Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Cofnod y Trafodion
The Record of Proceedings

Y Pwyllgor Cyfrifon Cyhoeddus

The Public Accounts Committee

16/10/2017

Agenda'r Cyfarfod
Meeting Agenda

Trawsgrifiadau'r Pwyllgor
Committee Transcripts

Cynnwys
Contents

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Neil Hamilton Bywgraffiad|Biography	UKIP Cymru UKIP Wales
Vikki Howells Bywgraffiad|Biography	Llafur Labour
Rhianon Passmore Bywgraffiad|Biography	Llafur Labour
Nick Ramsay Bywgraffiad|Biography	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Committee Chair)

Eraill yn bresennol
Others in attendance

Dr Darren Chant	Meddygfa Teifi, Llandysul Teifi Surgery, Llandysul
Dr Alun Edwards	Meddygfa Tŷ Bryn, Caerffili Tŷ Bryn Surgery, Caerphilly
Andrew Evans	Prif Swyddog Fferyllol, Llywodraeth Cymru Chief Pharmaceutical Officer, Welsh Government
Dr Carwyn Jones	Meddygfa Furnace House, Caerfyrddin Furnace House Surgery, Carmarthen
Yr Athro/Professor Chris Jones	Dirprwy Brif Swyddog Meddygol, Llywodraeth Cymru Deputy Chief Medical Officer, Welsh Government
Eryl Smeethe	Fferyllydd ac Arweinydd Rhwydweithiau Gofal yn y Gymdogaeth Gogledd Torfaen, Bwrdd Iechyd Lleol Aneurin Bevan Pharmacist and Neighbourhood Care Networks Lead Torfaen North, Aneurin Bevan Local Health Board

Dave Thomas	Swyddfa Archwilio Cymru Wales Audit Office
Huw Vaughan Thomas	Archwilydd Cyffredinol Cymru Auditor General for Wales
Dr Alun Walters	Cyfarwyddwr Clinigol, Gwasanaethau Gofal Sylfaenol a Chymunedol, Bwrdd Iechyd Lleol Aneurin Bevan Clinical Director, Primary Care and Community Service, Aneurin Bevan Local Health Board

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

Claire Griffiths	Dirprwy Glerc Deputy Clerk
Meriel Singleton	Clerc Clerk

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

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

[1] **Nick Ramsay**: Can I welcome members of the committee to this afternoon's meeting of the Public Accounts Committee? Headsets are available in the room for translation and for sound amplification. Can Members please ensure that any devices are on silent? In the event of an emergency, follow the directions from the ushers. We've received two apologies today, from Lee Waters and from Mohammad Asghar. We have no substitutions. Do Members have any declarations of interest they wish to make? No. Okay.

14:01

Papurau i'w Nodi
Papers to Note

[2] **Nick Ramsay**: Item 2. Under papers to note, first of all there are the

minutes of the last meeting—pack pages 1 to 3. Happy to note the minutes? Rhianon.

[3] **Rhianon Passmore:** We did spend some time talking about the expenditure in terms of the corridor. It says here that the capacity review report is to be completed by the end of the year in terms of the new way of working. Have we got any further information as to what that means? Is it the end of the financial year? The end of the year proper?

[4] **Nick Ramsay:** Are we on page 2?

[5] **Rhianon Passmore:** Page 3.

[6] **Nick Ramsay:** Oh, the calendar—

[7] **Ms Griffiths:** It's the end of this calendar year that they're expecting to report on the new way of working.

[8] **Rhianon Passmore:** Okay, fine. Thank you, Chair.

[9] **Nick Ramsay:** Yes, we can clarify that, if necessary. Okay.

14:02

Rheoli Meddyginiaethau: Gohebiaeth
Medicines Management: Correspondence

[10] **Nick Ramsay:** Item 3 and our medicines management correspondence. The Royal College of General Practitioners have sent a detailed response to my letter of 27 July, and they agree that there is scope to improve local planning and that there is room for improvement regarding medication and in particular with patients in receipt of multiple medicines. They recognise there is a need to increase patient involvement in decision making around medication. The royal college further states that areas with electronic discharge from secondary care are advantageous but that the administration procedure can be improved and welcomes that the NHS delivery unit is looking at the safe transfer of information. Are we happy with that letter? Happy to note it? Good. Okay.

Rheoli Meddyginiaethau: Sesiwn Dystiolaeth—Grŵp Clwstwr Meddygon Teulu o Fwrdd Iechyd Lleol Hywel Dda
Medicines Management: Evidence Session—GP Cluster Group from Hywel Dda Local Health Board

[11] **Nick Ramsay:** Without further ado, item 4. Can I welcome our witnesses? During the visits that Members undertook in June, we heard about the work of GP cluster groups and the work that's being undertaken in some areas. We agreed at the time to hold evidence sessions with representatives from a couple of such groups to explore the work they have and plan to undertake on medicines management. That seems a long time ago now, back before the summer. But thank you for agreeing to be with us today; it's really helpful to the committee's work. Would you like to give your name, your position and your organisation for the Record of Proceedings?

[12] **Dr Chant:** I'm Darren Chant. I'm a GP in south Ceredigion in Teifi Surgery and the cluster lead for south Ceredigion.

[13] **Dr Jones:** I'm Carwyn Jones, a GP in Carmarthen and GP lead of Tywi Taf. So, it's a 56,000 population of eight practices from Llandovery down through Carmarthen town to Whitland and St Clears, just to give you some geographical knowledge.

[14] **Nick Ramsay:** Good. As I say, thank you for being with us today. We've got a fair number of questions for you, so I'll kick off without further ado with the first. Can I ask you what actions the clusters are taking to quantify, understand and reduce medicines wastage? Who wants to take that—Darren or Carwyn?

[15] **Dr Jones:** I'm happy to start. I'm glad that the committee are looking at this because, speaking as a GP of 30-odd years, it's an area where there is considerable room for improvement. With regard to the cluster pharmacists, some of them are secondary care pharmacists who are now working in primary care, and others have been community pharmacists who are now working in primary care. I think some of the comments that I've had from them is that they're now working at a much higher level of competence. In NHS Wales, we need people working and stretching themselves professionally. By working really at the coalface with GPs, they understand that there are ways of improving the patient experience and reducing wastage. It's a complicated avenue. I've seen some of the papers already,

and, of course, it's down to the individual, but the control is not there at the moment, and I think there's an opportunity, by these pharmacists working very collaboratively in the practice, that procedures and individual patients—. We could be far more efficient in terms of cost and quality.

[16] **Nick Ramsay**: And what sort of issues are being caused by non-standard pack sizes and prescribing durations?

[17] **Dr Jones**: Most GPs would say 12 repeats or three repeats, or one repeat, depending on the medication. So, if somebody's ordering it, you've got people on regular medication, you've got people on intermittent medication and you've got people on as-required medication. So, if you're asked, then, what medication you want, you may find a stage, even if patients have taken them with 100 per cent compliance, which is always debatable, but even if they've been very good, you will have a patient saying, 'Well, I'm running out of this now, but I might run out of that in 15 days,' and that would cause problems, so they'll say, 'I'll have them all.'

[18] There is a small issue with 28-day packs and 30-day packs, but that's not a big issue. The big issue is that when people are asked when they want their medication at one point in time, it's a bit more complicated than just giving them another month, and quite often they're doing this electronically—My Health Online and things like that are very good—but if you lose that interface, there's a danger that we all tick boxes, and there are more boxes to tick, and the procedure could carry on and actually be less efficient.

[19] **Nick Ramsay**: Do you want to come in, Darren, before I bring Rhianon in?

[20] **Dr Chant**: I think sometimes patients have a poor understanding of the medications that they're taking. They don't understand the repeat ordering system. They feel if they use the pharmacist as the first point of contact for ordering, they have to have everything that is on their list without really appreciating the costs of that medication that they're requesting. I think that, as practices develop, as we become more efficient in-house, we can train our admin staff to liaise better with the retail pharmacists so that it's only those medications that are actually needed on a monthly basis are on order. I have an example of that in my own practice, where we employ an admin assistant who handles the majority of our repeat prescribing, but she also works part-time for a local pharmacist. She has no conflict of interest, but she has a

better understanding of how the retail pharmacy service works.

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

[22] **Rhianon Passmore**: Thank you, Chair. With regard to the direction of travel around e-management, you mentioned that if we lose the interface it may become a tick-box exercise and, therefore, there would be potential, if I hear you correctly, for oversubscription. So, do you want to just explore that again or have I misinterpreted what you said? Are you talking about the interface with GP or pharmacy or—?

[23] **Dr Jones:** Yes, well, My Health Online—[*Inaudible*.] Even when you do ask the question, there is a tendency, 'Well, I'll have them anyway.' If you're doing that electronically, you're more likely to tick a box because, yes, you're on that medication, you'll need it. Although the process of getting the medication might be much easier, so there's no reason to do that, but, in my experience, people tend to tick boxes that are there. And I think with pharmacists having a quantity-based contract, it does cause difficulties. I'd much rather we think about them having the quality contract, including, for example—. We have a prescribing incentive scheme for GPs. Maybe we should have an incentive scheme for them not to dispense, so that would be driving quality rather than quantity.

[24] **Rhianon Passmore**: So, you would actually point to a perverse incentive, potentially, in terms of that quantitative prescribing? I mean, if you look at it quite calmly, coolly, it's in-built in the system, isn't it? So, from your statement, you would say that that needs to change to be qualitative?

[25] **Dr Jones:** I think it would, and I think I can understand, and, yes, of course, it's a quantitative contract. I'm not saying that—. A lot of the community pharmacists are fantastic and the process is now driven in a very patient centred way, which, again, is to be applauded, but they don't see the pharmacist. The vans deliver these medications now and, as we make it more electronic, well, we make it less personal and the issues of quality and professional advice to patients may be lost.

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

[27] **Nick Ramsay**: You said earlier, when you answered my first question, that it's an extremely difficult thing to get to grips with, and we've been talking about this in the committee now for a long time, and it was going on

long before I was Chair of this committee. Is there a light at the end of the tunnel here? Do you think that we will get to this ideal situation where it will be in balance, that the amount of drugs being prescribed at any point in time will work and that patients will understand fully repeat prescribing? Or is it not necessarily for them to understand if the prescribers have a better handle on it?

[28] **Dr Chant:** I think the patient has to have an understanding of the value of the medication that they're receiving. I think if somebody's ordering medication without any contact with another human being, then that medication may be meaningless to the patient. If they're questioned as to, 'Do you need this tablet this month or this inhaler this month, Mrs Jones?', I think that will focus the patient a little bit more as to whether the medication is needed, and it doesn't become purely a tick-box exercise. So, education and human contact, rather than automation.

[29] **Nick Ramsay:** Good. Neil Hamilton.

[30] **Neil Hamilton:** I suppose every patient has a review of medication from time to time in the year, so is there scope for using that process to tighten these things up? What do you think about that?

[31] **Dr Jones:** Yes. There's no doubt that one of the things—. We had a cluster pharmacist and she was so good that the practice now employs her. So, we've got a cluster pharmacist and a practice pharmacist, and she's certainly key. And when we talk about prudent health, GPs don't need to keep on doing these tasks, because they're professionally driven and professionally led, but I just need to know that that person's had his blood pressure checked or their diabetes is in good standing or whatever. I don't need to go through those; I need to spend time with the people whose chronic disease management does need my attention. And so, the pharmacist is now doing that for me.

[32] An example, again, last Friday, the pharmacist did about 40 of those interventions for me that morning, and I know that I would not have been able to allow—. I wouldn't have had time to do my afternoon visits before afternoon surgery had she not done that. So, I was able to give continuity of care and do an appropriate piece of work last Friday afternoon, because the two pharmacists—the cluster and the practice pharmacist—that morning had cleared these tasks, which needed professional knowledge, but they were doing cross-checks on the fact that this person might have seen my diabetic

nurse or my cardiac nurse, but the practice itself hadn't actually got it completely right and airtight, because we're all busy and we don't always update things as we should. But the medication review is critical. And, in the old days, I've said, 'Well, GPs need to do that'. Well, then nurses did it and now, I think pharmacists have got a great role in doing that.

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

[34] **Rhianon Passmore:** Obviously, that is in terms of the direction of travel we seem to be moving towards, and for good, sound reason. So, in terms of just the checks and balances, in terms of that patient care, if there is anything that they would like to flag up, could you just talk me through how, then, they would be forwarded to you for your assessment?

[35] **Dr Jones:** Yes. The pharmacist would use my electronic communication by way of Daybook. So, it would be on my tasks to do. She could say whether it's urgent today or whether I could do it when I have some time to catch up on my paperwork, but it would not be paperwork; it's electronically driven. So, she would, perhaps, give a month's supply and a message to me that I need to do something, or she would give that message to our administrator who would book an appointment for that person. So, it's all done electronically and she can make a professional judgment on when that needs to be done, 'It doesn't need to be done today', or, 'It needs to be done by' whom. It might not need to be done by me; it could be done by my diabetic specialist nurse. So, it's really working cohesively and appropriately. And because of the IT skills that we have in the practices, almost invariably this happens very smoothly.

[36] **Rhianon Passmore:** Okay, thank you.

[37] **Nick Ramsay:** Your turn to have the floor.

[38] **Rhianon Passmore:** Thank you. I think you've partially addressed some of my questions, but I'll address them to both of you. What actions are clusters taking to quantify, understand and reduce medicine wastage?

