



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

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

**Dydd Mercher, 24 Medi 2014
Wednesday, 24 September 2014**

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Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir trawsgrifiad o'r cyfieithu ar y pryd.

The proceedings are reported in the language in which they were spoken in the committee. In addition, a transcription of the simultaneous interpretation is included.

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

Alun Davies	Llafur Labour
Janet Finch-Saunders	Ceidwadwyr Cymreig Welsh Conservatives
John Griffiths	Llafur Labour
Elin Jones	Plaid Cymru The Party of Wales
Darren Millar	Ceidwadwyr Cymreig Welsh Conservatives

Lynne Neagle	Llafur Labour
Gwyn R. Price	Llafur Labour
David Rees	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Lindsay Whittle	Plaid Cymru The Party of Wales
Kirsty Williams	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Mark Drakeford	Aelod Cynulliad, Llafur (Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol) Assembly Member, Labour (The Minister for Health and Social Services)
Andrew Evans	Prif Fferylllydd Iechyd Cyhoeddus Cymru Principal Pharmacist for Public Health Wales
Professor Roger Walker	Prif Swyddog Fferyllol Cymru Chief Pharmaceutical Officer for Wales

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

Amy Clifton	Uwch-swyddog Ymchwil Senior Research Officer
Helen Finlayson	Ail Glerc Second Clerk
Sian Giddins	Dirprwy Glerc Deputy Clerk
Llinos Madeley	Clerc Clerk
Rhys Morgan	Rheolwr Craffu Scrutiny Manager

Dechreuodd y cyfarfod am 09:19.
The meeting began at 09:19.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

[1] **David Rees:** Good morning. I welcome all Members to this morning's session of the Health and Social Care Committee, where we will undertake a review of the Welsh Government's community pharmacy programme and the Government's response to the committee's report back in 2012. I remind Members of some housekeeping business. All mobile phones should be switched off. If you have any devices that interfere with the broadcasting equipment, could you also switch those off? We do not have any scheduled fire alarms today, so if there is an alarm, please follow the directions of the ushers. Headphones can be used for simultaneous translation from Welsh to English on channel 1 and for amplification on channel 0.

09:20

Ymchwiliad Dilynol i Gyfraniad Fferylliaeth Gymunedol i Wasanaethau Iechyd
Follow-up Inquiry on the Contribution of Community Pharmacy to Health
Services

[2] **David Rees:** I welcome the Minister, Mark Drakeford, to this session. Minister, could you introduce your officials for us?

[3] **The Minister for Health and Social Services (Mark Drakeford):** Thank you, Chair. With me is Professor Roger Walker, who is the Chief Pharmaceutical Officer for the Welsh Government, and Andrew Evans, who is the principal pharmacist in the Welsh Government.

[4] **David Rees:** Thank you, good morning and welcome to the committee. We will go into questions straight away, because we are aware of the timescales that we must work to. Gwyn, you have the first question.

[5] **Gwyn R. Price:** Good morning everybody. In the context of publicising pharmacy services, Minister, you recently visited Mayberry Pharmacy in Blackwood with me. I was very impressed with the new robot that we saw that could put tablets into packages for everyday use. I think that that is the way forward. Do you think that that is the way forward? Are you still on target to develop guidance to pharmacies in 2015, as you state in your paper?

[6] **Mark Drakeford:** Thank you, Gwyn, for that question. The visit that we made earlier in the summer to Blackwood was a very instructive one, I thought, because it illustrated very well some of the gains that have been made since the committee's report was published in making it clearer to members of the public the services that are available from community pharmacists. Obviously, community pharmacies are hugely used by the Welsh public—74 million prescriptions are issued in primary care alone and the vast bulk of those are dispensed in community pharmacies. The issue that I think the committee considered last time was the extent to which members of the public now understood that there was a wider range of services available at pharmacies, above and beyond the normal prescribing service. For example, 86% of pharmacies in Wales now display on their premises a list of all of the additional things that that particular pharmacy provides. I am very keen that they do that and that they do it in a prominent way, because I am interested in these things. I look in windows of chemists as I go along and I see more and more pharmacies advertising in the window in a prominent position the fact that, if you go in there, they provide emergency hormonal contraception services, flu vaccination or whatever the service might be. We would like to make that 100%, but 86% is not bad.

[7] We are in discussions with the primary pharmacy community, as Gwyn has said, to allow it to use the Welsh NHS logo. We think that that will emphasise again to the Welsh public that pharmacies are more than just places where prescriptions are dispensed; they are places where you can get this wider range of NHS-type services—the nationally commissioned services. Allowing them, in a universal way, to use the NHS logo and to have the brand of the NHS more prominently displayed will, I hope, take a further step to getting the message across to the Welsh public that you do not always need to go to a GP, but that often a pharmacist will be able to give you very good advice and attend to the issue immediately. There is more that they can do for the future; we are on track to do that, as you ask, by 2015.

[8] **David Rees:** Minister, you have identified that pharmacies are advertising well, but is the advertising also going on in GP practices, so that they are making sure that people are aware that these services are available in pharmacies?

