. At the moment, they seem to be in competition rather than working for the benefit of the patient. So, it is a problem that we are aware of. There has been some quite robust research, which the National Pharmacy Association was involved in, showing the need for GPs and community pharmacists to work much closer together with MURs. The way forward is going to be targeted MURs, but there must be collaboration with the GPs for this to work. We do not want pharmacists saying one thing and GPs saying another. They really need to be singing from the same hymn sheet, and the patient should be in the middle.

10.00 a.m.

[73] **Elin Jones:** One of my questions leads on from that and it is on the effective development of the MURs. I was reading your vision in annex A, and the success of the implementation of that vision depends, to an extent, on access to information and sharing of information between the GP and the pharmacist and for that sharing of information to happen electronically. You have referred to that already this morning and it is also in your written evidence, as is the fact that the lack of sharing of information and the use of IT detracts from your ability to develop this pharmacy service. I am interested in what level of sharing of information you require. Do you see all patient information being shared with the local pharmacist, or would it only be on a particular prescription? How would that work? How do you see that electronic system working? Would it be through a wholly integrated IT system between GPs and pharmacists? I can see that being problematic, given the complexities of the relationships between different GPs and so on. Perhaps you could further outline how you see the level of information, the development potential and any pitfalls on the development of IT information sharing.

[74] On a completely different subject, I do not think that you have referred to this in your evidence, but we will be hearing evidence later from Community Pharmacy Wales, and it has referred to the role of pharmacies in flu vaccination. The role of the provision of vaccinations through pharmacies was raised by the previous Minister's task and finish group, and some work has been done to develop these schemes, although it has not been implemented anywhere in Wales, as yet. Do you have views on the role of community pharmacies and pharmacists in flu vaccination in areas where targets are not being met currently?

[75] **Ms Davies:** I will take the first part of the first question about what sort of

information we need and maybe give an example of why we need it and what level we need in community pharmacy. The first thing that we have to do is a clinical check on a script. To take an example, if a script comes through for an angiotensin-converting enzyme inhibitor, this is a drug that is used to treat hypertension and atrial fibrillation, but we do not know what the diagnosis is. So, can we check that the dose is right without that information? We might need to know some of the biochemical information and some results before we can decide. We do not have that information. The clinical pharmacist in a hospital has all that information, so the clinical check that they do is safe. That is why we need that information. Paul will talk about how.

[76] **Mr Gimson:** To go on from what Mair said, this is not a call for full, in-depth access to every detail of a patient's medical history. It is about access to the information that we need—some basic diagnostic information, blood tests and so on. It is also about the ability of the pharmacist to share the information that they have, because, often, the most accurate record of what a patient has taken is held in a pharmacy, because that is where they pick it up.

[77] 'How' is similar, without getting into the technical details. For example, I think that it is happening in Gwent; they have a portal where that essential information is held so that, in emergency situations, anyone in the NHS can access that information. That already exists. So, it is quite achievable. It is about having that central clinical portal where the basic, but essential, information is held. In developing anything like that, there will be all sorts of questions for us about confidentiality consent and so on, but one thing that pharmacists have taken part in over the last year is a round of information governance checks, which is a process whereby we are ensuring that all pharmacists are complying with all relevant confidentiality legislation and best practice, so that, when this hopefully comes into place, they are fully equipped to use that information in a way that the patients can trust. One of the elements of this is that we need to convince patients that we are sharing their information in their best interests.

[78] **Elin Jones:** So, you would see this working only with patients with chronic conditions. You do not envisage access to information on all patients in a GP's surgery.

[79] **Mr Gimson:** You would have a system whereby you would only have access to the information that you needed to treat a particular patient. I would not be able to type in, 'Elin Jones', and find out all about you.

[80] **Elin Jones:** No, I would not want that.

[81] **Mr Gimson:** I would envisage that it would mostly be based around chronic conditions. One of the things that we have talked about is the enhanced role of pharmacists in the management of chronic conditions; we can only do that if we have access to this information. It would be quite patient-specific.

[82] Your second question was on flu vaccinations. The general picture here is that, over the last few years, the role of pharmacists in giving flu vaccinations has grown, and it now quite a well-established service that lots of pharmacies offer. However, it is mostly a private service. There are examples around the country of pharmacists providing that within the NHS as well. If you look at the uptake figures, I think that the national target is 60 or 70 per cent. There are criteria for people who should have a flu jab—people with chronic conditions, essentially, who are vulnerable and have a greater risk of dying if they get the flu. There is target to reach about 60 per cent of these people, and, in Wales, we fell short of that target last year. So, one of the things that we proposed was a scheme whereby the pharmacy offered vaccinations. This goes back to the point about people who are hard to reach. We started to look at why certain groups were not accessing this service through their

GP—for example, it might be people with chronic conditions who also work. Not everyone with a chronic condition is 80 years old and based at home; there are people in their 40s and 50s with asthma who work every day, and who appreciate the convenience of getting the service through a pharmacy. They are the sort of people who are paying for the service. The scheme helped to bridge that gap, and to make use of pharmacists' accessibility in the community—but it has not happened yet.

[83] **Elin Jones:** Can you give a reason as to why it has not happened?

[84] **Ms Davies:** It goes back to the joint working, and bringing the contracts together. We need to be working together for the benefit of the patient, not to individual contracts.

[85] **Vaughan Gething:** Going back to the point about IT, you say that you would only want access to the information that you need, but how do you determine what that is, and how do you streamline the system to provide the information that you need? To me, that sounds easy to say but complex to deliver. Have you thought about how you could do that, and what sort of IT investment you are talking about? I am not so much interested in hardware as numbers—how much you would need, and where. Where would that money come from?

[86] **Ms Davies:** The Scottish model delivers what is needed there. I do not have details of how it does that, but I am sure that we can send that on to the committee. It supplies what is required.

[87] **Mr Gimson:** It will be interesting to see how it pans out north of the border, because they have said that pharmacists will have access to this information within two years. So it is happening in Britain already. You make a very good point—how do you filter the information through the system? There has to be an element of trust here. Pharmacists are registered healthcare professionals, and would only be accessing the information that they need. That is part of the reason why we can demonstrate that trust through the information governance work. Again, it is already happening—the shared clinical portal that is being developed is starting to be populated with that level of basic information, which has been assessed as meeting most needs.

[88] **Vaughan Gething:** What sort of level of investment are you talking about to deliver that in a consistent way?

[89] **Mr Gimson:** I do not know the answer to that, I am sorry.

[90] **Vaughan Gething:** It would be helpful if we could have an idea of that, rather than your recommending that we do this without knowing how much it would cost, or how it would be delivered.

[91] **Mr Gimson:** There are committees looking at that kind of thing. This is not a new idea. It has been considered and is on the table. I suspect that some of the committees—including the NHS Wales Informatics Service—could probably give you some indication on that, and I could follow that up.

[92] **Kirsty Williams:** Chair, given the fact that there has been a great deal of emphasis in this evidence session on the Scottish model—and I am grateful for the offer to send more information on that—would it be possible to have a video conference with someone in the Scottish Government or the equivalent organisation to this one in Scotland to hear how it is working in there? It seems to me that if they can find the answer to some of these very important issues in Scotland, it is not beyond the wit of the Welsh to do something similar.

[93] **Mark Drakeford:** That is a very useful suggestion. However, shall we get the information that we have been offered first? We can look at it and then, if we feel that we want to pursue it via a video conference, we could do that. However, let us get the information first and have a chance to look at it.

[94] **Vaughan Gething:** Going back to the point about primary care delivery, I expect that, within lots of the different things that we do, people say, 'The health system could be better for patients and you would save money, if only you would let us do more', but then people go on to blame health boards and GPs for that not happening. I am interested in where you are now with GP bodies. You say that you have a joint statement with the Royal College of General Practitioners. Where are you in terms of reaching agreement on that sharing of roles? That is obviously important. You ask for greater clinical freedom, but that really will not happen unless GPs are on board. Where are you now, and can you give us an indication as to why that has not happened before, given that you are very clear in your evidence that there is a very clear message on policy intention from the Government but that that is not being delivered?