[39] **Dr Chant:** Within south Ceredigion, we employ two pharmacists as part of a frailty project, and they undertake medication reviews in far more detail than GPs possibly can do.

14:15

[40] Our own service, in the last quarter, identified £170,000-worth of potential savings using the NICE Sheffield costing model. That's the potential for savings if an adverse incident had happened as a result of prescription errors. In terms of the actual amount of medications saved in the quarter, that was limited to £1,200. In previous years, the pharmacists have saved us significantly more money in that they were undertaking detailed care reviews within the home and residential home settings, where they were seeing far more patients with complex needs. Our project has now extended out into seeing patients at home, where they are more vulnerable, and more at risk of significant interactions. But they see fewer patients as a result of going into homes, and therefore the actual amount of cost savings has reduced this year.

[41] As Dr Jones has said, the pharmacists work very well with the GPs and we have good communications. The main issue we have, I think, at the moment with our pharmacists is that they're being funded by cluster moneys and we're only able to appoint, really, on short-term contracts, because we're not convinced that the money will be rolled over into future years. We continue to be at risk of losing our pharmacists, these really well-qualified people reviewing our medications, because they may go to other practices, they may go back to the health board, or they may choose to take up posts in the regional sector.

[42] **Rhianon Passmore:** So, in regard to what you both seem to be saying to this committee—that these are very valuable features for any GP practice in terms of economy of scale, in terms of medicine management—but what you're actually saying, then, is that the short-term nature of that funding at the moment is causing a bit of flux in the system, and there's uncertainty, then, in terms of future employment around professionals.

[43] **Dr Chant:** That's right. We've appointed one pharmacist on a permanent contract and one on a temporary contract, a secondment, but we're reliant on rolling moneys over from one financial year to the next without the full agreement and support yet of the health board.

[44] **Rhianon Passmore:** So, how have you managed that? I'm assuming that this is the same in other areas. So, how are managing that? You're just putting those mitigations in place?

[45] **Dr Chant:** Our own personal situation has been complicated by the

fact that the pharmacist that we have is likely to be leaving us for a short period of time, but we're liaising as closely as we can with the health board to agree on a transfer of money from one financial year to the next, so we can continue our frailty project.

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

[47] **Dr Jones:** The other thing, if I may say as well that is critical is small practices are not seeing the benefits as we do. Because the pharmacist in my practice—it's a large practice, and the pharmacist is there for a significant amount of time, and therefore procedures can be handled and helped in that respect. I have colleagues in small practices who don't find it quite as useful, and therefore the type of work they're doing at small practices may be project-based rather than really influencing the way the whole system works. So, there's an issue there with—the cluster pharmacist works very well if it has a quantity of work to do, and a time element. When they're in smaller practices, because we share them on the basis of population, I have colleagues in small practices saying, 'I'd love to be able to do what you do, but we haven't got enough pharmacy time to do that, so I'm asking her to do another project', which again is useful, but you're not seeing the benefits in smaller practices because the professional time isn't there to change systems.

[48] **Rhianon Passmore:** So, would it be possible, then, to, in a sense, federalise and widen that cluster, or is the rurality the issue in terms of time management from cluster to cluster?

[49] **Dr Jones:** Yes, it would be—federation amongst them. But, again, there's a benefit from having a number of patients, because the time's there. If you're a small practice you're getting a quarter of what I get, and that can be difficult, so unless you actually provide a lot more time for the small practices, it is difficult, because it's done on an equitable basis, but they're there for two hours a week. Well, if you're there for two hours a week, you're not working as cohesively and as efficiently with people, possibly.

[50] **Rhianon Passmore:** So, that's something potentially to look at. In terms of the issues that we've discussed earlier, you mentioned, I think, non-standard pack sizes and prescribing durations. Could you give us any indication as to whether this is a real issue? I think you referenced earlier that it wasn't so much of an issue in terms of medicine management.

[51] **Dr Chant:** I think the difference between a 28-day pack size and a 30-day pack size makes a small amount of difference to the way we work. I think it's the understanding of the patient, really, as to whether they are ordering medications 12 or 13 times a year, depending on a calendar or a lunar month. Most of the time, it doesn't make any difference.

[52] **Rhianon Passmore:** Okay. So, in terms of the thrust by others who say this is important and that we should be much more rigorous in terms of pack size, from your perspective, in terms of that type of pack size, you don't see it as an issue.

[53] **Dr Chant:** There's probably a difference between prescribing and dispensing. It's easy enough for GPs to change the computers to 28 or 30 days on a prescription, but that would make a significant difference at the retail side for the pharmacist.

[54] **Rhianon Passmore:** Is there any sense in having a different type of pack size completely, or is that just—?

[55] **Dr Jones:** I've never understood why they have 28 and 30 days, to be honest.

[56] **Rhianon Passmore:** Okay. So, for you, it's not really an issue.

[57] **Dr Jones:** No

[58] **Dr Chant:** No.

[59] **Rhianon Passmore:** Okay, thank you. What are clusters doing, then, to reduce the waste that's caused by problems in repeat prescribing processes? You've mentioned that interface in terms of that conversation, person to person; how would you respond to that?

[60] **Dr Jones:** They are certainly working at the point of discharge—so, to have accuracy. The accuracy of prescribing between primary and secondary care is critical, so they're doing medicines reconciliation. I think it's early days, really, to see—. That's not been really hugely on their agenda up to this point, if I'm honest. The main thing we've been doing at the moment is introducing them to a different working environment and starting to trust each other, mentor each other and support them. A significant amount of training is going into them as well. We haven't, to be honest, really driven the

wastage, and it's commendable that we're starting to look at that and we will be doing in future, certainly. It's a huge area.

[61] **Dr Chant:** Increased communication between primary and secondary care and retail pharmacists is essential, really.

[62] **Rhianon Passmore:** Okay. So, in terms of our having this conversation now, do you see this as being driven centrally in terms of wastage and medicine management, or do you want more direction?

[63] **Dr Chant:** More direction.

[64] **Dr Jones:** More direction, I think we'd agree, because we all go to patients' houses and we open cupboards and we have surprises. That's an anecdote, but you speak to people and if you've got elderly family members yourselves you'll see it, because of the complexity of getting the right amount of medication there all the time.

[65] **Rhianon Passmore:** And who should be directing?

[66] **Dr Jones:** I think the pharmacists should have a responsibility for efficiency, rather than quantity.

[67] **Dr Chant:** Education should come through all levels of the service, really, from hospital discharge to community nurse review, to GP review, to pharmacy.

[68] **Dr Jones:** And we have a responsibility as well to look at—. Because we're signing hundreds of prescriptions at a time—we do look at them, but you can't actually remember when you've signed that for that person unless you actually go into your computer and look at it. You will do that, for example, for people with asthma. When you see people having a lot of inhalers, you'll go and look at the screen and you'll realise that the mixture of inhalers they're having may not be the best and therefore you'll call them in or ask your nurse to call them in. But in terms of the actual looking at the wastage element, we haven't had the time to do that, and I think the cluster pharmacist might have a role, or the practice pharmacist certainly would be doing that.

[69] **Rhianon Passmore:** Okay, thank you.

[70] **Nick Ramsay**: Vikki Howells.

[71] **Vikki Howells**: How far has your cluster gone in extending the role of pharmacists?

[72] **Dr Chant**: We have two pharmacists in post at present. They work increasingly closely with our community nurses, our cluster nurses, going out into the community to review patients in the patients' own homes so they can have a better understanding of the way that patients work and the services that they want from us. Whilst the cluster employs the pharmacists, the process is done via the health board, with all education being provided by the health board. As a cluster, we've been very lucky in that, with the pharmacists we've appointed, we've done jointly with the health board and had support and encouragement from them.

[73] **Vikki Howells**: Great. And have you faced any barriers in extending the role of pharmacists, either of you?

[74] **Dr Jones**: No. I was speaking to cluster pharmacists, and they really enjoy the role. The fact that they can actually problem-solve—if you ask them at what level of their competence they are, they seem to be working at a much higher level. The fact is that they get presented with 30 or 40 problems in a session of an afternoon, and they value the opportunity of actually sorting out the problem. So, they're actually doing real things with patients. The comment I had is that it's working at a totally different level from where they were as community pharmacists, where they were occasionally having some patient contact but not as much as perhaps you'd think because, as I've said, a lot of people order their medication electronically, and a lot of them get them delivered by van drivers in our communities in Wales. Therefore, we're losing out the middle bit, which is where the wastage and the quality of that process should be professionally evaluated and improved. But there's been no—. They're loving their jobs, and what we're doing is we're employing people within a small group, so we're actually taking them out of quite often secondary care or local community pharmacies, and that would be a problem because they're actually applying for these jobs in droves. I've interviewed 13 or 15 this year, all of whom would have been fantastic. So, there is a feeling that professional opportunities are there for them to have a—. The pharmacist who's working in the practice will be running a lot of things. She's going to be doing a lot of her own clinic work, she's doing a minor injury qualification, she's going to be out in nursing homes looking at the pharmaceutical side of it, but also

developing skills in end of life, dementia and all these things that I'd love to do, but I haven't got the time to do it. So, it's a great job for them, and they're starting to appreciate it.

[75] **Dr Chant:** I think that as the role of the pharmacist extends, there may be an availability issue of pharmacists, especially within rural areas, because there's a very small pool of them available within Ceredigion. We're essentially stealing them from the health board and the health board are doing their best to steal them back from us, and we may end up with a situation where over the next few years we may not got enough coming through the system.

[76] **Vikki Howells:** And in terms, specifically, of cluster pharmacists, is that the only negative that you could allude to or are there other problems within the creation of that new role?

[77] **Dr Chant:** I think in terms of training, we've sourced our own pharmacists from secondary care because they seem to have a better understanding, and perhaps a slightly different level of experience to what the retail pharmacists currently provide. So, if we want to increase the number of pharmacists that are available to primary care, perhaps there needs to be an investment in training, especially in the retail sector.

[78] **Vikki Howells:** And what about patients? How well have they taken to these new extended roles for pharmacists? Are they aware of the totality of what pharmacists can actually deliver for them, or is there still work to be done around that?

[79] **Dr Chant:** I think all the experiences that we've had to date have been very, very positive; I can't think of any negative example we've had. When we're sending a pharmacist and a nurse into a patient's home to do a thorough complex review of their care, the patients are very, very grateful and can only benefit.

[80] **Dr Jones:** There have been no issues at all. They do and will have to increasingly accept a multiprofessional general practice team, and the more people we can help and mentor to do that—. They will need to have skills in community medicine in terms of GP support, and there may be areas where that support is stretched, but investing a little bit of our time in developing a team is what GPs have always done, and hopefully it's a success of independent contractors.

[81] **Vikki Howells:** Thank you. And when developing the wider medicines management plans, have clusters or health boards looked at the business case for greater investment in pharmacists? Are you aware of any work there?

[82] **Dr Chant:** Within our cluster, we've looked at the cost savings and the potential savings from adverse incidents. I think we've shown that the pharmacists have been very beneficial to us and cost-effective.

14:30

[83] **Dr Jones:** Certainly, as a practice, I had to put a business plan to the partners for them to accept it, and it didn't take me long to persuade them that we couldn't recruit GPs all the time, we're not likely to be able to recruit GPs, and this was a person who'd been working with us, and they didn't have that much time to just say, 'Grab her while you can', because she's made a big difference to our life. But the cluster as well—the cluster pharmacists have been well accepted, and the business plans, at the moment, they come through the cluster, and, as Darren was saying, there is a concern, but I think there is a great belief that cluster work is well recognised and is not going to go away, hopefully. So, I think, increasingly, we've actually got all our cluster pharmacists on permanent contracts now because we do have the belief that that is going to be maintained. I hope we're right.

[84] **Vikki Howells:** Thank you.

[85] **Nick Ramsay:** How common is it in the cluster for patients to be prescribed items that can be bought over the counter?

[86] **Dr Chant:** I think, with the availability of free prescriptions, a large number of patients consult with us first rather than thinking of old-fashioned, traditional homely-type medications and looking to get them and acquire them from a pharmacist or from a supermarket. We seem to be the first port of contact, and quite inappropriately at times.

[87] **Nick Ramsay:** And that's been a spin-off, a consequence, if you like, of the free prescriptions legislation.

[88] **Dr Chant:** I think so. I think very few people, patients, are aware of the true costs of the medications that they're taking, and that perhaps has devalued the medication to them.

[89] **Nick Ramsay:** So, if we were trying to be more efficient, for want of a better way of putting it, how do you get the balance right between encouraging patients to buy medication where it's more appropriate, but, at the same time, obviously, not to shut the door on patients who can't afford it?

[90] **Dr Jones:** I think there are areas of Wales that have done this, by allowing pharmacists to provide over-the-counter medication. When you're looking at prudent health and actually saying that we only need to do what we need to do, then it is difficult. If you've got hay fever in England, you'll go to the supermarket or the pharmacy and buy your antihistamines. In Wales, you will ring my number and my receptionist will answer it, take the details down, I'll sign the prescription. The NHS cost is significantly higher than the cost that some of the larger pharmacies can provide those antihistamines for, and then you're paying a professional fee for a pharmacist to dispense it. So, there's a cost issue, but also, there's the issue about taking care of your own health, as we look at that as of increasing importance for Wales, because our health has a number of challenges. People in Wales love the NHS, and quite rightly so. They have a very personal relationship with it, which, obviously, we want to maintain. But, to be responsible, people in that organisation, they should be doing as much as they can without having to involve the professionals and incur those costs.