[9] **Mark Drakeford:** I think that it is probably a more variable picture. In the place where we have the Choose Pharmacy pilot schemes going on in Cwm Taf Local Health Board and in Betsi Cadwaladr University Local Health Board areas, then it is a very active offer that GPs themselves make, because they are part of this experiment that includes 26 different conditions, agreed between GPs and pharmacists in Wales through the All Wales Medicines Strategy group. If you phone up one of the participating surgeries and ask for an appointment about your verruca, you are told by the GP, 'You go to the pharmacist for that'. So there is a positive push mechanism from GPs as well as a pull mechanism from pharmacists. I do not think that we could be confident that it is as active as that everywhere, but many, many other GPs who are not part of the Choose Pharmacy scheme do still quite prominently advertise in their surgeries the things that pharmacists are now able to do.

[10] **David Rees:** Janet, do you have a question on this particular topic?

[11] **Janet Finch-Saunders:** Yes, just following on from what the Chair has said. Certainly in my locality, I have spoken to pharmacists who feel that there is so much more they could be doing; they have the wherewithal to do it, but there are very poor lines of communication from hospitals and GP practices. It is not just a case of putting a notice up, saying what you can get if you go to your pharmacists. It is more about actual dialogue and people saying to people—. I know that, with regard to the flu vaccine, for instance, there is some frustration that pharmacists are not carrying out as many of those as they possibly could, and clearly we need to minimise the effects and the burdens on our other health providers. I think, really, that there is some work to be done on lines of communication from GPs and from hospitals, regarding pharmacists.

[12] **Mark Drakeford:** I entirely agree with that. This is a discussion which I remember very well having in the committee when we were doing the original report. So much of the barrier to allowing pharmacists to provide the full potential contribution that they could make is not to do with policy and it is not to do with infrastructure; it is to do with professional boundaries and the need to persuade some professionals in the system to give up turf that they have previously occupied, to allow others to do things that, in the past, only the first group could do.

[13] **Janet Finch-Saunders:** If I could just come back to you on that. What is your immediate strategy on that? This has been going on for a couple of years now, this inquiry. What is your priority with regard to this now?

[14] **Mark Drakeford:** Well, there are a series of ways in which we have tried to push the discussions further forward. There are some powerful organisations on our side in all of this: the Royal Pharmaceutical Society, the Royal College of General Practitioners. Last year, the Welsh NHS Confederation held meetings bringing the different players together to try to broker some agreements around this. This year, I hope that one of the ways in which we will push that agenda further forward again is through the 64 GP clusters that we now have in Wales. Some Members here will recall that we had a major renegotiation of the GP contract in Wales last year. We took a lot of points out of the quality and outcomes framework, which GPs told us were bureaucratic and just, sort of, handle-turning. We have put those QOF points into a new requirement on GP practices to participate, four times a year as a minimum, in GP cluster meetings. There are 64 clusters across Wales. They have to produce their cluster plan by the end of this month. I am saying to people I meet that I expect pharmacy interests to be represented in those cluster meetings and in that plan, so that we can get those conversations going at the local level where we need to make some of this break through.

[15] There are other things; sometimes you have to try to take an opportunity out of things that are challenging. There are some places in Wales where GP recruitment is a genuinely difficult issue. I think that we are finding GPs more willing to agree to participation in

primary care services by the wider primary care team than they were in the days when recruiting GPs themselves was easier. I think that, in some ways, they will lead the way in expanding the contribution that pharmacists can make out of necessity, because of the way in which change patterns of recruitment are driving that agenda.

09:30

[16] **David Rees:** I have a question now from Lindsay and then John.

[17] **Lindsay Whittle:** Good morning, Minister. I just want to link quickly into the first question that Gwyn Price asked you about the Paul Mayberry robot scheme. I was privileged to sponsor an event for Mayberry chemists here in July. I think that that helps to reduce waste, on the issue of too many tablets. We have had a report this morning on research by Bradford, South Wales and Cardiff Universities about the valuation of discharge medicines reviews. One of the most important things is that it is designed to support adherence to medication, which I think fits in nicely with the robot system. The report tells us that for every £100,000 invested, we can save a further £300,000 in the long term. I wonder whether you had any plans, maybe invest to save, to put some additional moneys into this sort of field.

[18] **Mark Drakeford:** I am pleased to say to the committee that we had our own independent evaluation of the discharge medicines review scheme already running in Wales. Quite rightly, I think, the Government's position was that, until we had an independent evaluation of what was already going on, we were not prepared to commit to the discharge medicines review scheme in perpetuity. That research was available in the first part of this year. It demonstrates some of the same things that Lindsay has pointed to, in that the independent evaluation shows that the DMR scheme was paying for itself and more than that in the way in which it identified errors—and that, in some ways, is the key thing. The point at which someone comes out of hospital is a pinch point in medication where things can go wrong, because people have prescriptions from the hospital and they have prescriptions from their GP. These things have to be reconciled and the right bundle of medication provided. We know that things can go wrong at that point. The evaluation showed that the scheme in Wales was very good at identifying places where things had gone wrong and putting them right quickly. As a result, we announced, back in April, that we were going to make the discharge medicines review scheme a permanent part of the funded landscape here in Wales. So, in some ways, we are already well down the path of the research that has been published today, because this is now an embedded part of the way in which we will do things in Wales. I hope that, now that pharmacists know that they have certainty about it and know that they will go on getting paid for the work they do in this area, they will step up their own investment in it, and we will see more of these reviews being carried out in Wales from now on.