[95] **Mr Gimson:** On where we are now, specifically, this is why a great deal of work has been done by the Pharmaceutical Society and the RCGP to issue this joint statement. It is quite a watershed, because the two professional bodies for the organisations have recognised that this is a big issue and are now looking for ways to solve it. That is the stage that we are at now. We have the agreement to work together, and we are now trying to work through the practicalities of that. In Wales, we have met the RCGP Cymru to have exactly the same discussions. So, we are now at the stage of trying to work through exactly what you have referred to, namely what the implications of this are and how we can take it forward. I cannot give you any more information than that, because we are at the stage of discussing it. The answer is that we are not quite sure. The intent is that the two professions will work much more closely together. There is still that gulf because the two contracts just do not meet and, in many ways, actually compete with each other.

[96] **Vaughan Gething:** That brings me to my final point. How much of a barrier are the different contracts? In some of your evidence, it does not appear that you are saying that the contract of pharmacists is a problem, necessarily; you are saying that, actually, the opportunities that exist have not been taken up. That appears to be a problem not with the contract itself, but with how your service is managed and the practical agreements with other primary healthcare professionals. Is that a fair summary?

[97] **Ms Davies:** Yes, I think it is. Earlier, we identified and commented on some of the solutions. On working with the RCGP, we have identified that there is a problem and there have been some suggestions for solutions. We are at a very early stage. We hope that we will be working with it quite closely.

[98] **Vaughan Gething:** When was the statement issued?

[99] **Ms Davies:** It was issued a month ago; it is that new.

[100] **Darren Millar:** My question is about the regulations in Wales compared with those in other parts of the UK. You have already made some comment on your perception that there is increased bureaucracy. One of the frustrations that has certainly been evident in my constituency—and I am sure that it is the case elsewhere—is that, when a request is made for a new pharmacy to be established that would be more convenient for patients, and patients want it, it is stifled by the system in Wales, where permission has to be granted by the LHB. Then there can be appeals, as there have been in my constituency, which have held things up for more than two years now. What is your view on the regulatory framework in Wales compared to that in other parts of the UK, particularly England, where the system

seems to be more fluid and certainly allows more competition?

10.15 a.m.

[101] **Mr Gimson:** I think that you are referring to the pharmaceutical regulations that govern where a pharmacy can be placed.

[102] **Darren Millar:** Yes.

[103] **Mr Gimson:** They are incredibly complicated. They have delivered, on the whole, quite a stable network in Wales. We have, I think, 708 contracts that are distributed as we would have put them, had we had a choice, excepting that there are one or two areas where there is a problem. Neither of us is an expert on the detail of the regulations, but we would like to see a system that is simpler, more streamlined, more transparent in terms of the deadlines—you mentioned that these appeals have taken two years—but also one that is linked to pharmaceutical need, so that, when decisions are being made about contracts and the services that are provided in certain areas, it is linked quite clearly in the regulations to what that locality needs. That is in there already, to a certain extent, and perhaps that is one part of it that could be strengthened. I do not know much about what goes on over the border. I know that there is a similar set of regulations, but there are some loopholes within those regulations that allow new entrants to the system. I honestly could not say whether that is good or bad for the patient.

[104] **Darren Millar:** Some of the issues also relate to the relocation of a pharmacy within a town, which, once again, can be awkward and difficult to deliver. If a GP surgery or medical centre closes and relocates, it may be convenient for patients and everyone else if the pharmacy relocates, but that does not tend to happen in a streamlined way.

[105] **Mr Gimson:** As I said, this is complicated and I would not pretend to understand some of the vagaries that you have talked about. However, once again, even the way in which people apply to move is set out in regulations and it needs to be more closely linked to pharmaceutical need.

[106] **Darren Millar:** So, you think that there needs to be a much clearer time frame on the decision-making process?

[107] **Mr Gimson:** Yes. The administration needs to be tidied up to make it simpler and there needs to be clearer timescales so that the people involved know when they can expect decisions. I am not sure whether we included this in our submission, but one issue is the expertise and the resources that are available to local health boards and to the civil service to deal with these situations. As far as I know, virtually every decision ends up going to appeal to the Welsh Government. A system that always ends in a high-level appeal seems a bit complicated.

[108] **Darren Millar:** You have made reference to the absence of community pharmacy representation on LHBs; do you think that that is contributing to the fact that these things are sometimes an afterthought? When a request comes through from a GP practice to relocate, for example, should it not automatically trigger a discussion on whether a pharmacy may need to relocate as a result? These things do not seem to work in parallel; they tend to happen one after the other, which can then cause significant inconvenience for patients.

[109] **Ms Davies:** I am no expert on regulations, so I was not going to comment, but I will say that the principle of the regulations should be that every patient in Wales should have access to pharmaceutical care. I will not comment on the regulations themselves, as that is a matter for the experts.

[110] **Mr Gimson:** There is a lack of expertise around the nuances of how the contracts line up. Sometimes, some of the decisions do not take the regulations into account. For example, planning new health services and assuming that you can put a pharmacy in place there without understanding that you cannot do so suggests that there is a level of expertise missing somewhere along the line.

[111] **Lynne Neagle:** I have three questions. The first relates to repeat dispensing, which you say in your evidence is the only essential service that it has been difficult to establish. It is worrying if there are essential services that have not been fully rolled out. It does not bode well for the enhanced services. You have alluded to problems with GPs, but, as it is obviously working in some areas, could you say a little more about why it is working in some places but not in others? You have been quite emphatic about the role of the LHB as being key to the failure to enhance the role of pharmacies. However, is there any evidence of pharmacists not wanting to engage in enhanced services?

[112] My final point was on the joint statement, which is very welcome. However, why has it taken until now, when we are six years in, to have such a joint statement? I would be interested to know what the impetus was for that statement, and whether or not you feel that the Welsh Government is doing enough to encourage the joint working that is so critical to underpin the success of all this.

[113] **Ms Davies:** On repeat dispensing, it is the same problem over and over again, in that collaborative working between GPs and community pharmacists has just not been happening and there is no facilitation by the LHB to make it work.

[114] **Lynne Neagle:** Why does it work in some areas? What are the agencies doing in some areas that is missing in others, because it seems to be a fairly fundamental element of all this?

[115] **Ms Davies:** I am not an expert on LHBs and I do not work in one, but I can say that where it has worked, it has been because there has been facilitation by LHB staff to make it work. I do not know if that is an expert opinion; it is just what I have seen in practice.

[116] **Mr Gimson:** It is a combination of local enthusiasm, where the GP or pharmacist has been keen to take this forward, supported by facilitation from the health board. It is the usual picture. It was successful in Bristol because there was also a financial incentive to the GPs. It is one of those services that requires initial investment in time and effort to set up, so you have to get over that hump to get the benefits.

[117] **Ms Davies:** The second question was about LHB engagement and whether pharmacists did not want to engage.

[118] **Lynne Neagle:** The question was on whether it is not just about the LHBs, but whether there are pharmacists who may not want to engage in enhanced services who may be a factor in all of this.

[119] **Ms Davies:** I have no knowledge on that; I do not think that we would know that information. It has not come to us in any way, so it is not a question that we can answer. Personally, I have found that people want to take on these services.

[120] I think that your last question was about the statement with the RCGP.

[121] **Mr Gimson:** The impetus for that came from our society. Before we split a year ago, without going into the history, we were a joint regulatory and professional body. One of the

issues was that that focus on regulation distracted the organisation from a focus on professional leadership. Before that split, some of the big issues facing our profession were looked at, and one of those big issues was the relationship with the GP, so we kicked off that work and went to the GPs.

[122] **Lynne Neagle:** Do you have a view on how Government can firm all of this up if this statement does not do the business?