[91] **Nick Ramsay:** So, you're having far more demands on your time than your counterparts would be having across the border.

[92] **Dr Jones:** I think we must be because, again, in the spring, we will be giving a lot of hay fever medications out, and, in England, I know my colleagues wouldn't be doing that. They would be expecting people to go and buy them.

[93] **Nick Ramsay:** We're not talking about complex decisions or medications, but I imagine, cumulatively, it must have an effect.

[94] **Dr Jones:** And I think it's an area where, if you say that a pharmacist still needs to oversee that, then there are ways around taking at least the ordering process away from GPs, or, you know—. The issue of free prescription, obviously, is a political decision, but you need to follow through the implications that it has for the individual in terms of their responsibility, and in terms of the system, which is all under stress, and the fact that you're

paying far more for those medications. So, hay fever in Wales is probably costing a lot more than hay fever in England, for the whole system.

[95] **Nick Ramsay:** An interesting way of putting it. [*Laughter.*] I've never thought of the cost of hay fever before. Interesting. Neil Hamilton.

[96] **Neil Hamilton:** I'd like to ask a few questions about the use of formularies and shared care protocols. I wonder how often you come across cases where the local formulary has not been complied with or—.

[97] **Nick Ramsay:** Who wants—who doesn't want that question? [*Interruption.*] Chuck it to the public gallery, I think. [*Laughter.*] Darren.

[98] **Dr Chant:** I think, over the years, that GP adherence to formularies has increased quite markedly. I think the majority of GPs now are aware of the local formularies that are needed to prescribe appropriately from within that formulary.

[99] **Neil Hamilton:** They are an important element in cost control, aren't they?

[100] **Dr Chant:** Certainly. We need to prescribe cost effectively and prescribe appropriately, with medications that will work.

[101] **Dr Jones:** And, again, looking at IT, when we do enter a prescription, if there is a cheaper option, we have a system called ScriptSwitch, which will tell us how much we can save. And most GPs will press that button unless they have a reason not to do that. So, I think, yes, formularies are important. You will see health boards making wide-scale changes, for example, in inhaler medications. And you've got to be a little bit careful because the drug companies are very clever people, and they will offer a cost now, and make a wholesale change, and there's a little bit of danger in the background that they might change that price at a future date, and then are you going to change it a second time, and a third time? So, there's a little bit of an issue there. But, in general, formularies are widely used, as Darren was saying, and it's made easy for us with the electronic reminders.

[102] **Neil Hamilton:** So, is there any more you can do in your practices, do you think, to improve the use of formularies, or is it not that big an issue?

[103] **Dr Jones:** I think it's easy to—you have your formulary, and you have a

reminder, even within a formulary, if there's something more cost-effective. So, it's easy to do, unless you want to go out of your way not to do it, and you will have individuals who will always be like that. It's just how much control you want on individual professionals.

[104] **Neil Hamilton:** Right.

[105] **Dr Chant:** I think we have a lot less exposure nowadays to pharmaceutical reps, and, with that reduction in exposure, inappropriate prescribing has been markedly reduced, and formulary adherence has increased.

[106] **Neil Hamilton:** Did you want to jump in there, Rhianon?

[107] **Rhianon Passmore:** I would, Chair, if that's okay. So, in regard to how widespread formularies are utilised, you can only speak, I presume, to your own areas, but you've mentioned you all have usage of e-technology, in terms of what you're doing. So, you say that, obviously, it's down to the individual in terms of whether they do that or not. Do you feel that there needs to be more cascading of those formularies out there to other GPs, or is it just the fact that it's a choice, autonomously, by that GP not to use what's available to them?

[108] **Dr Jones:** I think the information is there; you could decide how far you push adherence. You can sit in a prescribing group, and, when you see your practice is one end of the spectrum, then you go back and talk to your colleagues, and say, 'Look, we want to work cohesively with our colleagues, and we're standing out a little bit.' So, there's feedback from the meetings that we have when we discuss—and most of the all-Wales indicators are acceptable. There's one or two that you could challenge, but most of them are reasonable, they're written by reasonable people with a good understanding. They can be made much more interesting and more professionally driven by actually including hospital data. For example, we are trying to reduce the cost of inhaled steroids for asthma. Well, you've got to be assured that that's not at the risk of giving poor control for people with asthma, them ending up in hospital, or having mortalities.

[109] So, it's lovely to put the—. And we did this with diabetes, actually: we looked at the cost and we looked at the outcomes in terms of some of the surrogate outcomes from the quality outcomes framework, we put them on one chart, and we found that some practices were doing very well at high

expense; some people were doing very poorly at high expense. And then the pharmaceutical advisers had an idea of how to approach all the individual groups, instead of just going in and saying, 'You're poor because you're costing a lot', 'You're poor because you're costing a lot and you're having poor outcomes.' And we could then look at the practices that have good outcomes at good cost-effectiveness, and we could say, 'What are you doing that everybody else should be doing?' So, if you're looking at formularies, and looking at discussing and advising professionals, individual GPs would respond a bit better if we could have a bit of the qualitative information, and we should be able to do that.

[110] **Rhianon Passmore:** And who should be doing that, apart from individuals within your own GP practices? Would it be the local health board? Does there need to be, again, more direction from your local health boards, or even, perhaps, from Welsh Government around this? Or is it not an issue?

[111] **Dr Jones:** It is an issue, yes. I think it's a mixture of everyone who holds a professional responsibility to prescribe effectively and cost effectively and get good outcomes. And anything we can do to not only look at the cost of something, but the quality and the outcomes—if we can marry those two things together, that's what makes professionals tick. People don't go to work in the morning wanting to do a bad job. So, if you can show that they're different in any way, they're much more interested in a qualitative and quantitative discussion, rather than just, 'Oh, your practice is spending too much'.

[112] **Rhianon Passmore:** Yes. Okay.

[113] **Neil Hamilton:** Can I go on to ask about shared care protocols in the case of patients discharged from hospital and continuity of care? Are you able to use these shared care protocols effectively? Are they working well, do you think?

[114] **Dr Chant:** I think, by and large, we have good experience of shared care protocols. Our ability to support secondary care with the shared protocols is limited by communication. To be able to appropriately prescribe medication and monitor it, we need appropriate guidance and support from secondary care. I think sometimes there are examples where medications are suggested under a shared care protocol, with secondary care agreeing to a certain amount of monitoring and follow-up, and that follow-up doesn't actually occur, leaving the GP in a difficult position, in having to follow a

shared care protocol without the support around it.

[115] **Neil Hamilton**: I understand. You'd agree with that, would you, Dr Jones?

[116] **Dr Jones**: In general, they're working quite well. There's an issue sometimes of initial stabilisation, which should be done before we take over the routine care. But, in general, rheumatology departments and people that have to have our help, because their time isn't best spent in monitoring drugs; it's best spent in making an assessment, getting people well controlled and then handing them back to us. Diabetes, likewise, we see that 85 per cent, 86 per cent of my patients don't see secondary care at all, freeing up time for them to see complex people with pregnancies and other things that they need to see. So, shared care protocols for medication and for management of people are working very well, yes.

[117] **Neil Hamilton**: There are a number of issues that arise in the case of the discharge of patients from hospital and the continuity of their medication. One of them that's been drawn to our attention is that drugs are sometimes prescribed in hospital that are too expensive to continue after discharge. Is that an issue for your practice?

[118] **Dr Chant**: I think that's been an issue in the past. We use formularies, with primary care and secondary care both having input into the development of a local formulary, and, by and large, problems with inappropriately expensive medication that's been supplied initially by secondary care are probably disappearing.

[119] **Neil Hamilton**: So, that's not really a problem, in your estimation—in your experience, anyway.

[120] **Dr Jones**: No, I think people are aware of cost in primary and secondary care. There are very few times when we find that somebody has advised something very expensively when they could have been cheaper. There are areas of—. Especially when you have locums, to be honest, if you have people who are not aware of local procedures and local advice, there is a danger that they would bring their prescribing habits from another area of the NHS, and, where they haven't had maybe some support, if they're a locum and travelling around, then they're not there long enough for you to evaluate and for you to feed back what they're doing. Therefore, that may be an issue in areas where secondary care is relying on locums.

[121] **Neil Hamilton**: So, it's not a specific issue for specific specialities or practices. It doesn't sound from what you're saying that this is very high on your radar screen at all. Okay, thanks.

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

[123] **Rhianon Passmore**: I don't know what your response would be to the Royal College of General Practitioners' statement, where it states that the interface between primary and secondary care is an area of issue and accounts for a high number of clinical errors. There is a pertinent number of different things that they pointed out for that in terms of timely updating of systems in terms of electronic data. Would you recognise that in terms of an area of risk? And, as such, in terms of we talked about shared care, what are your thoughts in terms of mitigations for that? What can be improved if that is the case, and if you would agree with that statement?

14:45

[124] **Dr Jones**: We mentioned that the cluster pharmacists are actively doing the reconciliation. We've got very good information technology in primary care. Unfortunately, the IT services in hospitals are not quite as clever, and it would be lovely to have an individual patient record. We have an individual patient record. I think the public now expect us to be sharing that information on a need-to-know basis, and therefore it is a missed opportunity. Primary care's got such good IT that we've just really been waiting 15 years for hospitals to catch up, and we don't understand why that hasn't been driven. I know the experiences in NHS England. The year that they had was poorly managed, and I'm glad that Wales didn't push it at that time and took some care and attention to win the public over. But if you're a patient and you have the checks and procedures to say, 'Look, can I access that record?' and there are checks and audit trails to do that only appropriately, I think the Welsh public will expect primary and secondary care prescribing to be on one clinical system.

[125] **Dr Chant**: I think the flow of information from primary to secondary care is much better than the opposite direction. It's very easy for GPs to provide very detailed referral letters both for outpatient appointments and acute admissions by just pressing a few buttons on our IT system, which is very well developed. We can give a list of all the medications, investigations and results in a letter with very little work. The flow of information from

secondary care to primary care is the main issue that we have, and I think it's probably the main issue we have with prescription errors.

[126] **Rhianon Passmore:** Okay, so you would firmly say that you're at the forefront of that. In terms of cross-fertilisation, you've mentioned poaching—perhaps that's the wrong word—but in terms of taking secondary care pharmacists and then turning them into community pharmacists and that wider experience in that career progression, you would have thought that that would also go a little way in terms of improving that communication, but really what you're saying is it's that system that needs to be joined up, and it needs to be done very efficiently. Okay, thank you.

[127] **Nick Ramsay:** We're into the last few minutes. Do Members have any further questions they'd like to ask? No. Can I ask, then, if a review of a patient's medicines identifies the need to deprescribe a medicine, what approaches do you use in your health board cluster to persuade patients that deprescribing is the best course of action? Because I don't think they always do believe that is in their best interest, do they?

[128] **Dr Jones:** I'd challenge that. I think people, over the last 10 years, have worried about being in hospital, and they've worried about overmedication. I think people realise now that we're not making those decisions on the basis of cost. We believe that people can be kept at home and looked after far more effectively as long as we have a multiprofessional team and social care and integration working in our communities. I think the discussion that we have has matured, and likewise, with medications, I don't think that most people, if they have a good relationship with their primary care physicians and team, would start thinking that I want to stop a medication just because of cost. I think there is an element of trust there and, again, continuity may be the—. We've had a lot of concentration on access, and I think, now, some of our health boards are actually looking at the importance of continuity of care and good IT systems and developing a much better NHS, and I don't think that people will think I'm doing that just to save money. I honestly don't think that's the case.

[129] **Nick Ramsay:** You're doing what you feel is appropriate for the patient at that point in their treatment cycle.

[130] **Dr Jones:** Yes. They may think—. If you do widespread things, if you have a big scheme of changing everything, they might have some concerns, but deprescribing of medication that's inappropriate—. There is an issue

about once you put somebody on something that it's quite difficult to take it off them, but professionally, if you think that's the right thing, I don't think that they'll immediately say we're doing it to save money for the health board.

[131] **Dr Chant:** I think it comes down to the method by which medications are discontinued. If it's as a result of a face-to-face consultation, patients are much more happy and understanding. If it's done via a large, health board-wide issuing of letters because so-and-so medication is no longer indicated, they have less understanding. But face to face or via part of the multidisciplinary team, they have much more understanding. I think patients are more aware of side effects of medication as well, now.

[132] **Nick Ramsay:** Great, thank you. Can I thank our witnesses? Unless you have any last comments you'd like to add, we will—. Good. Thank you, Carwyn Jones and Darren Chant for being with us today. We will send you a copy of the transcript before we finalise it, just for you to check for accuracy. That's been really helpful, thanks.

14:52

Rheoli Meddyginiaethau: Sesiwn Dystiolaeth—Grŵp Clwstwr Meddygon Teulu o Fwrdd Iechyd Lleol Aneurin Bevan
Medicines Management: Evidence Session—GP Cluster Group from Aneurin Bevan Local Health Board

[133] **Nick Ramsay:** Can I welcome our three witnesses to this afternoon's meeting of the Public Accounts Committee? Thanks for being with us today. Would you like to give your name and positions for the Record of Proceedings?

[134] **Dr Walters:** I'm Alun Walters. I'm clinical director of primary care at Aneurin Bevan university health board, and I'm an ex neighbourhood care network or cluster lead.

[135] **Dr Edwards:** Alun Edwards. I'm a GP in Tŷ Bryn surgery in Trethomas and the Village surgery in Llanbradach. I'm also the NCN or cluster lead for Caerphilly south.