[19] **Lindsay Whittle:** I have just a quick follow-up to that. Two of the major barriers are that patients are unaware of this service and many pharmacists are saying that they are also unaware of the discharge information, and so we need to link those. If the health boards could link the pharmacies with the hospitals, then we are onto a winner, are we not?

[20] **Mark Drakeford:** Sure. We are using money from the health technologies fund this year, £2.23 million, to improve connectivity between primary and secondary care in dentistry, optometry and pharmacy. The top priority for that is what we call the medicines transcribing and e-discharge project. It is an NHS Wales Informatics Service project, and it is designed to make sure that, when someone is discharged from hospital, provided that the patient agrees, there will be an electronic transfer of the necessary information direct to the pharmacy. Patients have to agree and they have to nominate the pharmacy. At the moment, it is all paper. You are given a letter and you are told, 'Take this to your pharmacy'. Some people do, and quite a lot of people do not. If it is done automatically and electronically, then it will arrive at the pharmacist. If we get it right, an automatic alert will go off at the pharmacy's end to let

them know that the information has arrived. So, it will not be a matter of their having to go and check whether the letter has arrived when someone comes in, as they will know. They will have had an alert to tell them that the information is there. The information flow issue is crucial to getting it right.

[21] **Darren Millar:** On this particular issue, one of the concerns that the National Pharmacy Association has raised is that the allocation of resource for the discharge medicines reviews has not been fully utilised. It suggested that just about 10% of the resource has been utilised, which seems very disappointing and quite disheartening, given the positive impact that discharge medicines reviews can have on patients and indeed, the wider NHS. Can you tell us why community pharmacies are having to deliver these sorts of services, and why hospital pharmacists themselves should not be reviewing the medicines that patients have before they are discharged, so that we can get this right at source, rather than a week or two weeks later, by which time complications could have arisen?

[22] **Mark Drakeford:** I might ask Professor Walker just to say something on it, but actually, I think that community pharmacy is the right place for these things to be done, because they have the person there in front of them, actually in the community, at the point at which they are using the medication that has been provided to them, by which time, they might already have visited their GP on discharge. The community pharmacy is the best point in the system at which to reconcile all the different bits of it, because you have the person and everything that you need in front of you to do it. We should not believe that hospital pharmacies are not doing that in any case; they are, and they are much further down the road in terms of robotic and electronic ways of dispensing. However, we need a further safety net in the system, and community pharmacy is the right place for that to happen.

[23] **Professor Walker:** If I may say so, Chairman, this is a service that we introduced two and a half or three years ago, and I came to the committee the last time the paper was discussed, and it was merely a glimmer in our eyes at that point in time, as the service had just been introduced. This has proved a positive, a first, for Wales and NHS Wales. It resolves what has been an internationally recognised problem. When patients undergo the transition between different organisations, typically hospital and the community, there are problems with conveying the information about their medication. What we have managed to do within NHS Wales is get good communication between hospital pharmacy and community pharmacy. Yes, hospital pharmacy does its part of the work by ensuring that the correct prescription is issued when somebody leaves hospital, and by conveying that information to the community pharmacy and GP, but then, there is the issue for GPs as to whether that information is received in a timely way and whether they can actually change the repeat record of that individual before they issue the next prescription. So, it is the problem of the patient leaving hospital and having their first prescription issued after they have been in hospital.

[24] From the data that we have, the evaluation looked at over 14,000 of these discharge medication reviews and 80% of them had a discrepancy in them. There were many problems identified, eight were classed as life-threatening and 39% of them could potentially have resulted in a readmission to hospital had they not been addressed by the community pharmacy. So, there is a lot more that we can do with this service, but it provides a really good safeguard, which we have not had in the past, in actually ensuring that patients continue on the correct and prescribed medication that was intended when they left hospital.

[25] **Darren Millar:** So, what you are suggesting is that this scheme, effectively, addresses GP cock-ups in prescribing. So, why are you not using the resource, which is underutilised—90% of the £3.6 million—to ensure that there is proper prescribing by GPs that is not complicating matters for patients and making them more poorly rather than actually getting them better?

[26] **Mark Drakeford:** It is an utterly crude simplification to put it in the way that the Member just has. It just does not represent the position at all. What we want to see is more of these reviews done. We funded the system so that every pharmacist could carry out 140 of them. Not all of them, by any means, do that. Why is that? Well, I think that the best explanation is that, until pharmacists were confident that we were going to make this a permanently funded part of the landscape, some of them were reluctant to invest in providing that service. They do not provide it out of thin air; they have to find time, they have to find expertise, they have to invest in training, they have to get people involved, and, in the future they will have to invest in the electronic transfer of information. While we, as Government, were saying that, until we had the evidence to demonstrate that this was a worthwhile continued investment, we were not prepared to make that commitment. Now that we have, and pharmacists know that they will definitely get the remuneration for the work that they do, I think that we will see a very sharp up-swing in the number of discharge medicines reviews carried out, and that will be a very good thing.

[27] **Darren Millar:** I am not knocking the service. I welcome the service. I think that it is absolutely the right thing to do in terms of preventing further hospitalisation, which can be avoided. What I am asking you, though, is this. If there is a problem at source in terms of GP prescribing, why are we not also addressing that problem, which appears to be one of the things that the DMRs are trying to address? Should there be a greater emphasis from these resources, which are under-utilised at present, in order to address that particular problem at source?