[123] **Mr Gimson:** As I said, we tried deliberately not to point fingers, so I would not want to point a finger of blame at LHBs or the Government; it is a mix of everything. In the same way that the Government has given a policy intent but not an outline of delivery, it has also not looked at the barriers to implementation when issuing policy or at what barriers must be addressed. If you are going to manage chronic conditions in the community, you have to address the issue of how community pharmacists and GPs will work together for the benefit of that patient. It is that middle bit—the planning for the delivery—that has not happened. I am not sure where the blame for that sits.

[124] **Mark Drakeford:** Thank you very much. There will be a chance for you in a moment to come back to us with any final points that you would like to make, or to make sure that we have heard the key things that you think you want to say. I want to pick up on one question that ties a few things together from the questions that we have already had. Rebecca began by asking you a question about your evidence on reaching hard-to-reach groups. Do you believe that community pharmacists are immune from the inverse care law? Is it not the case that, just as with other health professions, services are weakest where need is greatest? If that is the case, how do you match it with the assertion that pharmacists are best placed to reach people who are not reached by other parts of the system?

[125] There has been a series of questions from around the table about consistency. May I ask you one more time the question that Lynne asked you a couple of times, namely: is not one of the problems with consistency in this field that community pharmacists are not consistent? Given that you have 708 around Wales, it would hardly be surprising to find that some are forward-thinking and professionally alert and that, in other places, some pharmacists are relatively content to sell cards and cosmetics and do a bit of pharmacy along with that. If there were to be a shift of services towards pharmacists, what confidence could the committee have that the profession is in a sufficiently robust condition to ensure that those new services would be delivered consistently in all parts of Wales?

[126] **Mr Gimson:** Two nice, easy ones to finish on. [*Laughter.*] I do not know the answer to the inverse care law one, but this is why we have talked about a pharmaceutical needs assessment, because if you assess what is needed in a community, you can plan services to deliver it. I would reinforce the point we made about the proper planning of services based on what is needed in the area.

[127] **Ms Davies:** I can answer the consistency one. The one thing that we have achieved very well in Wales is harmonisation of accreditation and training for pharmacists for enhanced services. So, within that framework, we can say that there will be consistency, because there is one service, one training and one accreditation for all of Wales.

[128] **Mark Drakeford:** Thank you very much for both those answers. We have two minutes if there are any final summing-up points that you want to ensure that we take away from the evidence that you have given to us.

[129] **Ms Davies:** Thank you for offering us this opportunity to contribute to the inquiry. We will forward the details of the Scottish contract and the joint statement for the RCGP to you. If there is anything else that I have missed, please let me know.



[130] Community pharmacy is an asset to the NHS and to all the people of Wales. Community pharmacists' expertise is in medicines, and this expertise is available to the public and the community. There is potential for them to use this expertise and accessibility to do so much more. The community pharmacy contractual framework should be better utilised to improve health by allowing community pharmacists to take more responsibility for the pharmaceutical care of their patients. Pharmaceutical care should feature more prominently in LHB planning with a bold and innovative approach taken to using models of care that include community pharmacy. The RPS calls for clinical networks of pharmaceutical care to be developed that facilitate a shift of services from hospitals to community settings. Welsh Government policy intent has always been positive, but there is a huge gap between policy intent and delivery, the reasons for which we hope that this inquiry will uncover and address. The RPS wants to make Wales and Britain the safest place in the world to take medicines. If we develop services that improve medicines management and allow community pharmacists to spend more time consulting with patients face to face, monitoring and advising them on medicine use and self-care, then we could move a step closer to that vision in Wales. We hope that that possibility excites you as much as it does us.

[131] **Mark Drakeford:** Diolch yn fawr am fod yn bresennol y bore yma. Yr ydym wedi mwynhau'r sesiwn a dysgu llawer o bethau hefyd. Ar ôl y cyfarfod, byddwch yn cael trawsgrifiad o'r dystiolaeth i chi gywiro unrhyw wallau ffeithiol. Diolch yn fawr am fod yma.

**Mark Drakeford:** Thank you for your attendance this morning. We have enjoyed this session and learned many things as well. Following the meeting, a transcript of the evidence will be sent to you for you to correct any factual errors. Thank you very much for your attendance.

*Gohiriwyd y cyfarfod rhwng 10.29 a.m. a 10.33 a.m.  
The meeting adjourned between 10.29 a.m. and 10.33 a.m.*

**Ymchwiliad i'r Cyfraniad a wneir gan Fferyllfeydd Cymunedol i  
Wasanaethau Iechyd yng Nghymru—Tystiolaeth gan Fferylliaeth  
Gymunedol Cymru**

**Inquiry into the Contribution of Community Pharmacy to Health Services in  
Wales—Evidence from Community Pharmacy Wales**

[132] **Mark Drakeford:** Hoffwn groesawu cynrychiolwyr Fferylliaeth Gymunedol Cymru, sef Russell Goodway, y prif weithredwr, Ian Cowan, y cadeirydd a Chris James, yr is-gadeirydd.

**Mark Drakeford:** I welcome the representatives of Community Pharmacy Wales, namely Russell Goodway, the chief executive, Ian Cowan, chair and Chris James, vice-chair.

[133] We have a few minutes for you to make a few opening remarks. All Members have seen the evidence that you have provided, but a brief introduction would be useful to lead us to our questions. Just before the end of the hour, my aim is to come back to you for any final statements that you wish to make, particularly if there are any issues that have not been raised that you want to ensure that Members take away from this session. I will be relying on you, Russell, to choreograph things a little. On the whole, it helps if there is a single answer to a question rather than three, so I will ask you to choose who will lead off on the responses. Rebecca has the first question.

[134] **Rebecca Evans:** I have a few questions about variation in provision across Wales. If community pharmacies were to play a greater role, how ready do you think they are for that work, not only in terms of where they are strongest, but where they are weakest? How

confident are you that the sector is fit for further responsibilities in all parts of Wales?

[135] **Mr Goodway:** Very confident. It is fair to say that the community pharmacy network has been tooling up its infrastructure in response to the 2005 contract, when there was a clear anticipation that a greater number of national health services would be delivered via the network. There is, therefore, a ready and willing partner across the network that is capable, with a skilled and highly trained workforce, with an infrastructure in place, in terms of its estate, and we are fairly confident that, if the NHS wanted to extend the contribution that community pharmacy could make, we could respond very quickly.

[136] **Mr James:** Over the past four or five years, pharmacists in Wales have done a lot in preparation for their new roles in terms of building consultation rooms, a lot of postgraduate training, and also the introduction of continuing professional development, which is monitored by the General Pharmaceutical Council. So, not only are pharmacists upskilling, but, at the same time, other pharmacy staff have also been upskilling for dispensing purposes, counter medicine sales and so on.

[137] **Rebecca Evans:** With that in mind, why is it that more than a quarter of all Welsh community pharmacies did not take part in the diabetes work that you reported in your evidence to the committee? Why is it that the figure for non-participation rises to 40 per cent in Pembrokeshire and Ceredigion?

[138] **Mr Goodway:** That is a difficult question to answer. We were very impressed that 75 per cent of the network actively participated in the campaign and went beyond what is required of them under the contract, because the public health campaigns that are part of the contractual requirements are basically awareness-raising campaigns—the odd poster or leaflet that you distribute to raise awareness of a particular issue among the population. We went further this time, simply because we wanted to demonstrate, with an evidence base, what type of contribution pharmacy could make in identifying people at risk of a particular condition. GPs have told us that they would like that to go further. For instance, with regard to diabetes, rather than the pharmacy just carrying out an assessment of a person's lifestyle, and whether they are overweight or not and so on, in order to ascertain whether or not they are a candidate for diabetes, GPs would like for the blood test to be taken in the pharmacy. Then, if there is an indication that the person has diabetes, they would be referred.

[139] **Mr James:** It is important to focus on the fact that, of the people who accessed this service, about 8.5 per cent were identified as high risk within pharmacies and were referred on to the appropriate places. That is one of the positives that came out of it.

[140] **Rebecca Evans:** Are there fewer locally enhanced services because pharmacists simply do not want to do them?

[141] **Mr Goodway:** No, it is, in the main, because they are not commissioned by health boards.