[136] **Ms Smeethe:** I'm Eryl Smeethe. I'm a pharmacist and prescribing

adviser for Torfaen, but I'm also the NCN lead for Torfaen north.

[137] **Nick Ramsay**: Good. We've got a few questions for you, so if I can kick off with the first. What actions are clusters taking to quantify, understand and reduce medicines wastage? Who wants to take that? Alun.

[138] **Dr Walters**: It's a difficult one to quantify wastage. I don't think there is an easy way to do it. Structure wise, one of our leads has done a recent bit of work in identifying wastage within care home settings—this demonstrated quite a lot of wastage—and has worked with the care homes to alter the way they do their repeat ordering, which has resulted in quite significant demonstrated savings over the last six months in that. So, that's a defined piece of work that was able to be done in a defined setting. I think it's much more difficult to quantify waste in the general population, in the general practice sort of setting.

[139] **Dr Edwards**: Actually quantifying and putting a value on waste can be difficult. We have been looking, in Aneurin Bevan, at a scheme to alter the way in which patients will order their medication. There is a repeat ordering service available via lots of the community pharmacies. Anecdotally—and I would stress that it's anecdotally—this can result in lots of waste. So, patients would say they haven't actually requested a particular medication that's on the repeat slip, but it's ordered anyway. So, we have considered ways where the medication can only be ordered via the GP surgery, and we use IT solutions like My Health Online to do that, or just ordering only via the surgery. So, that's something we're actively looking at, at the moment in some practices.

[140] **Nick Ramsay**: So, that negates the—. So currently, the patients in that situation wouldn't have requested them. It would just be in the system already, would it?

[141] **Dr Walters**: What people say happens and what happens doesn't appear to be necessarily the same. So, the community pharmacists would say that they check with the patient exactly what the patient wants to be ordered that month, and that's what gets ordered. The patients tell us as GPs that an awful lot of stuff arrives that they didn't order. Hopefully, by doing it directly through the GP practice and taking the pharmacy out of that ordering role, we're hoping that will result in some significant savings.

[142] **Ms Smeethe**: Coming from a pharmacy background, I know that when

we have—. They're called managed repeats when the pharmacy orders on behalf of the patient, and although the pharmacy has to ask the patient, for each item, whether they actually need it or not, quite often this is done a month in advance when they're collecting their previous month's prescription. So, they're anticipating what they will need in a month's time. Quite often, they just say yes to everything because they're not quite sure. So, taking away the managed repeats is a really good option. It is being piloted in one of our twelve neighbourhood care networks this year. As part of the pharmacy incentive scheme for the GPs, we've asked the NCNs to choose between doing this process or increasing batch prescribing. So, that's when a pharmacy has possibly six months or 12 months of prescriptions for that patient, they get held in the pharmacy and then the pharmacist—it's within their contract that they have to ask each month—they go through each item to ask the patient whether they need each item, and that's a contractual obligement then on behalf of the community pharmacy. So, we're hoping that both of those systems will decrease waste, but it will be quite nice to see the results of the one NCN that's taking away the managed repeats so we could possibly use that as a pilot to drive further work then.

[143] **Dr Edwards:** This has been done. It's been done in Luton, I understand, and I think a practice in Cardiff we've seen using it as well. There's no doubt that waste is an issue and I think that we're actively looking at it and trying to manage it. We're all aware of situations where there are stories of hundreds of inhalers in patients' houses, and it's something we need to do better.

[144] **Nick Ramsay:** Good. Rhianon Passmore, did you want to come in on this block?

[145] **Rhianon Passmore:** Yes, please. So, in regard to this being a pilot in terms of the batch approach compared to the managed approach—

[146] **Ms Smeethe:** The batch isn't a pilot, sorry. The batch has been around for years. But we haven't taken away the managed repeats as a designated piece of work before.

[147] **Rhianon Passmore:** So in terms of understanding what you've just placed before us, why is this pilot different, then? Because I fail to understand what you've meant.

[148] **Ms Smeethe:** Oh, sorry. So, do you understand the managed repeats

side of it—that the pharmacy is ordering on behalf of the patient?

[149] **Rhianon Passmore**: Yes.

[150] **Ms Smeethe**: So, with the Luton model, they stopped the pharmacy being able to order with the GP and empowered the patient to do that instead.

[151] **Rhianon Passmore**: So in terms of how widespread it is as a pilot, is it just in Aneurin Bevan at the moment, or is it in other areas across Wales?

[152] **Ms Smeethe**: I'm not aware of many other areas that are doing it, but they might be.

[153] **Rhianon Passmore**: Okay. So in terms of when you're going to evaluate if this has made any difference and contrast it across, is there going to be a timescale attached to this? It'd be interesting for this committee, Chair, to find out what the results would be.

[154] **Dr Walters**: I would think it would be a 12-month time frame on that one.

[155] **Dr Edwards**: Yes. So, the year runs April to April; it's the financial year. And provided that it is showing evidence that it's been effective, then other clusters will be keen to implement that, I would have thought. Luton have published and it's in the public domain, and they are quite—. You know, they're advocates of this. There are issues with it in terms of disadvantaging some patient groups in terms of the elderly and people getting to the surgery. Certain areas of the south Wales Valleys have very low computer use, so using My Health Online—. But generally, I think they'd be seen to be—. I'm struggling to see a difficulty with it. I think it's potentially a great idea.

[156] **Rhianon Passmore**: Okay. Thank you, Chair.

[157] **Nick Ramsay**: Do you have any further questions?

[158] **Rhianon Passmore**: No, thank you. I think they're yours, Vikki—page 50.

[159] **Nick Ramsay**: Vikki Howells.

[160] **Vikki Howells:** Thank you, Chair. I wonder how far you've gone in extending the role of pharmacists within the cluster. I don't know who would like to start off by telling us about that.

15:00

[161] **Ms Smeethe:** I don't mind. We don't call them 'clusters' in Aneurin Bevan; we call them 'NCNs'—neighbourhood care networks. We have 12 of those in Aneurin Bevan, and I think 11 of those are employing the NCN pharmacists. They have been developing their roles with IP training—so, independent prescribing training—and many of them now are prescribing within the practices. The NCN pharmacists are diverting patients from GPs with medication reviews, polypharmacy reviews; they are going out to housebound patients and going into care homes; and they are running clinics. The clinics that I'm aware of: they're doing respiratory reviews and inviting patients in to see if they can step patients down or whether they're being treated appropriately. I think with the NCN pharmacists, because their consultation time is longer than that of the GP, they can give a dedicated session to reviewing the medication and, hopefully, the patient will have an increased quality consultation with them because it's so dedicated, and, hopefully, the patient will be more satisfied because of that.

[162] **Vikki Howells:** So, you've already alluded to some of the strengths of this new approach. Are there any other strengths that you'd like to tell us about? Also, on the flip side of that, are there any weaknesses or problems that have arisen so far with this new role?

[163] **Dr Walters:** I think one of the strengths is when the cluster pharmacist then becomes directly employed by the practices. That's a sustainable model. Otherwise, they kind of sit on the cluster's books as it were, and we can't move forward. Where it's worked well is where they've been trained, they've had a lot of mentorship from the cluster, they've attained their independent prescribing because of that mentorship, and they've then gone off and become directly employed. That frees up that vacant slot then to repeat the process. I think, if we'd had our time again, I think we would have been more cognisant of that being a pipeline as opposed to a post, and I think that's probably one of the weaknesses of it, in that once these people are in post, they're in post and there was perhaps not that explicit expectation at the outset that they were going to move on and become directly employed.

[164] **Vikki Howells:** So, did that create a barrier in terms of recruitment?

[165] **Dr Walters:** I think that because the cluster money is a defined pot, while that's committed to one person, then there can't be any further recruitment into that pot. I think the majority of pharmacists that are now directly employed by practices have come through the cluster, but it's not uniquely so; some have gone directly into practice without going through the cluster. But, the major pipeline for the training has been through the clusters because of the level of mentorship and sort of investment that they need.

[166] **Vikki Howells:** Thank you. What about the business case for the greater involvement of pharmacists? How strong is that business case in your opinion?

[167] **Dr Walters:** I would say extremely strong. I think—

[168] **Dr Edwards:** I'd personally note a caution. I think Aneurin Bevan were reasonably early adopters of this model. I think, generally, it's been a positive experience. In terms of evaluation of this role, I'm not sure it's been totally evaluated as yet. From my perspective as a GP, I think they certainly bring quality. Whether they reduce GP workload, I think is a moot point. As within all professions, there's a spectrum of ability. In terms of training for these roles, I know 1000 Lives are looking to develop a community of practice for these new roles, but there has been not a huge amount of training, and I think there's scope for improvement. The role of the GP in terms of what we call 'dealing with uncertainty' can be quite difficult and it takes time to develop, and I think, sometimes, some of the training of the pharmacists, I would say especially if they've come from a hospital pharmacy where there are checks and balances and certain protocols in place, I think some people have difficulty making the transition.

[169] **Vikki Howells:** Can I just pick up on one thing you said there—

[170] **Dr Edwards:** Yes, absolutely.

[171] **Vikki Howells:** —which is about the impact on reducing the workload of GPs? Now, obviously, that's one of the strongest lines for actually saving money—

[172] **Dr Edwards:** Absolutely.

[173] **Vikki Howells:** —for the NHS, if that's done properly, so what do you think is needed there to improve that? Is it about patients' understanding, or lack of understanding, about what they can get from a pharmacist, in terms of advice and repeat prescriptions and so on?

[174] **Dr Edwards**: I think that's part of it; I think, patient willingness to see a pharmacist. These are obviously different from community pharmacists, so these are practice-based pharmacists, and I think it is training, experience, all the putting the things in place so that the pharmacists perhaps feel more able to do the job. There's still a lot of deferment back to the GP. My experience has been that lots of things are sent back my way. Has been.

[175] **Nick Ramsay**: Eryl Smeethe.

[176] **Ms Smeethe**: I think that there is a huge variety. There's a big variation within the NCNs, and I think that is dependent on how the practice use that pharmacist and how successfully they engage with them and integrate them into their team, but it also depends on the practice pharmacists themselves. So, their own competence and ability, and their own drive as well because some pharmacists work more autonomously than others. So, there is a big variation.

[177] **Vikki Howells**: Is there not a universal training model for these cluster pharmacists?

[178] **Dr Edwards**: No.

[179] **Ms Smeethe**: No. It's, I think, under development, but there is definitely room for improvement with that.

[180] **Dr Walters**: Can I—? To be fair, that's something that you see with a lot of these extended roles, whether it's a paramedic or a physiotherapist working in primary care. There isn't that one size fits all. If you're talking about training a GP, there's a recognised selection criteria, there's a recognised training course, there's a recognised exit exam, there's a recognised level of competencies. All of these extended roles will have massive variation from one practitioner to another, and it's working with those competencies and developing them that's the challenge with these new roles, really.

[181] **Vikki Howells**: Thank you.

[182] **Nick Ramsay**: Rhianon Passmore, did you have a supplementary?

[183] **Rhianon Passmore**: So, with regard to those checks and balances, you've already answered my question in terms of variation across Wales. There seems to be general agreement that this is a good direction of travel. You've mentioned the 1000 Lives and you've mentioned that there is no universal package in terms of those checks and balances. My question is really simple: should there be one and who should be doing that? Is it the local health board, is it yourselves, is it a mixture of that?

[184] **Dr Edwards**: In terms of training, I think we need to be, as with all these things, developing perhaps a training programme, whether that's at undergraduate level or postgraduate level, and whether this role should be part of undergraduate training for a pharmacist. There certainly should be some postgraduate training. A lot of this was done on the hoof, I think, when it was first mooted.

[185] Certainly, I think it's potentially a valuable role that certainly adds quality, and I think it's in development. Those bigger roles certainly have been evaluated by the university—I've certainly given some narrative feedback—but I think the role's developing, and I think, as with all these things, you need to perhaps develop the role and that's going to come down to the health board and, I think, to the universities as well.

[186] **Dr Walters**: For my mind, this would come under a training remit, and I would think it'd be more in line for the royal colleges to run that, then.

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

[188] **Nick Ramsay**: Eryl.

[189] **Ms Smeethe**: We have got, in development, because when you do your pharmacy, then you do your pre-reg training first, so we have got pre-regs coming into primary care, which hasn't really happened properly before, so there's a trend for that happening. And also for pharmacists who are in hospital, they go through a diploma, quite often, and there is a placement now in primary care, so they will be exposed more to the practice-based pharmacist's role. At least at that stage, it is going to be introduced to them at a much earlier stage.

[190] **Rhianon Passmore**: Okay. Thank you.

[191] **Nick Ramsay**: In terms of items that are prescribed, is it common in your cluster for patients to be prescribed items that can be bought over the counter, and what are the cost implications of that?

[192] **Dr Walters**: Absolutely.

[193] **Nick Ramsay**: I thought you were going to say that.

[194] **Dr Walters**: Cost implications: obviously, a lot of medicines that you can buy over the counter are very cheap for patients to buy, sub £1, like those antihistamines or simple analgesics. I don't need to tell the committee, really, that obviously, if it goes through a high-street pharmacy, through a prescription, there are all sorts of costs incurred from the GP side of things, through to the pharmacy—dispensing fees and all these other things—on top of whatever the ticket prices are, which might be well above what people would pay in a supermarket chain for it. So, yes, it is an issue.

[195] **Nick Ramsay:** Is the problem getting worse, or, over time, have people got used to the new regime and are they being more responsible in the way that they use it?