[28] **Professor Walker:** I think that it is an oversimplification to identify that it is the prescriber that is making a mistake, because sometimes the information is not delivered to the prescriber in a timely manner. The fact is that the information goes into a practice, and the need for a repeat prescription from a patient arises before the record has been changed and this sort of compounds the problem at times, but if the pharmacist is in a position where he has the same information as the GP, it does provide a safeguard.

[29] On the issue with the moneys, the moneys go to the health board and stay within the health board. They have also been used to fund the influenza vaccination service. We have not put new moneys in for pharmacies to deliver that service, so the moneys are used for that service. Clearly, the moneys are there for the health boards to use in other ways that they feel appropriate. This is one service for which we now have the evidence, and which we really think should be increased in its delivery across all health boards. That is something that we will be keeping a close eye on in the future.

[30] **David Rees:** Kirsty, do you wish to come in on this particular point?

[31] **Kirsty Williams:** It is about information sharing. One of the key recommendations in the committee report last time was that, if the goal that we all aspire to is to be achieved, pharmacies need to have much more access to patient records. On the IT investment that you have just talked about, is that in support of general pharmaceutical access to patient records? When would you believe that pharmacists would have access to a summary of a patient's healthcare notes, so that if someone was just going in for the minor ailments scheme, they would have an idea of what long-term medication that person would be on, and a more complete picture, so that they could advise more readily?

[32] **Mark Drakeford:** Andrew will be better placed to give the specific detail, but I think that the landscape this year has been that the Choose Pharmacy scheme itself made a step forward in the sharing of information electronically—between pharmacists in this case. Now, the next step is to make sure that the flow of information between pharmacists, the hospital and the GP comes next. Andrew will have some milestones on what we hope to achieve.

[33] **Mr Evans:** Absolutely. By the end of 2014-15, so the end of March 2015, we will have in place a proof-of-concept model that allows us to share hospital discharge information with community pharmacies. That is, broadly speaking, the same information that a GP would see following a discharge from hospital about a patient's medications when they leave hospital, but also those that have been changed or stopped during their admission. As Roger said, that is critical to the delivery of the DMR service. The way in which that project is being developed means that the infrastructure that supports that transfer of information also allows, in future, the sharing of information with other parts of the NHS. In terms of specific milestones, I think that, technologically, we could put markers down to say when that would happen, but we know that the barriers to that—and this committee pointed this out previously—are not always technological; they are about the relationships between individual professional groups, and so the work on that is still ongoing to deliver.

[34] **Kirsty Williams:** So, if it is technologically possible to do so, and your work to persuade people to participate proves not to move at a pace that is satisfactory to you, what can the Welsh Government do to compel people to participate in information sharing?

09:45

[35] **Mark Drakeford:** Actually, we do not have powers of compulsion very easily to hand, nor do I think that the evidence is good to show that compulsion is a productive way of trying to change people's minds and things. We rely on persuasion and we rely on using all the different strands that we have in the system to persuade professional groups to deliver on the ground the principles that they are generally signed up to. If you had representatives of the various bodies in front of you now, very few of them would argue against the propositions that Kirsty has just been putting on the table. It is just that when you come to actually delivering it on the ground, you get professional tensions and things that need to be resolved. So, we rely on using professional mechanisms, putting pressure into the system and doing everything we can to make it as easy as possible for these things to happen, so that people cannot hide behind claims that technology and equipment and things like that mean that they cannot do these things, and then you get a gradual shift in culture in the direction that you want. It is not often as fast as we would like, but it is probably more sustainable than if you just order people to do things that they resist doing, and then they retreat into resistance and find all sorts of other ways to subvert what it is that you have instructed them to do.

[36] **John Griffiths:** I have two matters to raise, if I may, Chair. The inverse healthcare law continues to be a major challenge for us and we need to ensure better delivery of health services in all our communities. I think that community pharmacists have quite a good reach in terms of their location across Wales, so they offer opportunity in terms of meeting those challenges. We have been talking about the services that community pharmacists provide themselves, but I am aware of some pharmacists that also have other health professionals providing services from their treatment rooms. I wonder whether anything is being done by Welsh Government to encourage that sort of co-location and joint provision of services. I know that some of the community pharmacy chains in particular have quite a lot of energy and ideas around this agenda, which is quite promising, so it would be good to know what Welsh Government is doing to encourage and facilitate that.

[37] The other matter, Chair, is a matter—

[38] **David Rees:** One question at a time—

[39] **John Griffiths:** Okay.

[40] **David Rees:** I will come back to you. I will let you ask that second question, so do

not worry about that.

[41] **Mark Drakeford:** I absolutely agree with what John has said and what I know the committee has said in the past about the fact that community pharmacies are still to be found, in very good numbers, in communities where other public services have been in retreat. So, the inverse care law is that services are weak where needs are greatest, but community pharmacy is the opposite: community pharmacy is strongest where needs are greatest. We have always believed this of community pharmacy in Wales and it has been said here, I know. The *BMJ* published a major research paper earlier this year that actually put a whole lot of numbers around this and demonstrated exactly what we have been saying here about the pattern of community pharmacy being the opposite of the inverse care law. Therefore, it is even more important to us in disadvantaged communities and in rural communities as well, because community pharmacies are strong in rural Wales as well, that we make maximum use of them.