[142] **Mark Drakeford:** I offered you a chance to make opening remarks and then denied it to you immediately by plummeting straight into the questions. However, I have a very long list of people wanting to ask questions, so I will let the questions flow for a while and give you a little longer at the end in case you have any points to raise. The next three Members to ask questions are Darren, William and Kirsty, but everyone will have the opportunity to ask questions.

[143] **Darren Millar:** Thank you for the paper, which is very comprehensive. I appreciated the opportunity to have a read through it. One striking thing that you mention in your paper is the potential for significant savings to the public purse from using the community

pharmacy network in a better and more efficient way. You give a figure of £95 million as a potential saving. How did you arrive at that figure and how robust is it?

[144] **Mr Goodway:** We think that our figures are very robust, because they are based on research—academic research, research by think tanks and the like—and on our own experience on the ground. The most significant figure is that on medicines waste, which we took the opportunity last November to demonstrate by bringing one box for every day. We know that, every week, one of those boxes is filled by every pharmacy in Wales with returned medicines. The research states that the value of the medicines in the boxes is around about £4 million per month. That is only what is being returned to the pharmacies. That is not counting what people have at home in their medicine cabinet, what they put in the bin or what they put down the toilet; it is just what we see being returned to the pharmacy. I am not saying for one minute that you will save the entire £48 million, but let us just save half and it would be a massive contribution.

[145] It is not just about saving money; it is about releasing resources. With regard to the minor ailments issues, we are saying that there are people at the moment who are going to GP surgeries for a consultation on a minor ailment when they do not need to do so. Again, in dialogue with the British Medical Association, we have been told time and again that GPs do not want to see people who are well; they need to see people who are sick. Some people who have minor ailments, such as head lice or whatever, really do not need to see a doctor; they would be better off coming to a pharmacy. In places such as Torfaen, for example, where the service has been well used, it is valued by local GPs and by the health board. The problem is that the Wanless funding that was made available for it is no longer there, and of course there is competition for resources.

[146] **Darren Millar:** We heard evidence in the previous evidence session from the Royal Pharmaceutical Society that pilot schemes are often deemed to be successful but are then not rolled out. Why is there a reluctance to roll out successful pilot schemes in Wales, whereas successful pilot schemes have been rolled out north of the English border, in Scotland?

[147] **Mr Goodway:** I am not sure that there is a reluctance. I am encouraged by some of the evidence that has been presented to the committee by the health boards, which seem to be enthusiastic about the capacity of community pharmacy and what they would like to see community pharmacy doing. There is, however, a competition for resources and someone has to kick-start it. In England, where the schemes seem to be sustainable, there is an invest-to-save type of approach, whereby some money is put in upfront and then the saving or the resource is generated and goes through the system. We are saying that the Government's agenda is understood. We know, from 'Setting the Direction', Chris Jones's report, that the ambition is to reduce the demands upon the secondary or acute sector, to transfer services into the community and to have them delivered in the primary care sector. We have a massive role to play in that, but someone has to kick-start it. We do not believe, frankly, that we will be able to deliver that unless the existing infrastructure is sweated. We just think that community pharmacy is an under-utilised asset.

[148] **Darren Millar:** The pace of change has been different in Wales to that seen in England and Scotland. What is it about Wales that makes it more difficult to realise the changes that everyone wants to see? The Government has set out in its policy direction that it wants to see the changes that you are talking about, but that just does not seem to be happening. What is the barrier that is in the way?

[149] **Mr Goodway:** The situation in Scotland is very different and Ian can probably tell you more about that. Scotland has benefited from a highly ambitious and enthusiastic chief pharmaceutical officer, who put his stamp on where he wanted things to happen. I would not like you to think that all of England provides a model, because it does not. There are pockets

of good practice, for example in Hampshire and the Isle of Wight, but there are other parts of England where the commissioning of services is as poor as in parts of Wales.

[150] **Mr Cowan:** I will pick up on the minor ailments scheme in Scotland, which has been a long time in coming to fruition. It involved access for people who were registered at a local pharmacy to alleviate health inequalities. The people who were eligible for it were those who would not have paid prescription charges at any point, and people who had difficulty in accessing surgeries. The scheme gave them the freedom to go to the local pharmacy for self-limiting minor ailments for which they would necessarily have gone to the surgery to get a prescription. The big plus was that, in effect, pharmacists were prescribing from a list or formula. Under certain circumstances, they were able to prescribe what would have been prescription-only medicines, and to provide help for people who had conjunctivitis, for example, who could not access care at the weekend and would have gone to an accident and emergency department. Such conditions could be treated on a local basis. By providing healthcare in that way, they reduced the burden on accident and emergency departments on the weekend, and on surgeries during the week.

10.45 a.m.

[151] **Darren Millar:** Was there an issue in Scotland in terms of public education in order to encourage people to present to a pharmacy rather than their GP? We know that, even in areas of Wales where these services are available through a pharmacy, people will still go to their GP inappropriately.

[152] **Mr Cowan:** A publication was circulated in the media and within pharmacies on a standard format from the Scottish Government; it informed the public about who could access this service, how it could be accessed, and it encouraged people, in the initial stages, to register. That was the gateway: registration with a pharmacy. You could change your registration afterwards, but there was a publicity campaign from the Scottish Government saying that this was available across the whole estate in Scotland to those who were eligible.

[153] **William Graham:** Looking at your written evidence, I would like to draw you on the section where you say that,

[154] ‘CPW believes that the existing contractual arrangements in Wales are in danger of becoming a major barrier to enhancing the contribution of community pharmacy to health and wellbeing services’.

[155] Would you care to elaborate?

[156] **Mr Goodway:** The issue that we have is that the contract remains a Wales-and-England contract. In England, it is underpinned by a new set of regulations that were drawn up after 2005. In Wales, the framework is underpinned by the 1992 regulations, which have been amended from time to time. It is a struggle to accommodate the consequential changes that come out of the English contract within that Welsh framework.

[157] An example is what we are going through at the moment. The Department of Health at Whitehall negotiates with the pharmaceutical services negotiating committee, of which we are currently a constituent member. However, we are now told that the negotiation is for England only, and Department of Health officials make clear that the situation in Wales, and the consequential arrangements, are a matter for the Welsh Government and for CPW. However, the new service that is being rolled out in England from 1 October is a new medicine service. The Department of Health has agreed with PSNC that £55 million will be set aside to deliver that. The consequential funding for Wales is £3.6 million, but of course that is for delivering a service that the Welsh Government does not want to deliver—it wants

to do something else. That is fine, but it will not necessarily cost £3.6 million. What the Welsh Government wants to do may cost less or more, but because of the consequential, we have to somehow or other develop a service for that amount of money, and then make sure that it is underpinned within the existing regulatory framework. That is a huge challenge, particularly for the civil service machine working with pharmacy, which we believe is probably understaffed. We are better served now than we have ever been—the appointments that have been made in the last year have made an incredible difference to us—however, I have to say that we detect capacity issues, even within the legal services department that is bringing the regulations up to date. We would say that that is probably an important priority.

[158] **William Graham:** What are the obstacles to consolidating the Welsh pharmacy regulations?

[159] **Mr Goodway:** You would have to ask the Minister that question. It may just be a simple lack of capacity within the legal service. We would not necessarily advocate consolidating the existing regulations to be in line with England. There is an opportunity for us to get a clear understanding from Government of its aspirations for the community pharmacy network, and for the community pharmacy service in Wales. Once we have established that, we can put a regulatory framework around it that will make it happen. That is something that I would like to see. It could be that we will adopt the core framework of the English contract, so it may not be that ambitious. On the other hand, the Government may choose to look at what is happening in Scotland, or elsewhere, and adopt that sort of arrangement. However, we need a clear understanding of where the Government wants community pharmacy to be five or 10 years from now to ensure that the framework that underpins it drives the result.