[196] **Dr Walters:** I wouldn't think things have changed an awful lot. It's bad. I don't know if it's getting any worse, and certainly you have got that cohort of patients who would never think of coming to the GP to get paracetamol. They never have and they probably never will. I'm not sure there are massive changes in it. If you think about hay fever season, I'm not sure I'm doing many more scripts for antihistamines than I was five years ago, but I'm still doing an awful lot of scripts for antihistamines.

[197] **Nick Ramsay:** Did you want to come in, Eryl?

[198] **Ms Smeethe:** Yes, if that's okay. We have got a scheme called Choose Pharmacy. That is a minor ailment scheme, but recently it's been developed into Choose Pharmacy with a much larger number of indications. And something else that we're looking at doing within the neighbourhood care networks is reception navigation training, so signposting patients, at the reception, to the most appropriate healthcare option. So, hopefully, there will be a bit of diversion from the GP in those instances. So, if someone wanted to get some antihistamines, then if the receptionist could identify that, then

they could be directed to Choose Pharmacy, rather than have a GP appointment and a prescription.

[199] **Nick Ramsay:** You just anticipated—. I was going to ask you: how do you encourage people to do that without then closing the door on people who really do need to be able to come to the GP? But I think you've said that; that's one solution, so that's good. Rhianon Passmore, did you want to come in?

[200] **Rhianon Passmore:** Thank you. With regard to the visits that we have made as a committee, there has been great conversation around the ability not to be able to just prescribe paracetamol, et cetera. So, there seems to be, from what I've heard, recognition out there that we shouldn't just be doing that. But with regard to the point around quantitative versus qualitative contracts around prescribing, do you feel that there is an in-built perverse incentive in terms of being able to do so as far as dispensing and the pharmacy itself, placed, and if so, does that need to be changed?

[201] **Dr Walters:** From the point of view of over-the-counter medication, I don't feel that there's a drive from the pharmacists to drive that; I think that comes more from the patient, if that's what you're asking.

[202] **Rhianon Passmore:** With regard to the fact that it would be possible to be able to 'intentionally'—I'm using that word very loosely, in inverted commas—overprescribe in terms of a pharmacy perspective, or is that completely unfounded?

[203] **Ms Smeethe:** No. I think that is true. I don't really know how to get around that.

[204] **Dr Edwards:** If patients, in terms of Choose Pharmacy, go to the pharmacist intentionally getting more than they should do, or is this just about—?

[205] **Ms Smeethe:** I think what Rhianon means is when the pharmacist will get reimbursed for—

[206] **Rhianon Passmore:** I'm talking about the contract.

[207] **Ms Smeethe:** Yes, for dispensing paracetamol, as opposed to just selling it cheaply across the counter.

[208] **Rhianon Passmore:** So, if there is any recognition of that. That's what I'm asking.

[209] **Ms Smeethe:** Yes. I think a lot of it could be patient education, and I think that needs to come from the Government, possibly, as an all-Wales initiative. So, I think that patient education is a lot of it, but then it's patient expectation as well, isn't it? Because they know that they don't have to pay for their prescriptions, so—. There is a patient responsibility, I think, but yes, you're right—

[210] **Nick Ramsay:** In terms of drugs like paracetamol, you're talking about £1.00—

[211] **Ms Smeethe:** Sixteen pence.

[212] **Nick Ramsay:** Sixteen pence.

[213] **Ms Smeethe:** Yes. Whereas, dispensed on a prescription, then it's more like, I think—

[214] **Nick Ramsay:** It's a lot more. Which goes back to Rhianon's point about whether there's an incentive for pharmacies, really, to allow it to go down that line.

[215] **Dr Walters:** There may well be that incentive if you look for it, but I really don't feel that that's where it's coming from.

[216] **Dr Edwards:** It's patient driven, by patient expectation. I don't know whether there would be variation in terms of—. I practise in a—. Parts of my practice area are quite deprived, and I see—you will see patients who come in just purely for a prescription where the medication is available over the counter. It's a difficult conversation. There is patient expectation. How you phrase it: 'Are you aware this is available over the counter?' 'Yes, but I'd like it anyway'—or some patients will take that message away and go to the chemist, and some of them don't actually expect you to prescribe. There's huge variation.

15:15

[217] **Nick Ramsay:** So, basically it's about educating the patient as the only

person who can change this at this point. It's about educating the patient and saying, 'Look, you've got a good system. Don't abuse it'.

[218] **Ms Smeethe**: I think so.

[219] **Dr Edwards**: Yes.

[220] **Ms Smeethe**: I think it needs to be a universal education system rather than just a locality one. It just needs to be something that there's a big drive on.

[221] **Rhianon Passmore**: So, through the Chair, if I may, just to follow up, to underscore what I'm asking you, as there's some confusion there, you don't see that there's any perverse incentive in terms of dispensing from the pharmacy. You feel it's more just patient education. Because we've had different witness evidence on that.

[222] **Dr Edwards**: I must admit that's not something I've considered or picked up on, personally.

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

[224] **Ms Smeethe**: I don't think it's all the patient's fault. [*Laughter*.]

[225] **Rhianon Passmore**: No, we're not saying that.

[226] **Nick Ramsay**: No. We'll move on now. We've got the balance just about right, I think. Neil Hamilton.

[227] **Neil Hamilton**: The medicines budget in Wales is over £800 million a year, so even small percentage changes in usage could free up funds to spend in other areas, and more productively. So, this is an important reason for us conducting this inquiry. One way in which we've been able to make some inroads into cost control in the drugs budget is through the use of local formularies, and I wonder if you could give us some idea of your own experience with these. Are they complied with generally very well, or do you come across cases where they haven't been, where they should have been?

[228] **Dr Edwards**: I think the situation has changed significantly over the last five or 10 years. Formulary compliance has increased markedly. This afternoon in Caerphilly there is a continuing professional development

session from the health board pharmacists, and they will cover off areas that are issues for the health board. Awareness of costs in formularies has gone up and, in comparison to where we were 10 years ago, it has significantly improved.

[229] **Neil Hamilton**: So, doctors are aware of the differences in costs of drugs themselves, even though the patients may not be.

[230] **Dr Edwards**: Absolutely. When I prescribe a medication, with the system I use, I can see immediately the cost of this. We sit down and chat over a coffee at lunchtime. For example, the cost of a particular eye drop to treat conjunctivitis has gone up hugely within the last—bizarre; it's really strange—few months. We're all aware of that, and we don't use it.

[231] **Neil Hamilton**: So there is a suitable alternative that is cheaper.

[232] **Dr Edwards**: Yes, and the computer will tell us that. We're able to see what's happening. ScriptSwitch is available on all the computers. The IT we've got allows us to make those decisions. We get reminders flagged up. The formulary's available on all desktops within Aneurin Bevan, so we can dial into that. So, the awareness has increased massively.

[233] **Neil Hamilton**: And that's your experience too from the pharmacist viewpoint.

[234] **Ms Smeethe**: Yes, I think that adherence to the formulary is generally pretty good. You do get your occasional complex patients, and they are prescribed things off-formulary, and sometimes they started on it when it was on the formulary and it's been reviewed since. Sometimes the cost of drugs escalates, as Alun said, and they can be reviewed, but, yes, I think in general the adherence to the formulary is pretty good.

[235] **Neil Hamilton**: And moving on to a related topic about shared care protocols where patients are discharged from hospitals and you then take over, preserving continuity of care, you of course may take a different view on the medication that they've been receiving compared with what they need afterwards. So, I was wondering if you could give us some idea of how effective these shared care protocols are in this respect of prescribing medicines that are appropriate to the patient's need as well as keeping costs under control so that we're not wasting money.

[236] **Dr Edwards:** The shared care protocols in general have been for more complex drugs rather than costly drugs—drugs to treat rheumatological conditions, drugs to treat dementia. So, that's where they're generally used, the shared care protocols, in Aneurin Bevan at least. I think secondary care consultants have been accused of prescribing the most expensive drug and then expecting us to continue with them. In Aneurin Bevan, we've developed a system where we can respond quickly to a request, where we can refuse to prescribe that medication and bat it back. So, we have a form—what's the form called?

[237] **Dr Walters:** Decline to prescribe.

[238] **Dr Edwards:** The decline to prescribe form. So, we can use that, and that's strictly adhered to, and it's supported by the prescribing support pharmacist, and the local medical committee have been really keen to promote that. So, that's something, I think, that has, again, changed. And across the primary and secondary care boundary in Aneurin Bevan, we adhere to it quite strictly. It's not a huge deal anymore, I don't feel.

[239] **Neil Hamilton:** You've anticipated the next question I was going to ask, which was precisely that. We had one response from a surgery that said that, often, patients are prescribed newer, more expensive, drugs in hospital as there are not the same incentives to consider the cost of medication in hospital as with GP practices, and it's difficult to take somebody off a certain medication if patients then think, 'Well, my consultant prescribed this, so what's going on here, and what's in your mind in changing the medication?' Is that a problem that you've encountered?

[240] **Dr Edwards:** Less so—significantly less than it used to be. That's my general feeling. Alun?

[241] **Dr Walters:** Yes, I think that's right. I think, given that we've lived through 10 years of austerity, patients are much more accepting of the fact that you can have that rational conversation, 'This costs x, this costs y, and that's a large part of the rationale as to why we might not be giving you this medication. This medication is equally as effective'. And it's having that mature conversation with the patients, really, and most of them get it.

[242] **Dr Edwards:** One of the major cost issues in Aneurin Bevan and throughout Wales has been inhalers—inhalers are a significant cost. But we've worked across the primary and secondary care boundary to reduce the

cost of inhalers, making sure patients are on the most appropriate, cost-effective inhalers, and that's all of us—primary and secondary, the whole team. So there's increased awareness from the consultants about cost.

[243] **Neil Hamilton**: Good. It sounds as though, at least in Aneurin Bevan, there's a great deal of collaboration on this between GPs and others.

[244] **Dr Edwards**: Yes, I think there is.

[245] **Dr Walters**: Just to quantify it, that inhaler work we estimate saves around £1 million a year of our budget.

[246] **Dr Edwards**: Which we've reinvested in more cost-effective intervention. So, pulmonary rehabilitation, which has been shown to offer much more in terms of cost-effectiveness and quality of life, we've been able to reinvest the money in that.

[247] **Neil Hamilton**: Good. Thank you very much.

[248] **Nick Ramsay**: Rhianon.

[249] **Rhianon Passmore**: With regard to that inhaler work, then, how are you cascading that? Have you got any duty to do so and are others doing that? And the second point I wanted to ask you about is: according to the Royal College of General Practitioners, that interface between secondary and primary care is an area of risk. So, how much of that would be down to the issues around medicine management, as to whether there's going to be a certificate of refusal, or whether it's purely down to the electronic transfer of data on the system? I don't know whether you have any comment around that point as well.

[250] **Ms Smeethe**: As to cascading the inhaler training, all of the practice-based pharmacists have been trained to provide clinics with the inhaler training. So, getting patients to get the most out of their inhalers is really important, and they've all been trained to do that. So, there are practice-based pharmacists running clinics, and there's one particularly good clinic, I think, in Caerphilly east, and he has done his independent prescribing in respiratory—in that area. There is also the RIPP group—

[251] **Dr Walters**: The respiratory implementation group.

[252] **Ms Smeethe**: Yes, the respiratory implementation group. They work on all of the pathways for asthma and chronic obstructive pulmonary disease, and then that is shared across the whole of the board.

[253] **Rhianon Passmore**: Sorry to interrupt, Chair, but I'm thinking more outside the board. If you're talking about savings of £1 million in one board and one particular period of time, how is that being replicated across Wales?

[254] **Dr Walters**: My understanding is that there's a Wales-level respiratory implementation group, and that work has been taken there.

[255] **Rhianon Passmore**: Okay, thank you. And with regard to my last comment, in terms of that interface between secondary and primary care as being an area of clinical risk, because there's obviously a gap there.

[256] **Dr Edwards**: There is, yes. We use a system called clinical workstation in Gwent, in Aneurin Bevan, where electronic discharge summaries are meant to be generated within 24 hours. They don't hit our system—the information doesn't go in there—but we get them within 24 hours and we're able to reconcile the medication pretty quickly. I think it is, again, significantly better than the old days and the issues with carbon paper where things weren't—. It's bizarre to think this is so recent, but you couldn't see what the prescription was—the writing was terrible. We still get those from Cardiff. In Aneurin Bevan, they're generated within 24 hours. It would be great if they immediately went into our IT system. We're not quite there, but this is the next best thing. We do get the information promptly and quickly.

[257] **Ms Smeethe**: And then, the practice-based pharmacists have been put into—. They've been doing the medicines reconciliations in the GP surgeries as well. That's an area that they're practising in quite a lot. But also on the interface of patients going into hospital, I believe that the wards have got access to a limited amount of the GP record, so they are able to see what that patient's medication record is so that they can actually prescribe appropriately when they get admitted onto the ward as well.

[258] **Nick Ramsay**: Do you have any further questions?

[259] **Rhianon Passmore**: In regard to the vice versa of that in terms of secondary to primary, would you say that that is as robust as primary to secondary transference of information?

[260] **Ms Smeethe:** Yes. I think the CWS is readily available, isn't it?