[42] The public health White Paper, Members will be aware, has a whole chapter in it on our wish to move to a new form of pharmaceutical needs assessment. That is about us having greater levers in the system to encourage those community pharmacies that provide this wider range of services. At the moment, if you want to enter the market as a pharmacist, our rulebook essentially looks to see whether there is another dispensing pharmacist within a certain distance of where you want to set up. So, if the dispensing service is good enough nearby, you are likely to be turned down as a new entrant. There is nothing we can do very much to say to people who are basically providing a dispensing service, and not providing all these other things, that we want them to do more.

[43] The pharmaceutical needs assessment will change the rulebook in a number of different ways, but these two are key. First, if you are a new entrant and you can show not just that you will be providing a dispensing service, but that you will be providing that longer list of things, including involving other health professionals in what you do, then you are much more likely to be given a licence to enter that locality. It also provides local health boards with new powers to say to existing pharmacists, 'If you don't want to provide these services, we will find somebody else who is willing to provide them'. We will always offer the person on the ground the first refusal, and if they are willing to do it, that will be great, because it will have increased the range of services provided, but if they are not interested in doing it, health boards will be able to go out and seek people who are willing to provide it and do exactly the sorts of things, John, that you are referring to.

[44] **David Rees:** John, again, on the same question.

[45] **John Griffiths:** Yes, the other item, Chair, is around the relationship between community pharmacists and GP practices. I have come across a number of issues around repeat prescriptions, where repeat prescriptions have not been available—the medication has not been available for collection when it should have been. It very often comes down to the community pharmacists blaming the GP practice, and the GP practice blaming the community pharmacist. It has caused a lot of problems for people in terms of anxiety and it affects their wellbeing, as well as possible problems because the medication is not available when it should be. I wonder if that is a problem that is recognised and, if so, whether much can be done about it in terms of identifying where the problem lies and resolving it.

[46] **Mark Drakeford:** In the grand scheme of things, in the millions and millions of prescriptions that are dispensed, I do not think that it is a systemic problem at all. There are certainly individual instances where things go missing, things are not communicated and so on. I will ask Roger whether there is any evidence of this being a general problem and, if not, where it is a specific problem, what we are able to do to help resolve it.

[47] **Professor Walker:** I am not aware that it is a systemic problem, but, clearly, where professionals come into conflict with each other or make challenges to each other's profession, there may be problems. What we do know is that where GPs and pharmacists work together well, there is something tangible about it—their communication is good, the information flow is good, and it helps patient safety—and that is what we want to deliver within every practice. However, you then think, 'Well, we've got 715 community pharmacists and slightly fewer GP practices and between individuals, from time to time, there are going to be tensions in certain areas'. I am not aware that this is a large-scale problem. There are sometimes issues about medicine shortages—I understate that, because there are frequently issues with medicine shortages where pharmacists end up being on the front line. The medicine shortages—we also end up dealing with the questions and issues around them—are often due to manufacturing and supply problems and out of the control of the individual pharmacy and pharmacist, but they take a lot of criticism on the front line if a medicine is not available. So, I think that that has been the cause of the problem in the recent past. We could have a long discussion about why there are medicine shortages, but that, I guess, is not the agenda for today's meeting. In part, it is influenced by the strength of the pound and where the medicines are exported by larger companies, other than community pharmacies.

[48] **David Rees:** Thank you for that.

[49] **Elin Jones:** Mae'r cwestiwn cyntaf yn ymwneud â'r ffaith ei fod yn gyfnod y flwyddyn ar gyfer y brechiad fflw eto ac, yn ei dystiolaeth, mae Fferylliaeth Gymunedol Cymru wedi mynegi siom nad oedd Llywodraeth Cymru wedi ymgymryd ag ymgyrch hysbysebu a hyrwyddo'r brechiad fflw llynedd ar lefel mor fawr ag y mae wedi gwneud yn y gorffennol. Felly, roedd y pwyllgor yn awyddus i weld fferyllfeydd yn chwarae mwy o rôl wrth ddarparu'r brechiad. Beth yw eich cynlluniau chi ar gyfer eleni o ran hyrwyddo pwysigrwydd y brechiad hwn i'r grwpiau sydd ei angen?

Elin Jones: The first question is to do with the fact that it is the time of the year for the flu vaccination once again, and, in its evidence, Community Pharmacy Wales has expressed disappointment that the Welsh Government did not carry out a promotional campaign for the flu vaccine last year on such a large scale as it had in the past. So, the committee was eager to see pharmacies playing more of a role in providing the vaccination. What are your plans for this year in terms of promoting the importance of this vaccination for those groups who need it?

[50] Yn gyflym, yn ail, hoffwn ofyn ichi ein diweddaru ynglŷn â'r argymhelliad a rhoesom y byddai gwasanaeth cyflyrau cronig cenedlaethol o fudd petai'n cael ei ddatblygu yng Nghymru. O'r hyn rwyf wedi ei weld o'r dystiolaeth sydd wedi dod ar gyfer ein cyfarfod heddiw, nid yw'n ymddangos bod lot fawr o gynnydd wedi ei wneud o ran datblygu'r gwasanaeth hwn.