[160] **Kirsty Williams:** Given that that is your view and that is what we need to make the opportunities presented by the renegotiated contract a reality, do you agree with the comments made by previous witnesses, who said that there was a sense of disappointment that the aspirations back in 2005 for this enhanced role have not been realised? If your answer is that the Government needs to have a strategic vision that is then underpinned by new regulations, are you disappointed that, in the Government's delivery programme that was published yesterday, there is no commitment to developing such a vision, and in the section regarding how it will know that its actions are on track to develop twenty-first century healthcare, pharmacy is not mentioned at all? There is not a single mention in that document. There are percentages on care plans for mental health care and for access to thrombolysis for stroke, and there are many things that will demonstrate whether we are making any progress, but pharmacy is not there.

[161] **Mr Goodway:** I am never disappointed by what the Government does; I am frustrated more than disappointed, I guess. I get frustrated—and you will understand where I am coming from—that this is the case despite there being a clear aspiration among politicians, and, in this case, there is an aspiration for community pharmacy that crosses the parties. Since I took up this role, all of the parties have told me clearly that they understand and acknowledge what community pharmacy can do and that they are ambitious to do it. I share the frustration when that does not happen on the ground.

[162] I genuinely believe that part of the problem is the contractual arrangements that exist, and we need to get a modern framework within which we can operate. However, more than that, we need a route map for delivering the Government's commitments. We were very appreciative that all of the parties captured community pharmacy commitments in their manifestoes. We were particularly impressed with the fact that there were five commitments within the governing party's programme for community pharmacy. We would now like to see a route map to make that happen, and we would like to work with the Government on that.

[163] If we get the framework and the route map, the third thing that we would like to see—and perhaps the committee could help by encouraging the Government to put the arrangements in place—is some sort of arena that will facilitate collaboration across primary care providers. That is not in place at the moment. There is no mechanism for ensuring that NHS services are delivered in the most cost-effective way by the appropriate provider. You have to deal with seven health boards that do things in different ways. Having some sort of national arrangement that would bring those providers together and a shared understanding of what each of us does best would provide a mechanism for improving the quality of services on the ground.

[164] **Lynne Neagle:** I want to pick up on the minor ailments service in Torfaen, which I am familiar with. You said in your evidence that the possible decommissioning of the service is due to the fact that the Wanless moneys have gone, and that the decision of the LHB is a matter of straight mathematics. Given that there are so few of these enhanced services, it is important that we understand the reasons for that. You said that the Cwmbran pharmacy generated savings of £10,800 in one year for the LHB, but what kind of investment has the LHB had to make, using the former Wanless moneys, to generate such savings? Do you have any figures on that?

[165] **Mr Goodway:** I am sorry, I do not, but perhaps I should because, as I said, we have been in active negotiation with Aneurin Bevan Local Health Board to try to persuade it not to decommission the service at this stage, particularly as there is a commitment in the Government's programme to have a national minor ailments scheme. However, the experience on the ground is that that service has been immensely valued by the public and by GPs. The health board would like to see it continue, but in the absence of any specific funding, they have concluded that doctors are being paid to do this within their arrangement, so they would have to use health board money twice.

[166] I say in our submission that if that is the case, perhaps we are paying doctors to do the wrong thing and that we need to shift the responsibility to release doctors. That is not to say that we want to take funding away from the doctors—we just have to find a way of releasing money. We think that the big saving would come from secondary care, if we could use our skills to keep people from going to hospital. The best way of improving hospital services is to stop people from going into them. We can contribute in a major way to preventing people from going into hospital.

[167] **Lynne Neagle:** I have two other questions. The first is on out-of-hours services. You said in your written evidence that the community pharmacy network is open seven days a week, 365 days a year and operates outside the hours of 9 a.m. to 5 p.m.. I must admit that, when I read that I found myself saying 'Really?', because that is certainly not the case in my experience of Valleys communities. The great strength of community pharmacy is its accessibility, but on a Sunday in a Valleys community it may be open for two hours in the morning, bus services do not run and there are low levels of car ownership. To what extent is that hindering the types of things that you mentioned about stopping people from going into hospital unnecessarily? Where would you say that the fault lies for that—is it the pharmacist or the LHB not commissioning sufficient out-of-hours provision for pharmacy?

[168] Finally, you said emphatically in response to Rebecca's question that it was because LHBs are not commissioning enhanced services, and that it was not the case that pharmacies do not want to run enhanced services. Do you have any data on that to share with the committee? Are there examples of pharmacists that have been desperate to run enhanced services but have been blocked by their LHBs?

[169] **Mr Goodway:** On your last question, CPW is surveying the contractor network at the

moment to see what provision of enhanced services exists, what they would like to do and what they feel is needed by the communities that they serve. I would be more than happy to share the results of that survey with the committee when they are available.

[170] You are right to say that the network is not perfect—not every pharmacy is open every day for extended hours. However, somewhere in the network is available at most times, if not at all times. You are right in saying that you may have to travel, and that it may be difficult for people in Valleys communities to get to a pharmacy. However, a pharmacy near a railway station will always be open at the time that commuters are going by. A pharmacy in a retail park will probably be open at weekends when the retail park is open. However, you are right that in particular communities, such as the Valleys, there are pockets where you would have to travel some distance to access out-of-hours pharmaceutical services.

[171] **Elin Jones:** Regarding the comments on flu vaccination in your paper, it seems that there is an aspiration that community pharmacies play a role in flu vaccination, especially for under 65s, where the targets are far from being met. You say that pilot proposals were withdrawn. What is the frustration in developing that service?

[172] In our previous evidence session, there was quite a bit of discussion about the frustration experienced in developing electronic information-sharing with GPs. This issue has not been highlighted in your evidence thus far. Do you have any views on how and to what extent information between GPs and community pharmacies can be shared, and whether that should be done for specific conditions such as chronic disease management or more generally? How can you place safeguards in that system to manage what is sensitive information?

11.00 a.m.

[173] **Mr Goodway:** I will ask Chris to deal with the issue of flu and Ian will deal with electronic transfer and information sharing.

[174] **Mr James:** I carried out about 100 flu vaccinations in my pharmacy last year as a private service. In Wales, we are not hitting the targets for flu vaccinations for those who are eligible and for susceptible groups. This is not about pharmacies taking over the service, because I do not think that pharmacies have the capacity to cope with it. It is, rather, a case of mopping up shortfall in those people who are not taking up free flu vaccinations on the NHS. It is also about the consequences of them then having the flu and becoming very ill and the consequences for the business community in Wales as well. The people who come under that category are under the age of 65 and are chronically ill but are still working. They find it difficult to fit in an appointment with a GP to have their flu vaccination. Like everything in modern life, people think that they will get around to doing it, but they never do. However, every month, these people are in the pharmacy collecting their repeat prescription. While they are there, they could take the opportunity to have a flu vaccination. The pharmacist could do it without an appointment, which they generally do. We are looking at mopping up those people for the Government to hit its target of 70 per cent coverage, which will hopefully reduce the impact of flu on health and commerce in Wales.

[175] **Elin Jones:** Why has that not happened?

[176] **Mr Goodway:** Do you mean in the pilot areas? We submitted our proposal for a community-pharmacy-based service because we were asked to do so by the Government. In January of this year, there was a meeting with the chief medical officer at which we rehearsed the poor take-up among the target and at-risk groups. The Government was looking for solutions to ensure that a poor take-up did not happen in the forthcoming season.

We submitted proposals to health boards where there are inequalities, such as Cwm Taf Local Health Board and Aneurin Bevan Local Health Board. We came forward with an offer to pilot a community-pharmacy-based scheme, particularly around GP surgeries where there was a poorer take-up. In the end, I think that communications issues between the various parties meant that the health boards withdrew the offer to pilot the services. At a recent meeting of the Welsh Pharmaceutical Committee, the chief pharmaceutical officer indicated that he is keen to ensure that there is a community-pharmacy-based service, if not this winter then the next. We will continue to work with the Government to ensure that that service is put in place. As Chris has said, we do not see us taking over the service from GPs—the network would not have the capacity to do that—but we can target those hard-to-reach people. We can ensure that we get to people in the under-65 age group in particular who are not taking up the service.