[261] **Dr Edwards:** There are two elements to the discharge summary. There's the medication that the patient is discharged on. Invariably, that gets to us within 24 hours. The actual description of the admission is not so good. That can take a bit more time, but I know that each of the teams gets performance managed, so they're aware of what percentage of discharge summaries get to the GP within 24 hours. I can see the spreadsheet and some consultants will get them back at 100 per cent within 24 hours, whereas others are 50 per cent. And the consultants get this, so they're aware of who's doing well and who isn't.

[262] **Nick Ramsay:** Can I ask you about deprescribing and what approach your cluster health board is taking to persuade patients that deprescribing is in their interests?

[263] **Ms Smeethe:** So, within the medication reviews performed by the practice-based pharmacists, that is something that they are very much aware of. Polypharmacy used to be part of the quality assurance framework, but now that it's not it doesn't mean that that stops. So, that is the target for pharmacists to see patients and see if every medication is appropriately prescribed, and whether that patient needs that medication anymore. So, if it can be taken away, then it will be, if it's appropriate.

[264] **Nick Ramsay:** And are the patients fully involved in the prescribing and deprescribing process? What could be done to improve that?

[265] **Ms Smeethe:** That's one of the prudent healthcare aims, isn't it, as co-production. It needs to be an agreement between whoever is consulting with that patient, and to be aware of what that patient would like to do.

[266] **Dr Edwards:** Yes. That's the conversation between the professional—the GP or the pharmacist—and the patient, really. That's where it should be, explaining the risks and benefits, and it needs to be an individual decision. Deprescribing is something we're certainly getting into. There's been a lot more education within the last few years. We have tools to look at this. We're looking in terms of educating GP trainees. There are various tools. STOPP/START we use, but there are there different ways of doing this. It tends to be an individual—rather than mass education—decision with the patient and practitioner.

[267] **Ms Smeethe:** I think community pharmacies can get involved in it as well.

[268] **Dr Edwards:** Yes. The MUR is an opportunity, isn't it?

[269] **Nick Ramsay:** Good. Vikki Howells, did you have any further questions?

[270] **Vikki Howells:** No, I'm okay.

[271] **Nick Ramsay:** No. Okay, I think that's it then. We've ended the session in good time. Can I thank our witnesses, Alan Walters, Alun Edwards and Eryl Smeethe for being with us today? That's been really helpful. We'll send you a copy of the transcript for today before it's finalised, to check. Thank you. And, with that, we'll take a short break of 15 minutes or so.

Gohiriwyd y cyfarfod rhwng 15:30 a 15:46.
The meeting adjourned between 15:30 and 15:46.

Rheoli Meddyginiaethau: Sesiwn Dystiolaeth—Llywodraeth Cymru
Medicines Management: Evidence Session—Welsh Government

[272] **Nick Ramsay:** Can I welcome our Members back, and also welcome our witnesses to this afternoon's meeting? Would you like to give your names and positions for our Record of Proceedings?

[273] **Professor Jones:** I'm Chris Jones, deputy chief medical officer.

[274] **Mr Evans:** And I'm Andrew Evans, the chief pharmaceutical officer.

[275] **Nick Ramsay:** Great. Can I welcome you to the meeting here today? I believe that Professor Jean White, the chief nursing officer, was also due to be with us, but she's unable to attend as she is as at the Russian federation of nurses' annual congress—impressive. I understand that if there is a nursing-specific question that she would like to answer, then she will give a written response to us at a later date.

[276] Okay, can I kick off with the first question? What is being done at a national level to quantify, understand and reduce medicines wastage?

[277] **Mr Evans:** Shall I start?

[278] **Nick Ramsay**: Andrew.

[279] **Mr Evans**: Okay. Can I start, Chair, by saying that we absolutely recognise that releasing medicines waste is a potential opportunity to improve the efficiency across NHS Wales. However, we would want to point out to committee that it is certainly the case that not all waste is avoidable, and the causes of waste, particularly around medicines, whilst they are often a concern for professionals and the public, are incredibly complex and not easy to resolve. In fact, they're not terribly easy to evaluate or measure either. In terms of quantifying waste, we rely heavily on work that was undertaken by the York Health Economics Consortium and University College London School of Pharmacy, which undertook a very robust piece of work to look at the scale of medicines waste in primary care, and came up with an estimate of around £1 of waste for every £25 of medicines expenditure, but then drew some conclusions around how much of that was actually likely to be recoverable, and found that probably only around half of that was economically recoverable and still there would be a cost associated with recovering that. So, whilst there's a large problem with waste, we're faced with—. Sorry, whilst there is a large volume of waste, we're faced with a situation where the reasons for that waste are often unavoidable, difficult to understand, and, actually, as a proportion of the overall health service budget, they may represent a relatively small proportion of what is spent, not only on medicines, but the health service overall.

[280] In terms of what is being done, we have very clear expectations on health professionals and the NHS in Wales that they must be doing all they can to reduce waste. However, given the complexity of the nature of waste, the approaches need to be sensitive to those different causes, and therefore we rather expected it is with health professionals themselves and with the NHS to look for opportunities to reduce waste, rather than us prescribing particular activities they must participate in.

[281] **Nick Ramsay**: Good. Chris Jones, did you have anything to add?

[282] **Professor Jones**: I think, if I may, I'd quite like to try to cast it in a wider context, because I think we would prefer to consider the issue of medicines waste as one of medicines adherence. If medicines are being wasted, why is it that they're being prescribed, and people are not taking them? Surely we would prefer, in a sense, the prescription to be entirely appropriate and highly effective, that the patient would fully understand why this tablet had been prescribed, and was fully committed to its purpose and

its cause and the commitment to taking it. And, in a sense, through those consequences, presumably, of shared decision making, we would expect our medicines waste to decrease.

[283] I think that we are increasingly, in policy terms, emphasising the importance of shared decision making, of a changing role for doctors in the doctor-patient consultation, to become more of a supporter, educator, facilitator, mentor, with the patient being the person who makes their own decisions, depending upon how they feel about how they want to be treated, and what sort of outcomes they want to achieve. So, that is, in a way, a central plank of our prudence healthcare commitment. Interestingly, medicines was one of the three areas of focus in the prudent healthcare plan that we published about two years ago, called 'Securing Health and Well-being for Future Generations', and shared decision making is absolutely central.

[284] I think, if I may make one more point, in very general terms, we probably need to step back a little bit from slavish commitment to evidence-based medicine. I think we've learnt in recent years, from very large randomised control trials, about the population benefits of giving drugs at scale to populations. And, in a sense, that's made us want to give drugs at scale to populations to deliver those benefits. But I think we've also realised that that has to be tempered with the individual nature of every consultation, and that, actually, there's no point in prescribing drugs if the patient doesn't fully understand why, and if they're not committed to taking them themselves. So, I think that the evidence-based medicine is powerful evidence that informs those discussions, but, in the end, they have to be more individualised than perhaps we've considered to be necessary in the past.

[285] **Nick Ramsay:** Thanks. Rhianon Passmore.

[286] **Rhianon Passmore:** Thank you. In an era of deepening austerity, what can be done to persuade patients not to stockpile medicine?

[287] **Mr Evans:** I think that's a very good question. The stockpiling of medicines is something that, anecdotally, we will often receive reports of. I listened to some of the doctors who were here in the sessions previously, who, again, gave their anecdotes of turning up to home visits and finding stocks of medicine stored in people's cabinets. I think we need to look at what might be causing people to stockpile medicines. So, as Dr Jones said,

we're working on an assumption that medicines are prescribed for people in good faith—they're there to treat someone's condition, or ameliorate their symptoms; they're not prescribed with the sense that they're going to be stockpiled or wasted in any way. Regrettably, stockpiling results, however, where people don't take their medicines as we had intended, and therefore are left with quantities that we would have thought would have been used up by the time they ordered their next repeat prescription.

[288] So, if I use inhalers as an example, in good faith, an inhaler will be prescribed for a period that we assume will last 30 days; a patient won't use it in the way that it is prescribed, and that means that it will carry on beyond that 30 days. They'll order another one, and, over time, that generates the risk that medicines will stock up. If that's one of the causes of stockpiling, then our approach will have to be to help patients understand how to use their medicines effectively, so that they're using them more in the way that we'd intended when they were prescribed, but also encouraging patients to not reorder medicines when they're not needed. So, where patients know that they might be on a 28-day cycle with a repeat prescription, if they know they've still got one inhaler left in the cabinet, then what are we doing to encourage patients not to order that inhaler? And that's a discussion between the patient and the people who are supporting them in ordering their prescriptions—whether it's the GP or the community pharmacy.

[289] **Rhianon Passmore:** So, in regard to that duality of approach, which everyone seems to accept is a good way forward and a good direction of travel, do you see, as some have stated this morning, that there may be potential for a perverse incentive around pharmacy prescription, if there is a cost attached to that, in terms of a quantitative contract, or is that purely unevaluated?

[290] **Mr Evans:** I think it's a common perception. So, the arrangements we have with community pharmacies—very simply, reward them for dispensing more items than dispensing fewer items. So, they get paid on an items of service basis. Therefore, if they dispense one extra prescription, that comes with one extra fee. So, you could argue there is an incentive for them to do that. We've put some controls in place. So, since 2015-16, the total amount of funding for community pharmacy in Wales has been a global sum. That means that where the number of prescriptions has increased, the amount of funding available hasn't necessarily increased to accommodate that increase in growth. So, in effect, we're cutting the cake into more slices, so there is less incentive for community pharmacy as a sector to go out and increase

volume.

[291] I also think there's a professional argument against the nature of perverse incentives. The vast majority of community pharmacists will be employees. Only around a third of the pharmacies are owned by what we would term as independent contractors, and even then, they will largely be utilising employee pharmacists, rather than being the owners themselves. So, there isn't really a financial incentive for the people in the pharmacy to grow volume.

[292] **Rhianon Passmore:** I'm slightly confused by that, in terms of you said that there is a small incentive. So, is there any incentive or not?

[293] **Mr Evans:** So, there is an incentive for the pharmacy—. In some respects, there is an incentive for the pharmacy, to the bottom line of the pharmacy. If I dispense more prescriptions than my counterpart, I will receive a bigger slice of the cake than they will. However, the cake is of a fixed size, so the opportunity for doing that is limited. And, actually—I'm just playing out the arguments; I'm not saying one way or the other whether I can objectively say the incentive drives behaviour. What I'm saying is that the perception is the incentive. But, in reality, several factors would lead us to conclude that it—. Why would there be an incentive for an individual who is paid on a salary basis to increase the number of prescriptions they dispense when that's more workload for them with less return on it?

[294] **Rhianon Passmore:** So, in terms of evaluating that, you have studied this in terms of being evidential in your response, rather than anecdotal?

[295] **Mr Evans:** No, I couldn't say that. I think this is largely me just describing the situation as it stands to you. I don't think there is a strong piece of evidence that leads us to believe pharmacy would necessarily drive prescription volume. It's hard to see in some respects how pharmacy would. If you take the case of inhalers, those prescriptions are ordered by patients, they are signed by general practitioners and, eventually, they are dispensed by pharmacies. There isn't really a mechanism for them to generate excessive numbers of prescriptions that they can then dispense.

[296] **Rhianon Passmore:** So, in your view, there is no incentive for that to occur. I'm trying to build a picture in my mind.

[297] **Mr Evans:** I'm saying I'm unaware of evidence either way that proves

the various actors in the system result in incentivisation of one behaviour or not.

[298] **Rhianon Passmore:** So, perhaps it's important to ascertain if that is the case or not.

[299] **Mr Evans:** Yes, I think there's an argument for us understanding to what extent pharmacists are able to influence prescribing volumes and whether those incentives actually play out.

[300] **Rhianon Passmore:** I think so. Okay, thank you.

[301] **Nick Ramsay:** Vikki Howells.

[302] **Vikki Howells:** Thank you, Chair. I, like many other Assembly Members, have been privileged to go and see the Choose Pharmacy scheme in my constituency, and there are obviously great benefits to that. But how much scope is there across Wales to reduce demand on GPs by extending the role of pharmacists?

[303] **Mr Evans:** There are pharmacists working in different settings. So, if we take your example of the Choose Pharmacy scheme, that's a way of utilising community pharmacists to reduce the workload on general practice. There are various pieces of evidence. There's a systematic review that looks at the amount of minor ailment workload that's undertaken in general practice, and that estimates that around 18 per cent of general practice activity could be transferred to a pharmacy. There are varying estimates. So, the Proprietary Association of Great Britain places that estimate higher, but other studies have suggested that it's lower. The evidence we're seeing from Choose Pharmacy, and particularly from the common ailment service element of the Choose Pharmacy application, is that now well over 1,000 consultations are taking place in pharmacies across Wales every month under that scheme, and a high proportion of people who use that scheme report that had they not done so, they would have otherwise visited their general practitioner.

[304] I know that, earlier today, you were talking to clusters. There's also the opportunity to engage pharmacists in a very different way, and that's by using them directly in general practice. I think that's been an incredibly important innovation for us here in Wales. The appetite amongst clusters has been insatiable in some respects. We've seen a real drive for increasing the

number of pharmacists there.

16:00

[305] There is a limited amount of evidence coming out of clusters that suggests employing pharmacists—so, this is based on work in one cluster in Bridgend—for every one hour of clinical pharmacist time you employ in a practice you can save around 25 minutes of general practitioner time. The trend is that that's increasing as the competence of those pharmacists increases over time.

[306] **Vikki Howells:** Thank you. And what are the barriers to actually achieving this extended role for pharmacists? Is there an issue around recruitment and training of pharmacists, for example?