Very quickly, secondly, I would like to ask you to give us an update on the recommendation that we put forward that a national chronic conditions service would be of benefit were it to be developed in Wales. From what I have seen of the evidence that has been provided for our meeting today, it does not appear that a great deal of progress has been made in developing that service.

[51] **Mark Drakeford:** Diolch yn fawr, Elin. Rydym wedi gweld twf eithaf cryf a chyflym yn y gwaith y mae'r fferyllfeydd yn gallu ei wneud ym maes fflw. Yn y flwyddyn gyntaf, roedd 18 o fferyllfeydd yn rhoi'r flu vaccination, ac roedd bit 1,600 o bobl wedi derbyn y gwasanaeth newydd. Yn yr ail flwyddyn, roedd nifer y fferyllfeydd a gymerodd rhan wedi cynyddu i 195 ac roedd nifer y bobl a dderbyniodd y gwasanaeth

Mark Drakeford: Thank you very much, Elin. We have seen relatively strong and swift growth in the work that pharmacies are able to do in terms of flu vaccination. In the first year, 18 pharmacies were providing flu vaccinations, and around 1,600 people had accessed that new service. In the second year, the number of pharmacies participating in the scheme had increased to 195 and the number of people who had received the vaccination

wedi cynyddu i 7,851. Felly, roedd cynnydd digon cyflym rhwng un flwyddyn a'r nesaf. Roedd 27% o fferyllfeydd wedi cymryd rhan yn y cynllun y llynedd. Rydym wedi dweud wrth y byrddau iechyd ein bod ni am iddynt sicrhau bod mwy na chwarter o'i fferyllfeydd yn cynnig y gwasanaeth yn y flwyddyn hon ac i drio codi'r nifer hyd yn oed yn uwch na hynny.

[52] Rydym wedi dweud trwy'r amser nad pwrpas gwasanaeth gan y fferyllfeydd ym maes fflw oedd gwneud yr hyn y mae GPs yn ei wneud yn barod, ond helpu i lenwi'r bwlch rhwng nifer y bobl sydd yn derbyn y gwasanaeth a nifer y bobl yr hoffwn iddynt dderbyn y gwasanaeth. Roedd rhyw chwarter o'r bobl a dderbyniodd y gwasanaeth mewn fferyllfeydd yng Nghymru y llynedd heb dderbyn y gwasanaeth o gwbl cyn hynny. Felly, mae tystiolaeth yn dod mas i ddangos, drwy weithio gyda'r fferyllfeydd, gallwn lwyddo i gael pobl nad ydynt wedi derbyn y gwasanaeth o gwbl o'r blaen i'w dderbyn yn awr. Felly, y cynllun yw trio adeiladu ar y llwyddiant rydym wedi ei gael yn barod ac i wneud mwy dros y flwyddyn nesaf. Ar yr un pryd, rydym am gadw'r GPs i gyd gyda ni a dangos iddynt nad yw'r hyn rydym yn ei wneud yn y maes hwn yn mynd i achosi problemau mawr iddyn nhw o ran y gwaith maen nhw yn ei wneud.

had increased to 7,851. Therefore, the growth was relatively swift between one year and the next. Some 27% of pharmacies participated in the scheme last year. We have told the health boards that we want them to ensure that more than a quarter of pharmacies provide these services this year and then try to develop that and increase the number even further in future.

We have said consistently that the purpose of pharmacies providing flu services is not to do what the GPs are doing already, but to assist in bridging the gap between the number of people who receive the service and those whom we want to receive the service. Around a quarter of the people who received services in pharmacies in Wales last year were people who had not had any service at all previously. Therefore, evidence is emerging that demonstrates that, by working through our pharmacies, we can succeed in ensuring that people who have had no service in the past do actually receive that service. So, the plan is to try to build upon the successes that we have already had and to do more in the next year. Simultaneously, we want to ensure that all of the GPs remain on side and show them that what we are doing in this area is not going to cause major problems for them in the work that they are undertaking.

[53] Turning to the second question, the development of an identified chronic conditions service in community pharmacies is not in the top part of our agenda at the moment. We are very busy in the pharmacy world, with the Choose Pharmacy experiments, with the continued development of nationally set services and with the work that we are doing through the public health Bill. So, we have a very busy agenda here. While we do not have a specified chronic conditions service in pharmacies, we have two of the three ingredients of the Scottish scheme already happening in Wales. Let us look at what it provides. It has a medicines use review component. In our medicines use reviews, we require community pharmacists to carry out 50% as a minimum of the medicine use reviews on four conditions, two of which are major chronic conditions. So, two of the four involve the prescription of respiratory drugs and the prescription of drugs for hypertension. So, through the medicines use review, we have one of the three components that they have in Scotland. The second component in Scotland is a repeat prescribing dimension, and we have that in Wales.

10:00

[54] The component that we do not have yet—and I think I read some of the evidence that the committee has had for this part of its work—is that, in Scotland, they have a patient registration scheme to underpin it. We do not yet have that in Wales. Part of the reason we do not have it is that it is pretty controversial out there in the community pharmacy and pharmacy world. So, while we do not have an identified service as such, Elin, I think that, when you look under it, we actually have already quite a lot of the activity that, in other

places, is badged as a chronic conditions service.