[177] **Kirsty Williams:** What kind of communication issues stop a solution that has been designed on the request of the Government? Call a spade a spade: what happened?

[178] **Mr Goodway:** You need to ask the health boards and the Minister. I was not party to the communication with other providers.

[179] **Mark Drakeford:** Thank you for that attempt at an explanation. We will move on to the second part of the question, on the electronic transfer of information.

[180] **Mr Cowan:** For some considerable time, it has been an aspiration of community pharmacy to share some patient information. I do not think that the aspiration is full clinical-record sharing, but it is becoming increasingly important that a summary should be shared with community pharmacy. This summary would detail the medication that a patient is on, with an outline of why they are on it. As you know, medications are becoming increasingly complex and are used for different disease states.

[181] If the pharmacist is going to be responsible for patient care, particularly in respect of patients with long-term conditions, it is important that the treatment is correct. As you know, there are drugs that become generic when the patent of the proprietary ends. Often, the generic drugs do not have the same licence as the proprietary. In order for the pharmacist to make the best economic use of the generic drug—and making savings on the health bill is an aspiration on which we would work with the Government—we need to know what the indications are for the drug. For instance, the patent recently ended for a drug to treat diabetes. The name of the drug is Pioglitazone. It is a drug used mainly in conjunction with other drugs, but the licence for it only allows it to be used for treatment in two cases. The pharmacist, when he receives a generic prescription for Pioglitazone, does not know the complete picture in terms of the condition of the patient and what medication has been provided. That is the sort of information that would help pharmacists decide upon the best treatment, in respect of patient safety.

[182] I appreciate that there is a considerable unquantified cost in this. Wales has an informatics service that is working very hard with pharmacies. I think that it is fair to say that Wales is at the forefront of electronic claims for enhanced services and electronic payments. We also receive electronic alerts, and I feel that this would be a natural progression in the field of healthcare.

[183] **Elin Jones:** How close are we to achieving that, in terms of the work that is being done and to which you just referred?

[184] **Mr Cowan:** It is a long-term plan, but at the moment, there is no process to allow community pharmacy access to a summary care record. Referring back to Scotland again, a chronic medications management system will be introduced there, and community



pharmacies will have access to summary care records. So, the process is there, as well as costings that can be looked at.

[185] **Mark Drakeford:** This is a topic that came up in our first evidence session, and Members are clearly interested in it. Looking at the clock, I think that we will have time for me to bring in everyone else who has a question and to come back to this topic. I just want to let you know that Lynne and Darren have both indicated that they want to ask questions on this topic too. Therefore, we will come back to it before the end. However, I want to make sure that everyone has a chance. I will bring Vaughan in next, then Lindsay, then Mick, and we will then return to this topic.

[186] **Vaughan Gething:** I am interested in two aspects of what you have said and what we have heard this morning. One aspect is contracts. You have been very clear in your evidence about a number of issues over which you are concerned and where you feel improvements could be made. However, this morning's evidence appeared to suggest that, while there are issues relating to the contract, the biggest issue was how the contract had been used and whether it had been used effectively. It was suggested that what you are able to do within the contract had not been delivered in practice, as opposed to the suggestion that the big problem was the terms of the contract itself. You have said here that there are problems with the contract. However, are you saying that the problem is the terms of the contract, or is it the way in which the terms are being used, which I suppose would take us into health service planning and delivery?

[187] **Mr Goodway:** I think that I am saying that it is both of those things. I would, just to cover everything, would I not? [*Laughter.*] It is clear that the current contractual framework would allow health boards, in particular, to enhance more community pharmacy services, if they chose to do so. However, there is a real problem in terms of developing a pattern of service delivery in Wales that is so different to the pattern in England and that will allow the integrity of the contract to remain. We have only started to have these sorts of discussions about how we pull such things together, in the last few months. I detect that Government officials are struggling to maintain the integrity of the contract, because at this point they do not want to move too far away from the English arrangement, and yet what is happening in England is not necessarily happening in Wales—justifiably so, because we have different healthcare needs. So, I think that it is both: there is a need to tidy-up the contractual arrangements, and, as I said earlier, before we do that, we need a discussion with politicians about what their ambitions are for a community pharmacy service in Wales, and to build a framework around it.

[188] There is an issue for politicians. I do not understand the relationship between Government and health boards. Silly old me thought that health boards were agents of the Government. In other words, I thought that they did as they were told. It does not seem to work that way. They seem to be able to have their own priorities and their own agendas, and that is frustrating sometimes. When we were going through an exercise to scope how we could roll out the Government's manifesto commitments, one official said, 'Well, we have our own priorities'. I thought, 'No, you don't; you work for the Government and the Government's priorities are your priorities'. So, I am confused about that and it would help to understand that relationship.

[189] **Vaughan Gething:** To go back to the word that you used earlier, it appears that you are not so much confused as frustrated. Looking at your evidence, you are quite strident in your criticism of some health boards and the way that they plan, or do not plan, provision. I am also interested in some of the points in the previous evidence about where the responsibility lies for rolling this out, because we have heard that there is a clear policy intention of wanting to have more people dealt with in primary care, and not in secondary care. That is understood. There does not seem to be any confusion about that, but it is not

being delivered.

[190] We have the health boards now, and I am interested in your relationship with health boards and to what extent you think that the dialogue with them does or does not work. If it does not work, I would like to know whether you have a view on why that is the case. Then there are the primary care providers, and, in particular, there are both oblique and more explicit criticisms of some GPs and their working practices. You talked earlier about having a dialogue with GPs. I am interested in how far advanced that dialogue is in delivering practically, and in this confluence between what you say pharmacists could do better to allow GPs to spend more time on what they should do best, and in what level of agreement there is on this. The Royal Pharmaceutical Society talked about an agreed joint statement with the Royal College of General Practitioners, but that is only in the last month, whereas the contract was issued six years ago.

[191] **Mr Goodway:** I think that it is fair to say—and these guys work at the coal face, as it were—that the relationship between GPs and pharmacists on the ground is very good. They rely on one another a lot to pick up on issues of patient care and safety. No-one wants to do anything to jeopardise that good working relationship. The issue of what the most cost-effective way of doing things is and who the most appropriate healthcare provider is has to be resolved on another level; the guys on the ground cannot resolve that, because there are contractual issues for the various providers.

[192] Also, you have to bring nurses into the picture, because if you develop community pharmacy services, it will not necessarily be a pharmacist who is employed to deliver them. There could be multidisciplinary teams in pharmacies that could carry out such things as vaccination services; you could have accredited health trainers that could help people with their lifestyle choices. So, it is not about placing demands on pharmacists per se, but using the infrastructure that already exists across Wales for multidisciplinary healthcare teams to engage with patients—there are 35 million visits to pharmacies a year—as they come through the door and to challenge them as to whether they are smokers, drink too much alcohol, or are too fat, and to offer screening services. It is about having a conversation. I have visited some of the healthy living pharmacies in Portsmouth in England and how people there have been trained to start a conversation with someone such as me and to ask, ‘Have you thought about losing weight?’ is something to see. The reply might be, ‘Well, I have thought about it a lot but it has never worked; when I have lost weight I have put it back on again’, and then those people can really help you to do those things.

11.15 a.m.

[193] You asked me about the relationship with the health boards. There is a model relationship with Betsi Cadwaladr University Local Health Board, for instance. It is a classic and good example in how it works with us to pilot and commission services. It is one of the few to have a good smoking cessation service. So, it is a really good model in Wales. It now has quit rates of around 46 per cent, which is as good as any of the other providers. Yet, in other health boards, you struggle to get them to commission a supply-only service.

[194] **Vaughan Gething:** Which health boards? I am interested in what works and what does not.

[195] **Mr Goodway:** Well, the easiest example to give you is that Hywel Dda Local Health Board does not commission any enhanced services.