[307] **Mr Evans:** I don't think there's an issue around recruitment, or at least not in the sense of recruiting to clusters. Since 2010—so, between 2010 and September of this year—there has been a 28.3 per cent increase in the pharmacist workforce in NHS Wales. If my colleagues from secondary came here to talk about it, they'd tell you their headcount for pharmacists has probably gone down in that time. So, all that growth has gone into primary care and general practice. That's further evidenced by the majority of that 28 per cent increase, around 20 per cent, being since September 2015, which coincides with the publication of the Welsh Government's primary care workforce plan, which advocated putting pharmacists into general practice.

[308] So, there's certainly no difficulty in recruiting pharmacists to work in general practice. Whether that has knock-on effects for other parts of the system is something I think we could discuss. I think there certainly has been some degree of drawing from secondary care to fill those roles, and that's forcing or encouraging our health boards and our chief pharmacists in health boards to be more creative in the way they deliver services, utilising pharmacy technicians in new ways, but also encouraging pharmacists out of community pharmacy into secondary care and more clinical roles as well.

[309] There have been some wider recruitment issues, but certainly not into the advanced roles, and we're seeing that similarly with pharmacists in NHS 111. So, we've seen a great increase in the number of pharmacists who are working in that setting. That generally doesn't have a recruitment issue, because those pharmacists are working additional hours, out of hours. So, they're holding down day jobs as well as working for NHS 111.

[310] There are then—. So, if we go beyond the recruitment issues, there are some issues around training and competency talked about. We've done a great deal of work to look at the competence of pharmacists who are going to work in primary care. The Wales Centre for Pharmacy Professional Education, which is the postgraduate education provider for pharmacists in Wales, have done some work around orientating pharmacists in general practice, giving them a baseline understanding of what's going on in general practice, so that they hit the ground at least with an understanding of the complexity of that environment.

[311] We're doing work with the professional body to understand what the competencies of general practice pharmacists look like. We don't necessarily have a training programme that they follow, but I think having a competence framework recognises that different individuals might take different routes to becoming competent. So, assuming everyone has to sit a taught course to become competent is a rather, as I understand it in educational terms, old way of thinking about it. We're trying to be more creative and saying there is a place for postgraduate taught education, but, equally, people might do this through shadowing or experiential learning and various other aspects.

[312] We're also addressing that through preregistration training. So, increasingly, we're taking pharmacists after their undergraduate course, putting them into preregistration training years in Wales, where they are exposed to primary care practice, so they have an understanding before they register of what those roles entail and are therefore more able to adapt to them should they go into them post registration.

[313] **Vikki Howells:** So, there's clearly a range of different ways in which pharmacists are supported and trained to fill these roles, but to what extent are we seeing good practice in individual health boards and how can that be joined up so that good practice can be shared across Wales?

[314] **Mr Evans:** A couple of things I'd draw your attention to: the first is an annual event we run each year—I say 'we', the All Wales Therapeutics and Toxicology Centre, who are part of the All Wales Medicines Strategy Group, run a good-practice day every year. They ran theirs recently to coincide with the fifteenth year anniversary of the All Wales Medicines Strategy Group where they pulled together examples of good practice and asked people to present and showcase what they're doing so that can be taken away and promulgated.

[315] Perhaps more interestingly, some work that was commissioned around 18 months ago—the research has concluded but the work is ongoing—is work that's been done with the 1000 Lives Plus service improvements team with the Wales Centre for Pharmacy Professional Education and Cardiff University, the school of medical and dental research there, have been looking at developing a community of practice model for practice-based pharmacists, where they come together three or four times during the year, share their experiences and share what they are doing. On the sides of those meetings, they might run specific workshops around building their capability or understanding around particular topics, so they can go away and translate good practice from one part of Wales in their own practices when they take them back to another part of Wales. The research that has been undertaken—funded by the Health Foundation but undertaken by Cardiff University—and will be published shortly has been very clear that the community of practice model has helped support pharmacists working in general practice.

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

[317] **Rhianon Passmore:** Thank you. In regard to this emergent field, in a sense, and the professionalisation around it, I don't know what other European or wider research Welsh Government has done around a wider framework of competencies that goes further than a competency framework for community pharmacists. Bearing in mind the increasing thrust strategically around more and more usage of them, and the sense that goes with that, it's obviously very important there is huge confidence in the public that this is effective in terms of meeting their needs. So, what research has been done outside of Wales around putting in place a more holistic training framework? There's lots going on, from what I can understand, but there are those out there now, on the ground, that seem to have a mixed response from our witnesses today in terms of how those community cluster pharmacists are actually being moderated and evaluated. So, I don't know if you have any comment to make around that.

[318] **Mr Evans:** I think, as a body, we need to clarify that the role of pharmacists in general practice is not necessarily new. So, in 1996, there was a report by the Nuffield Foundation that looked at advocating the role of pharmacists working in general practice. In the 1990s, associated with GP fundholding, there was a significant increase in pharmacists working in general practice. Back in 2002, I first worked in a general practice. So, it is not necessarily a new phenomenon, but what we have seen is a scale in the

last couple of years that has meant the numbers working in those roles have significantly increased. When you stretch your resource in a very short space of time to fill a large number of places, then it's inevitable that the competence of individuals taking up those roles will be very varied. I think there's a point that there's a need to support those individuals. I think one way we're doing that, as I described, is through the competence framework, allowing people to understand what would be expected of them when they go into those roles. So, rather than people going in blind and then finding they're not able to do it, we are explaining very clearly what it is people should be able to do. The work with the Wales Centre for Pharmacy Professional Education is very much about providing a foundation and understanding for people going into the roles so they can understand it before they take up emerging positions. Then, there's also a role on the practices themselves. So, practices are teams, and there's a need for people going into any new job to be afforded the sort of induction—

[319] **Rhianon Passmore:** Through the Chair, what I'm asking you succinctly, then, is: is that enough? Because there seems to be variety in the moderation in terms of what we've heard today, and I don't know whether that's typical or atypical across Wales. Is all that enough, bearing in mind that the scale—as you've already acknowledged—is unprecedented in Wales?

[320] **Mr Evans:** I think it's very close to being as much as we could do, short of taking all those pharmacists and teaching them a particular way of doing things, which itself would have been resource intensive and, as I said earlier, doesn't necessarily reflect the way people can go about gaining the necessary experience or skills to take up those roles. If you create a large number of roles—and I suspect we're talking about 100 over the last two years—with the best will in the world and all the training behind it, there is going to be a variation in the ability and competence of those 100 individuals, and I'm not sure you could have controlled for that. The approach we're taking is to ensure that individuals are supported by people who really understand the role. So, I think the other thing we need to reflect on is the fact that these are new roles, they are developing in different ways, and there aren't necessarily a group of individuals, as good as they might be, who could sit round and tell people what they need to know for roles that are developing at the rate at which they are developing. So, there isn't necessarily a field of experts who could have said, 'The thing you need to know before going into this role is a, b and c.' The reality is this is being developed more iteratively than that and the community of practice model and the response we're getting from the postgraduate education provider is

much more about recognising the changing practice and responding to it than trying to teach people a rather prescriptive way of doing this job.

[321] **Rhianon Passmore:** So, finally from me on this particular point, in terms of what you've told me, it sounds innovative. We're doing a lot of things in different ways, flexibly. So, my question still remains: is that in any sense ad hoc? Should there be any universality around that approach, moving forward?

[322] **Mr Evans:** I think there is some—. So, the competence framework we provide provides a degree of consistency around that. There's consistency around job descriptions, there's regular contact between the chief pharmacists and health boards, to whom these people are generally professionally accountable. So, there's a high degree of understanding of what's going on, and, whilst there may be pharmacists working in general practice who are taking on different projects or particular nuances in the work they're doing, actually, we could bring it together under six or seven very common themes. So, work that might appear disparate actually isn't that dissimilar, although the topic might be dissimilar from one area to another.

[323] **Rhianon Passmore:** Okay. Thank you, Chair.

[324] **Nick Ramsay:** Can I ask you: what's the Welsh Government's position on the prescribing of medicines that are available to buy over the counter? Who wants to take that? Andrew? You're in the hot seat again.

[325] **Mr Evans:** Well, the decision to prescribe or not to prescribe is a matter for clinicians and not for Government. Our position is that it can be appropriate for over-the-counter medicines to be prescribed, and we must remember that over-the-counter medicines are over-the-counter medicines for a good reason. That is, they are safe and effective to make available to the public without a health professional being required to intervene or supervise that sale or prescribe for those patients. It's a complex area. So, patients, in my experience, tend not to present at general practice demanding a particular medicine. They tend to present with a series of symptoms, for which a medicine will be appropriate. Sometimes, that will be an over-the-counter medicine, as opposed to one that is prescribed, but the patient or the prescriber won't necessarily know that until after the patient has presented in the practice. There's also a cost implication, so, whilst some medicines are relatively inexpensive, others are not so. Others might be

particularly expensive. If you think about treatments for head lice, for example, if you were treating a family, then that could actually be a significant cost, particularly for people on lower incomes, where it would represent a significant proportion of their household income.

[326] **Nick Ramsay:** Did you want to come in, Chris?

[327] **Professor Jones:** Well, I think—. We were discussing the situation with paracetamol, for instance, before we came in, and we were reflecting on the fact that paracetamol prescribing would be most prevalent in either children or in the very elderly. If you consider both groups, then the cost is potentially much more than it appears. So, for children, children would generally need some liquid preparation of paracetamol, and that doesn't cost peanuts, and actually can be quite expensive. For the very elderly, who may have arthritic pain, paracetamol prescribed at two tablets four times a day would mean they would have to go to buy their 32 tablets seven or eight times during every month, which, again, is quite a personal cost, because there is a limit to the number of paracetamol tablets you can buy. So, I think, taking the case of paracetamol, it's not quite as straightforward as it seems.

[328] **Nick Ramsay:** Not as cut and dried as it seems.

[329] **Professor Jones:** No, and, though standard paracetamol is very cheap, it would be very hard to say that that over-the-counter medicine can't be prescribed but the others can. And where would you draw the line? I think the feeling is that, often, when you look for alternatives to these rather simple agents, you're looking at more expensive prescribed drugs anyway.

[330] **Nick Ramsay:** That's been the problem, hasn't it, where you draw the line so that, okay, people are encouraged, where they can, to go and buy their paracetamol at the supermarket, but, at the same time, those who really do need to be at the doctor's and get the free prescriptions are able to get them.

[331] **Mr Evans:** Absolutely, and there could be wider system costs. So, if we continue the paracetamol example, if we were to drive people to say they could no longer go to their GP for paracetamol, they might then present and be treated with opiate-based painkillers or nonsteroidal anti-inflammatory drugs, all of which are associated with side effects. Nonsteroidal anti-inflammatory drugs are highly associated with hospital-related admissions. You might actually be driving other costs in the system in your attempt to

drive them out in one particular area.

16:15

[332] **Professor Jones:** If I could offer a couple of facts that I've put in my briefing here: between 2007 and 2016, the increase in paracetamol prescribing in Wales was 17 per cent, whereas in England it was 38 per cent. Also, at the same time, the decrease in prescribing of cough preparations in Wales was 65 per cent, while in England it was just 52 per cent. So, it does appear that, actually, we are being quite prudent about these prescriptions, despite the lack of a Government ban on their prescription.

[333] **Mr Evans**: Yes, and we heard evidence earlier from the doctors who presented first to you this afternoon about the position around hay fever. We were able to look at that information. Between 2011 and 2016, the increase in antihistamine prescribing in Wales was 20 per cent, and in England it was about 24 per cent. So, a perception that doctors in England simply don't prescribe for hay fever is not one that we would recognise from the data.

[334] **Nick Ramsay:** Maybe there's been more of a focus on it in recent—. Because of the different regime here, maybe there's been a requirement to try and monitor and keep down the statistics. Interesting.

[335] **Neil Hamilton:** If I could follow up—[*Inaudible*.]

[336] **Nick Ramsay:** I was going to ask one more in terms of consistency of rules regarding prescription of over-the-counter medicines. Do you think there's a consistency across the board in Wales, or is there good practice in some areas that could be spread into other areas?

[337] **Mr Evans:** Given the position we've taken in respect of over-the-counter prescribing being a decision for individual clinicians, I think it's hard to say that rules are either well adhered to or not well adhered to. They really are individual decisions that should be made on a case-by-case basis by prescribers with patients.

[338] **Nick Ramsay:** That's fine.

[339] **Rhianon Passmore:** On this particular point—

[340] **Nick Ramsay:** On this particular subject. Then I'll bring Neil Hamilton

in. Rhianon.

[341] **Rhianon Passmore:** We heard from Aneurin Bevan health board that they have managed to 'save', in their words, £1 million in terms of their approach to management of inhaler prescription. Now, I'm not sure if you're in any position to comment on that, but in terms of the wider point, when we have the pockets of best practice in terms of your positions and wider across Wales, what are we doing to disseminate that? Because like diabetes and heart disease, asthmatic and respiratory diseases, as you very well know, are a huge issue for us in Wales.

[342] **Professor Jones:** In fact, I do happen to know that that is part of a national approach: that we have a respiratory health implementation plan and a national respiratory health implementation group. The national clinical lead for respiratory health issues is Dr Simon Barry, who is based in Cardiff, and he is, I know, passionate about improving the quality of inhaler therapy and the cost-effectiveness of inhaler treatments as well, to produce substantial savings across Wales, some of which could then be reinvested back into respiratory services. So, I think what you have is an excellent example, but I actually think it's being delivered across Wales.