[55] **David Rees:** Can we focus on the first question? Are there any more questions on flu vaccinations? Okay. I see that there are not.

[56] **Elin Jones:** Just on the chronic conditions plan or service, you did accept that recommendation—I think that you were the Minister at the time, were you not?

[57] **Mark Drakeford:** No.

[58] **David Rees:** No. He was Chair of the committee at the time—

[59] **Elin Jones:** I know that you were the Chair, but I thought that it was one of those situations where you were the Chair and then, by the time the response came—

[60] **Mark Drakeford:** No, not this one.

[61] **Elin Jones:** Not this one. Okay. So, the Minister at the time, in the Welsh Government, accepted that recommendation. Just to be clear, your view now is that it is not a priority to work towards a nationally identified chronic conditions service for pharmacies.

[62] **Mark Drakeford:** Put it like this, Chair, arguments that were accepted as to why pharmacists could do more to contribute to the management of chronic conditions are definitely still accepted. Whether we want to go about it by making as a priority the specific identification of a chronic conditions scheme, I think that that is not where we are at the moment, although most of the components, other than that one major one, that you would need are already there and are happening. We just do not badge it up in that way.

[63] **Elin Jones:** Okay, that is clear.

[64] **David Rees:** Minister, recommendation 3 highlights the issue of capitation payments. In your evidence, you support that concept, but Community Pharmacy Wales has expressed concern about that issue. Can you identify why you are supporting that process still and how you will address those concerns?

[65] **Mark Drakeford:** The Welsh Government's position is not to move to a universal patient registration system, partly because, as the evidence you have had suggests, that would have a very destabilising effect on quite a lot of community pharmacies. Also, there are some important arguments about the extent to which that might restrict patient choice in the community pharmacy that someone might wish to use. Where we are moving forward on it, though, is in that, if you want to have a minor ailments scheme, like Choose Pharmacy, you have to have people sign up to use it, because, otherwise, the system cannot be made to work. By the end of this month, I think that we will have 1,500 people signed up to the scheme in the 32 pharmacies that we are using for it and about 2,000 consultations will have been carried out under it. So, if you want a chronic conditions management scheme of the Scottish sort, you need it to be underpinned by a patient registration system. I am in favour of patient registration systems for specific purposes where, in order to make that service work, you need to know that you have the person in front of you to whom the information you are using relates and that that information is accurate and relevant. Do I think that, in order to use a pharmacist in Wales you ought to be registered with the pharmacy that you use and restrict your use of pharmacy services in that way? I do not think that we are in that position.

[66] **Lynne Neagle:** May I ask about information sharing, Mark? That was a key theme when we did the initial inquiry—the difficulties that pharmacists encountered in getting GPs and others to share information, especially electronically. Are you able to provide an update

on progress in that area?

[67] **Mark Drakeford:** I think that I have touched on some aspects of that already this morning. It is essentially a cultural and inter-professional matter rather than a matter of technology. The NHS Wales Informatics System always says to me that it can make the information flow around the system, if that is what it was asked to do. There would be work to do to make it happen, but it is not a technological problem; the problem is getting professional agreement between different players as to what can be shared with whom. We are not making as rapid progress on it as we would have wanted to make a couple of years ago when we were talking about the issue in this committee, but we have taken some steps forward through the efforts of the profession itself, by us making the electronic side of things happen and by breaking new ground in the Choose Pharmacy service arena, where we have brokered agreement around the formulary and the information that flows with that. The next big steps are the ones that Andrew outlined earlier.

[68] The tide is flowing in only one direction on this right across the NHS in Wales. Health professionals generally have a job of work to do to catch up to where members of the public already are in their attitude to information sharing on the one hand, and their ability to share information themselves on the other through devices that they have in their pocket that are small enough to carry around with them all the time.

[69] My summary of it is that progress is not as fast as we would like it to be, but there is only one direction of travel in this, and it is the one that we would like it to be.

[70] **David Rees:** Just for clarification in my own mind, is the situation such that the information that we are talking about, which is e-data going across, is currently going across between hospital discharge and the GP practice, or are we talking about simply an extension to community pharmacy, or are we talking about developing a system for both?

[71] **Professor Walker:** We are looking to improve the flow of information from hospitals to community pharmacy, but we are also looking to put a system in place whereby GPs can access information on activity undertaken in a community pharmacy. This is through the Choose Pharmacy scheme whereby an individual patient goes in and receives medication, the GP can see that information should they want to. Equally, we would like to move to a position of being able to access the medication part of the patient record as well, to help the pharmacist make more informed clinical decisions about the treatment that a patient requires.

[72] **Mark Drakeford:** The flow of information between GPs and hospitals is already far further down the track in terms of electronic flows. Over half the tests that are ordered by GPs in Wales today are ordered online, and they receive all the information back electronically as well. There are health boards in Wales where the discharge letter that the GP would traditionally have got through the post or by hand flows to them over the electronic network already. So, pharmacy, in a way, is trying to be part of a wider picture where others have already made greater progress.

[73] **David Rees:** I just wanted to clarify that. Thank you for that. Darren is next.

[74] **Darren Millar:** I want to touch on smoking cessation services, if that is okay. Your paper suggests that there has been limited progress on agreeing a single specification for smoking cessation services through pharmacies in Wales. We heard during the evidence that we received when you were Chair of this committee that some excellent pilots had taken place, particularly in north Wales, on smoking cessation. Given that we have seen some positive results from the pilots, why is there limited progress on this and why cannot we see more of a roll-out?