[196] **Mr Cowan:** To give an example of a health board that is working closely with community pharmacies, in north Wales, where our practice is, an application for funding was made by Gwynedd council to the rural health fund, which allowed patients who were

suffering from stress and depression to access, in the community pharmacy, a cognitive behavioural therapy programme called 'Beating the Blues'. It is available in three rural pharmacies, and clients can come in and access it at will. It is supported by the health board and by the local GPs, who have referred some people to the service. They realise that they have on-site access to a healthcare professional who is trusted by the health board, the patient and the GP. That has been shown to allow people to access the service in their community in a non-invasive way. They do not have to travel to health centres to access it. It is proving positive, and that is the sort of collaboration that we can have. It is not all about supplying medication; it is about being an integral part of healthcare, and I think that this is a pilot scheme that will grow. That is how a forward-thinking health board can work with us as integral providers.

[197] **Vaughan Gething:** You talked earlier about the dialogue with GPs, and you mentioned an encounter with the BMA. You then said that relationships are good on the ground. However, in your evidence there is a comment about potential problems in some areas with GPs. I am interested in where that dialogue is at present between GPs and you as a body. There are two groups of healthcare professionals here who supposedly have a joint commitment to improving healthcare outcomes. I am interested in where that dialogue is and whether you have identified structural barriers, or whether the barriers are just personal barriers in each area, as to why services are not already working as you say that they could do.

[198] **Mr Goodway:** They are not personal barriers. As I say, with regard to such things as minor ailments, and even the Government's ambitions for health checks, dealing with the so-called 'worried well', and people who have chronic conditions, who, providing their condition is managed effectively, are not ill, but just have something that the effective use of medication can enable them to live with, GPs are upfront in saying that those people could be better looked after in a pharmacy environment rather than by having to go to see the GP all the time. It is just that, as we say in the submission, every time that you try to open up a dialogue with the health boards they say, 'We are already paying doctors to do that.' We will never move forward the Government's overall agenda of looking after more people in the community, thus releasing GPs and practice nurses to, say, do domiciliary visits for people who are being cared for at home, if, as is the case at the moment, the health board is paying them to syringe someone's ears. That is the point that we are trying to get across.

[199] **Mark Drakeford:** I want to try to ensure that we have enough time for questions from Lindsay and Mick, and then to go back briefly to the electronic record issue and to give you a chance to sum up at the end. We have approximately 10 minutes in which to do all that.

[200] **Lindsay Whittle:** I will be brief, Chair. I have heard a lot about Scotland. I canvassed for the Glasgow East by-election recently, where the average life expectancy for men is 58. As a 58-year-old, I felt quite near the end of my time. [*Laughter.*] I want to ask about the barriers. We have heard about good practice from the pharmacy community here in Wales—in Wrexham and Torfaen and in residential care in north Wales. I was going to ask what the barriers are to rolling out good practice, but I think that I am hearing the answer already. From what you say, Russell, the barriers seem to be the health boards themselves. You are right: they are answerable to this Government, and it is about time that we, as a committee, said to our Ministers—and I am sure that they will listen—that the health boards must now start answering to this committee and the people whom we represent.

[201] However, you yourselves have some part to play. As we heard in previous evidence, about 150 pharmacies in Wales do not have any private confidential facilities for dealing with even the minor ailments that can be embarrassing for some people. I do not have any embarrassing ailments—[*Laughter.*] I want that on record. However, I do not want to talk

about an embarrassing ailment at the counter in Asda or Sainsbury's—other supermarkets are available. [*Laughter.*] I do not want to talk about that in front of other people; I want it to be confidential. There are far too many people in surgeries in Wales wasting doctors' time, and waiting for possibly half an hour at a time, when they could walk into the pharmacy, as we have heard good evidence for today—great evidence in fact; well done—and be treated there and then. That is what we need.

[202] **Kirsty Williams:** There is nothing wrong with head lice. [*Laughter.*]

[203] **Lindsay Whittle:** I am sure that you speak from personal experience.

[204] **Mr Cowan:** Was that a statement?

[205] **Mark Drakeford:** The second question was to do with progress in relation to private consultation facilities.

[206] **Mr Goodway:** I think that Lindsay is correct that what we need in terms of removing the barriers is to get a route-map from Government through its agencies to engage with the whole primary care sector to identify how we can best deliver the menu of services available through the NHS in the primary sector. In response to the specific question about consultation rooms, the vast majority of the estate has private consultation rooms. Where they do not exist, very often, it is in rural communities or out-of-the-way communities, where sometimes the constraint is the premises themselves. It can be difficult to accommodate such a facility. However, again, if health boards really commissioned new services sustainably and consistently, that would justify additional investment in the premises. What needs to come first is the decision to say that we want these services provided across the estate, and then you will see the response from the contractors in investing in premises, and even moving premises, to create the facilities in which those services can be delivered.

[207] **Mick Antoniw:** It seems a prerequisite of all planning policy now that every street must have its own Asda or Tesco. One of the areas that I have serious concerns about is the extent to which these intensely commercial environments fit within the ethos of developing community pharmacy. All of us with kids have been at the counter—you ask quietly for the nit lotion and the woman shouts out: 'The gentleman wants some nit lotion'. I find it difficult to see how those environments are going to change and fit within your ethos. Do you have any particular concerns about that expansion and their capacity to almost control the market? How should that be regulated?

[208] **Mr Goodway:** We believe that, wherever pharmaceutical services are provided in the community, it should be in an environment that protects patient confidentiality, is patient-focused and ensures that the patient gets the best advice about the medication they are buying or getting on prescription. The issue is that Government overall in recent years has wanted to give people choice about where they access services. People talk about convenience. It is convenient to be able to go into a supermarket, pop your prescription in the pharmacy, go to do your shopping and pick it up on the way out.

[209] It really is an issue for Government to make its view on whether convenience is the driver or whether it is the quality of the environment, in that people should perhaps be in a more clinical environment when they receive these services and what services are commissioned from particular outlets. We cannot say that the Government has been wrong in giving people choice and making sure that they can access these services in the most convenient way. Supermarkets can offer that. In Wales, we have protected the service to some extent by not having the 100-hour pharmacies that are in England, where many supermarket chains have just used that as a vehicle to open a pharmacy by saying they are

going to be open 100 hours and therefore they get their applications granted. That does not happen here. You have to justify the desirability or necessity to provide that service in that locality.

[210] **Mick Antoniw:** With the growth comes the evaluation and quality control. From all the evidence that I have heard, there is the assumption that every pharmacist can do just about anything that is asked of them. However, we know from other professions that that is not necessarily the case. How do you envisage the growth of training and quality evaluation in pharmacies as responsibilities increase?

[211] **Mr James:** Taking flu vaccinations as an example, that is a service where we have to undertake further training over and above our normal qualifications. So, every year, we have to do a day's training on flu injection technique, and equally importantly, incorporated within that training is an element of first aid and anaphylaxis training, which the GPs and nurses have to do as well. You have to do that on an annual basis to be reaccredited in order to provide the flu vaccination service. So, a lot of the services require further training.

[212] **Mr Goodway:** Since taking up this role, I have been amazed at the training requirements for pharmacists, compared to other professionals. Every time there is a new patient group direction, you go through a training session to become accredited for that particular direction. That would not happen in law or accountancy. If there is a new accountancy standard, an accountant is assumed to be qualified to read it and implement it. The training requirements on pharmacists are very demanding and, sometimes, I think they get frustrated, justifiably. The infrastructure is in place. The Government funds training through the Wales Centre for Pharmacy Professional Education, and training programmes are offered across the country. Electronic training sessions are being developed now so that you can take them on the internet. There are specific training requirements for the emergency hormonal contraception service that was rolled out in April. If you have any fears about the quality and standard of professionalism in pharmacy, I think it is probably among the highest.

[213] **Mick Antoniw:** I think it is only because the papers we have seen seem to have little about quality evaluation, development and so on.

[214] **Mark Drakeford:** I said that we would come back to the issue of record sharing. Lynne and Darren have both indicated that they have specific questions. I will ask both Members to go through their questions and allow you one chance to deal with both.