[343] **Rhianon Passmore:** Okay, thank you.

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

[345] **Neil Hamilton:** Just to go back to the cost of over-the-counter prescriptions and so on, some of these things—. Dispersible aspirin, for example, is almost universally provided now, certainly in cases of hypertension and so on. I don't know whether there is a significant difference in the price that the NHS pays for these drugs, which are no longer patent protected, compared with the over-the-counter medicines. It seems to me, with the massive purchasing power of the NHS, you should be able to get an even better deal than the over-the-counter price. The price that was quoted by one of our earlier witnesses was 16p for whatever quantity it is of paracetamol that you can buy in the chemist's shop. So, what scope is there within the medicines budget for the NHS to do better deals with the drug companies, particularly for these mass medication products, such as those that Professor Jones started off by mentioning?

[346] **Mr Evans:** I'll use some examples and then I'll explain a little bit about how costs are controlled within NHS pricing. I looked up the price of 32

paracetamol tablets in a large, well-known supermarket before coming in, and 32 in this supermarket were costing 60p. The price the NHS pays for 32 tablets is listed as 64p, but we take a discount off that, depending on the activity of pharmacy contractors, so the prices are comparable. To go back to hay fever, cetirizine, a commonly prescribed antihistamine: 30 tablets of that has an NHS price of 70p, whereas the lowest price I could find it in an online supermarket was £2.50 for the same quantity of tablets. So I don't think this perception of, 'The NHS is paying a higher price for its medicines than supermarkets are' is necessarily borne out by the evidence. I'm not able to comment on supermarket pricing strategies, but they have different levers and incentives in the system that sometimes mean—not necessarily in this case—they will sell things at a loss because of the wider benefits it has for their business. So, it's hard to make direct comparisons. What we have in terms of medicines pricing across the UK are system-wide controls. So, we tend not to apply controls at individual product level. What we apply is a control on the amount of profit that pharmacy contractors are able to make from purchasing medicines. That means that whilst on occasion a pharmacy might get paid a certain amount for dispensing a medicine, and that might look higher than the price you might be able to buy that in a retail environment for, it all contains a strictly controlled level of profit that means were they being paid too much for that medicine, it will be being clawed back out of the system somewhere else. So other medicines would be paid at a lower rate. It's very difficult when you look at individual medicines to apply that to a system-wide control on medicines pricing, which is delivered both from a cap on pharmacy profit, from strong competition in the generic medicines market and close monitoring of that by UK Government. And also, in the case of branded medicines, there's something called the pharmaceutical price regulatory scheme, which I won't go into the detail of, but in effect, it caps the total spend the NHS in the UK has on branded medicines. So in the system, there are rather tight controls on medicine prices.

[347] **Neil Hamilton**: Thank you very much. It's obviously very complicated.

[348] **Professor Jones**: Could I also make the, I suppose, slightly obvious wider health economic point about the example you raised, which is that aspirin is prescribed because of its evidence base in preventing cardiovascular events, which clearly cost us a great deal of money when they occur? So, the issue, in a way, is whether one just allows that population benefit to be delivered as and when people choose to buy their aspirin or not, or whether actually having it on the prescription encourages them to

take it on a more consistent basis, because the cost to the system of just leaving it to individuals may be much greater than the cost difference in the drug.

[349] **Neil Hamilton**: Yes, I understand that point. I'd like to move on now to a question of local formularies and whether there is anything that the NHS and Welsh Government can do to support health boards to develop local formularies. Is there more scope here for containing costs within the medicines budget through local formularies?

[350] **Mr Evans**: I think the evidence you've heard already today is that, generally, compliance with formularies is thought to be very good. It's something that's very difficult for us to measure nationally, so we can't necessarily say why a GP might be prescribing a particular item and whether that's in line with their formulary or not. If I give you one example of how we might measure this at a global level, if we look at the prescribing of statins drugs for high cholesterol, then until 2015-16 I think it was, in Wales, we had a national indicator that looked at the proportion of statin prescriptions that were for what we call low-acquisition-cost statins, so the ones we preferred versus the very expensive ones that might also have been available. That indicator was retired in 2015-16 because national compliance was around 95 per cent with that indicator, which I think is a fair degree of flexibility for people to use medicines that in this case aren't necessarily excluded from formularies, but may be less favoured in formularies. So, our evidence, subjective as it might be, is that formularies compliance is actually very good and there are good systems in place to support that. Just on the specifics, the all-Wales medicines strategy group provides advice for health boards on how to operate their formularies and what to include, and in particular, the appraisals that are undertaken by the all-Wales medicine strategy group must be included in local formularies because health boards are directed to provide those medicines by Ministers.

[351] **Neil Hamilton**: So as far as you're aware, there's no great variation between health board areas at a local level.

[352] **Mr Evans**: Not particularly; not that I'm aware of.

[353] **Professor Jones**: All drugs, as Andrew said, that are approved by NICE or AWMSG would be expected to be on the formulary. I think we have in recent times seen some variation in different geographical formularies when there have been emergent drugs hitting the market, and actually a lot of

work has been going on that you'll be very well aware of to try to unify those processes and speed them up as well, so that actually there is not a difference depending upon where you live in Wales. My recollection about the adherence to formularies from when I was a hospital cardiologist was that you had to go through quite a process to prescribe anything that wasn't on the formulary, and that would be entirely right, because what you expect to find on a formulary is effective and cost-effective, and so I think it was quite tightly controlled and I think the controls in primary care are probably even tighter.

[354] **Neil Hamilton**: You probably heard me read out the response we got from one surgery when we had our outreach sessions about the shared care protocols, where we were told that there are not the same incentives to consider the cost of medication in hospitals and, therefore, when patients are discharged, questions may arise if the GP wants to change the medication and then the patient will wonder why there's a difference between the consultant's advice and the GP's advice. Do you recognise this as a potential problem of any scale?

[355] **Mr Evans**: Yes, I do recognise it. Whether I recognise it as being something that's current, I'm not sure is the case. It certainly is something that would have happened historically when we had a less integrated health system, so, when trusts were perhaps trying to push costs to health boards and playing the system. In some respect, in an integrated system it really doesn't matter. If the medicine's appropriate for the patient, the cost is being picked up by the health service, regardless of whether it's prescribed by a GP or a secondary care doctor. The important thing is that it's an appropriate choice of medication for that patient.

[356] **Neil Hamilton**: Your experience as a cardiologist in a hospital as well would incline you to agree with that—that that cost is not ignored, shall we say, in the prescription in hospital.

[357] **Professor Jones**: No, and in my latter years as a cardiologist in Bridgend, I was the clinical director of medicine and I appointed a pharmacist on to my management group and we wanted to improve the quality of prescribing. We recognised that also would bring savings too. So, I think actually there's great awareness, and that was before health boards were formed in the integrated way Andrew describes.

[358] **Neil Hamilton**: Can you tell me if the Welsh Government does have a

role in standardising shared care protocols across Wales?

[359] **Mr Evans**: I don't think it's a Welsh Government role to standardise shared care protocols across Wales. There is work under the auspices of the all-Wales medicines strategy group to look at improving consistency. It's something I think the service could work on, and AWMSG have already provided some guidance for health boards on a more consistent approach to dealing with shared care. I think there does need to be some reflection of local circumstances in shared care protocols. So, treatment pathways may be different from one area to another and that might necessitate slight differences in shared care protocols. But on the whole, their format should be relatively consistent and the way in which they're produced should be consistent, and AWMSG are doing a very good job in driving that.

[360] **Neil Hamilton**: For the uninitiated like me, can you perhaps explain what you mean when you say that local care pathways might vary geographically? What's the implication of this?

[361] **Professor Jones**: I think my understanding would be that, for a minority of drugs, they may be very effective drugs, but they may have a relatively low therapeutic margin, so, that there may be more need to look out for side effects on a proactive basis, so there may be some monitoring requirements. I'm thinking of drugs like methotrexate, which is very effective for some forms of arthritis. You would use other simple measures first, but some patients would benefit greatly from that, but that requires monitoring. And sometimes, the interpretation of the monitoring results will need some specialist opinion. Another drug in my past practice would be amiodarone, which was a heart rhythm stabilising drug that had a lot of side effects, but it was fine if you could look out for them and anticipate them and stop the drug as soon as they started. So, I think these are agreements about how you monitor the efficacy—well, it's more the side effects of drugs—and then how you work together as a single clinical community should there be any change in any of these monitoring criteria. And I would expect hospital doctors to be there in support of primary care doctors who are doing this prescribing. I would hope it wouldn't mean the patient continually bouncing between clinics. I would hope that actually some of that could happen over the telephone or through specialist nurse support, but it would be a much easier thing to achieve collectively in an integrated health board than perhaps in two separate organisations.

[362] **Neil Hamilton**: Thank you very much.

[363] **Nick Ramsay:** Great. Rhianon Passmore, did you have a supplementary?

[364] **Rhianon Passmore:** Yes. With regard to the Royal College of General Practitioners' statement that the interface between primary and secondary care—following on from what you've just said—presents with a high number of clinical errors, or is an area of risk, what more needs to be done around medicine management within that interface in order to be able to improve that risk level?

16:30

[365] **Mr Evans:** Transfers of care, whether that's from secondary care to primary care or primary to secondary, or even within primary care, are well understood as being potential sources of risk around medicines. We know that when people are admitted to hospital and then discharged, it is highly likely that their medicines will have been changed. There's a high proportion of medicines that will be discontinued or a new medicine started, and there's a risk that isn't effectively communicated to prescribers in primary care. In Wales, I think we're making very good progress with addressing the problems at the interface through our electronic approach to sharing information.

[366] So, across five of our health boards now, we have something called the medicines transcribing and e-discharge system rolling out. It's almost ubiquitously available in Cardiff and Vale. It's very widely available in Betsi Cadwaladr and Cwm Taf, and it's starting to roll out in Hywel Dda and Powys as well. That provides for an electronic record of a patient's medicines and the summary of their admission to be shared with their GP within 24 hours of their discharge from hospital, and for that information to be taken into the GP record and actioned appropriately. That's giving us a very positive impact on sharing information at the interface.

[367] Our two other health boards, Abertawe Bro Morgannwg University Local Health Board and Aneurin Bevan have pre-existing systems, which is why they're perhaps lower down the list of priorities for MTeD roll-out, but they will also be taking the MTeD system, which integrates fully with general practice systems to allow sharing of information after discharges.

[368] Then, in Wales, we're also taking the increasingly recognised step of

sharing that information with community pharmacists, so we don't have a situation where patients are presenting to collect their prescriptions from a community pharmacy with their medicines having been changed during a hospital admission and their pharmacist, who dispenses the medicines, not knowing about that. So, we've got various controls within the system that are being facilitated by our approach to IT. Just to give you a sense of it, in September, I understand there were just over 9,000 electronic discharge letters shared with GPs across the five health boards I mentioned earlier through the MTeD system, and the number is increasing significantly. So, we've seen a more than doubling in Cardiff and Vale in the number of discharges sent electronically in the last 12 months, an increase of 50 per cent in Cwm Taf and, again, an increase of more than double in Betsi Cadwaladr health board—

[369] **Rhianon Passmore**: So, when do you anticipate that we will reach the end game when it is actually all rolled out across Wales?

[370] **Mr Evans**: I'm sorry, I don't know the answer to that, but I'd be happy to go back and talk to colleagues in the NHS Wales Informatics Service and ask them to provide you with—

[371] **Rhianon Passmore**: Yes, please.

[372] **Mr Evans**: —some degree of assurance around that plan.

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

[374] **Nick Ramsay**: That would be great, yes. And last but not least, Vikki Howells.

[375] **Vikki Howells**: Thank you, Chair. A related question really, then, about how much progress is being made in joining up the information systems between primary and secondary care.

[376] **Mr Evans**: Just to build on my last response, I think the systems in Wales are exceptional. The Professional Record Standards Body, which is a UK organisation looking at quality and the impact of information sharing, have recognised the work that's going on in Wales around information sharing—whether that's MTeD, sharing information from secondary care back to primary care, or whether it's access to the Welsh GP record for clinicians, pharmacists, pharmacy technicians and others in secondary care when

patients are admitted. We're making excellent progress in that regard, and I expect us to go further, particularly with the sharing of information with community pharmacists, which we hope to be able to expand upon shortly.

[377] **Vikki Howells:** Thank you.

[378] **Nick Ramsay:** Great, thank you. Can I thank our witnesses, Andrew Evans and Chris Jones, for being with us today? That's been really helpful. We'll send you a transcript of today's meeting for you to check before it's finalised. Thanks; it's been really helpful.

16:34

Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o'r Cyfarfod ar gyfer Eitem 8 a'r Cyfarfod ar 23 Hydref 2017
Motion under Standing Order 17.42 to Resolve to Exclude the Public from the meeting for Item 8 and the Meeting on 23 October 2017

Cynnig:	*Motion:*
bod y pwyllgor yn penderfynu gwahardd y cyhoedd o weddill y cyfarfod a'r cyfarfod ar 23 Hydref yn unol â Rheol Sefydlog 17.42(vi).	*that the committee resolves to exclude the public from the remainder of the meeting and the meeting on 23 October in accordance with Standing Order 17.42(vi).*

Cynigiwyd y cynnig.
Motion moved.

[379] **Nick Ramsay:** Okay. Can I move Standing Order 17.42 to go into private session for item 8 of today's meeting and for the next meeting?

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 16:34.
The public part of the meeting ended at 16:34.