[215] **Lynne Neagle:** In your example of a diabetes drug about which the pharmacist might have clinical safety concerns, what would they do now in that kind of situation? Would they pick up the phone to the surgery, or would they just dispense the script? How common is it for pharmacists to have clinical safety concerns about a GP's prescription.

[216] **Darren Millar:** I have a more general question. You were talking about having access to limited information about patients. Would you envisage that to be on the basis of registration with a pharmacy, as in Scotland, which I think you alluded to earlier? I, for one, would not be comfortable with every pharmacy in Wales having access to my prescription record. I am sure that most patients would feel the same. So, it would be on a registration basis?

11.30 a.m.

[217] **Mr Cowan:** I think that is certainly the way forward. It is not every person with every prescription. We are not looking for access to information about an acute patient coming in for an antibiotic to know their full clinical history, because we can find out,

through counselling the patient, if they are allergic to the antibiotic, for example. It is more appropriate in the case of people with long-term conditions. The acceptance is that, sometime in the future, if you are to manage those patients, to have pharmaceutical care of them, you will have to have registration. To go back to the situation that you just mentioned, on the specific drug, the consensus is that we would not use the generic, because that could put patients at risk and hinder savings to the Government.

[218] **Mark Drakeford:** We have covered an enormous amount of ground in an hour, and we have got through an awful lot of questions, and that is largely due to the focused way in which all three of you have responded to the questions that Members have asked. We are all grateful for that. There are a few minutes available now for any last remarks that you would like to make, drawing together any of the points that you think are important—particularly if there is anything you think we did not ask about that we should have on the record. Here is your chance.

[219] **Mr Goodway:** There is just one issue that has not been mentioned. I had been anticipating this question and practising my answer all week—a question from Darren about Abergele. I just wanted the committee to know that we have been working with Government on the control of entry regulations, and you should be aware that it is likely that a consultation document will be out towards the end of the year, which may address some of the issues that you have raised with me in the past.

[220] **Darren Millar:** If I could touch on that briefly in response, I did not want to labour the point, or go into detail on constituency issues, but we did raise this earlier with the royal society—

[221] **Mr Goodway:** What did they say?

[222] **Darren Millar:** They did not have strong views on the matter, but they did say that a clear timescale was the biggest issue that they wanted to see addressed. I am pleased to hear your evidence.

[223] **Mr Goodway:** We think that the proposals that we have been discussing with Government will address some of the concerns that you have raised with me in the past, but will also enable the quality of provision across Wales to be monitored and enhanced. Having said that, Chair, could I just thank you for giving us the opportunity to come and talk to you this morning? I do not want to leave you thinking that Community Pharmacy Wales believes that community pharmacy is a panacea for all of the challenges facing the NHS; we do not. We cannot do everything. However, we understand the Government's agenda, and in terms of delivering that agenda, community pharmacy can offer an existing infrastructure that will help to address the challenges. Government will find a willing partner in Community Pharmacy Wales, but we need to enhance the level of collaboration across the primary care providers so that we can develop a set of citizen-focused national health services that can be delivered in the most cost-effective way by the most appropriate healthcare provider. We hope that what we have submitted in writing and what we have contributed today will help you to explore how we can achieve just that.

[224] **Mark Drakeford:** Diolch yn fawr      **Mark Drakeford:** Thanks once again to all  
unwaith eto i chi i gyd am ddod y bore yma.      of you for coming here this morning.

[225] We will send a transcript of the session to you so that it can be checked for factual accuracy. Many thanks for your evidence, which we have all found very useful.

11.34 a.m.

**Ymchwiliad i Ofal Preswyl i Bobl Hŷn—Cyntuno'r Cylch Gorchwyl**  
**Inquiry into Residential Care for Older People—Agreement of Terms of Reference**

[226] **Mark Drakeford:** Mae un eitem ar ôl ar yr agenda i ni y bore yma; y bedwaredd eitem. Mae'r papur ar gael ar waelod y bwndel sydd gennych. **Mark Drakeford:** There is one final item on the agenda for us this morning; the fourth item. The paper is available at the bottom of the bundle that you have.

[227] I want to ensure that we are all content that the draft terms of reference cover all the things that we want this inquiry to deal with. Does anybody want to make any final observations on it?

[228] **Mick Antoniw:** I have a concern about one of the matters that we have discussed several times, namely the balance of provision between the private and public sectors. That is an issue, particularly in the light of the way in which the Southern Cross issue arose and is developing. So, there is a rough wedding in the balance of provision between the public and private sectors—the mixed economy balance within our care provision is an issue.

[229] **William Graham:** [*Inaudible.*]

[230] **Mark Drakeford:** The suggested terms of reference refer to alternative funding models, but you want to have a phrase in there to do with the balance of provision across the sectors.

[231] **Mick Antoniw:** Yes, it is about the balance, particularly in the public sector. There is reference to 'alternative', 'co-operative' and so on, but a significant amount of care provision remains within local authority jurisdictions and so on, so we need something that is more comprehensive.

[232] **Mark Drakeford:** That is in the spirit of what we talked about in the past. So, if you just want that to be slightly more explicit in the terms of reference, then we will make sure that it is. Is there anything else? I should not abuse my position now, because I have had a chance to look at the terms; I just want to make sure that we are confident that the terms of reference allow us to look at the journeys that people make to get into residential care, as well as what happens after they are through the door. We might have one more read to make sure that the terms of reference are clear on that. We are not just interested in what happens after the decision has already been made about residential care; we want to know how that decision came to be made.

[233] **William Graham:** I have one point on this, which, within the spirit of the terms, is probably covered. Is it worth hearing from those local authorities that have withdrawn from residential care in Wales to hear why they did it?

[234] **Mark Drakeford:** Yes. It would be a good idea to hear a contrasting experience—from those who continue to do it and those who have chosen not to continue.

[235] To make sure that people are clear about what happens next, I should say that we have already let interested parties in the sector know that there will be a two-week consultation period for external stakeholders so that they can comment on the terms of reference. We are trying to make it as clear as we can to people in the sector that what we are interested in is the narrow issue of whether the terms of reference do the job that we want them to do. We are not looking for them to send us all their evidence at this stage. Once we have those responses, the committee will have the job of signing off the final,

agreed terms of reference, and at that point, we will call for wider evidence. We will issue that call later this term.

[236] In terms of the balance of our work, at the last meeting, Members asked whether there was any further information from the Government on the legislative programme. We have made those enquiries and the response is that there is nothing more specific than what we know from the legislative programme statement. However, there is one thing that we have learned, which the committee will need to consider, albeit not today. We are hearing from the Government that its intention when publishing White Papers, rather than draft Bills, is for there to be a full 12-week consultation. According to the statement, the organ donation legislation will start as a White Paper, so we need to think whether we as a committee want to play a role at the White Paper stage. There is nothing in the Assembly's Standing Orders that provides a role for us, but nor is there anything that prevents us from taking part if we want to. I do not necessarily want to start the debate today, but it is an important thing for us to think through.

[237] **Darren Millar:** If we have a clear view during the White Paper consultation stage, would that then preclude us from taking a different view during the formal legislative scrutiny process? The reason I ask is that we have had a similar issue with the Public Accounts Committee.

[238] **Mark Drakeford:** That is a very good point that we will need to consider. My understanding is that the role that the committee would have in the formal Bill stage is preserved for us in Standing Orders, and we could exercise it to the full if we were to choose. This is part of a wider debate that we need to have about what role the committee might or might not most usefully play at the White Paper stage. It will come to us quite early on, so we will probably be the first committee to have a White Paper form of legislation to consider. So, that is what we have learnt on that.

[239] Next week, we have a session on Thursday in the morning, when we will be returning to the stroke services inquiry. In the afternoon, we have a session with the Commissioner for Older People in Wales to scrutinise her annual report. We will resume today's inquiry a fortnight from today. Diolch yn fawr.

*Daeth y cyfarfod i ben am 11.40 a.m.  
The meeting ended at 11.40 a.m.*