[75] **Mark Drakeford:** Just to put some facts in front of the committee in terms of where we are on smoking cessation services, 317 pharmacies in six health boards today provide level 2 smoking cessation services, and 157 pharmacists across four health boards provide level 3 smoking cessation services. By the end of this year, Hywel Dda and Abertawe Bro Morgannwg, which are the two health boards that do not provide any level 3 services, will be providing level 3 services in parts of their health board area. So, there has been a considerable move in this direction.

[76] Getting a national specification for smoking cessation services has been more difficult than it has been in some other health boards, partly because some health boards had already begun to do the work themselves in their own way. So, you are trying to bring back into a national specification work that has already started in many different places, but, by 2015—the beginning of next year—we are confident that we will have a national specification. So, everybody who provides smoking cessation services through community pharmacies in Wales will get the qualifications they need in order to be able to provide that service in the same way. They all have to do the same course provided by the same provider. So, that is an asset to us in having a national specification because they are all already participating in a common way of doing these things. As I say, we are making good progress in getting services on the ground. We will catch up in getting a national specification around all that activity early next year.

[77] If I could, just for a second, Chair, say to Darren that, to my mind, this is all part of a bigger piece of work that the chief medical officer and the new chief executive of Public Health Wales are doing. We have a national smoking cessation service for Wales provided by Public Health Wales. What it is doing is looking to see whether that service is as successful as we would like it to be and whether there are other services that we can see being provided that can demonstrate a greater level of success in getting us to where we need to be for the tier 1 target of 5% of all people who smoke in Wales accessing smoking cessation services. I have been very impressed by what I have seen in community pharmacies. In north Wales in particular, I have been to a number, which demonstrate, to my mind, very good evidence of what a level 3 service can do in reaching a wider range of people and a group of people who might not find that the Public Health Wales service fits in with the way that they live their lives and the way that they would like to get the help that they need. So, there may be a further way in which we will be able to bolster some of this work as part of that wider review of how we provide smoking cessation services generally in Wales.

[78] **Darren Millar:** May I just ask as a follow up when that review is likely to be completed?

[79] **Mark Drakeford:** I do not have a date immediately in my head. You will know that the chief executive of Public Health Wales took up post in June, so she has spent the summer getting herself familiar with all the different aspects of its work. I spoke to the chief medical officer only a week ago about the work that they were doing jointly, so it is very actively going on. We can get you the date by which they hope to get it to a conclusion, but I do not have it in my head.

[80] **David Rees:** Minister, this morning we heard the announcement that more professionals will be allowed to prescribe in Wales. How do you see this now working with community pharmacies?

[81] **Mark Drakeford:** I do not see the overlap as being huge to be honest. It is part of a wider programme that we have in the Welsh NHS of trying to make greater use of the skills of all the different health professionals that we have, and extending prescribing rights to groups who previously were denied them—physiotherapists, podiatrists and chiropractors in the announcement today. It is part of that wider effort to make sure that all the people who

work in our NHS are able to work at the top of their clinical licence and do the most that they possibly can, and prescribing is an important part of that. We have previously extended prescribing rights to pharmacists, with consultant pharmacists also now possible in the Welsh NHS. So, it is part of the broader picture, but I do not think that there is a direct relationship between podiatrists being able to prescribe in the future in Wales and what we hope community pharmacies will do.

[82] **David Rees:** You just mentioned consultant pharmacists. Do we have any at the moment in Wales?

[83] **Professor Walker:** We have appointed two consultant pharmacists to all-Wales posts at this point in time, and there is a third one under consideration. When I say 'under consideration', there are a number of stages for approving the infrastructure for the post and the individual who may already be in post or may be an external applicant to the post. However, we do have two posts in place now.

[84] **Elin Jones:** When you say 'we', do you mean that separate local health boards have appointed them or are they national posts?

10:15

[85] **Professor Walker:** They are two national posts, but they are hosted in Cardiff and Vale LHB at this point in time. The third post is linked with a hospital in the ABMU LHB area. Last week, I had discussions with a colleague from north Wales about the possibility of establishing posts in that area.

[86] **Elin Jones:** They have a national remit, then, do they, to develop services and oversee—

[87] **Professor Walker:** No, it is one of those quirks of coincidence that the two posts became available because two people retired, and they had all-Wales remits in actual fact. Those posts have now been filled with consultant pharmacists.

[88] **David Rees:** Kirsty, you have the last question.

[89] **Kirsty Williams:** Forgive my ignorance, but what exactly does a consultant pharmacist actually do?

[90] **Professor Walker:** What it allows the pharmacist to do is to pursue a career where they are patient-facing practitioners. They are our leading-edge practitioners working in the service and it prevents them—and I am using the word 'prevent' because we want to stop losing them to management roles; our best pharmacists currently move into management, particularly in the hospital sector, and we want to keep them on the front line. To keep them on the front line, we have established consultant posts to allow them to do that. They will work in the field with other clinicians, who may be pharmacists and people from other professions as well, but they would be working in face-to-face contact with patients on a regular basis. They will be undertaking research as part of their remit and they will undertake teaching as part of their remit as well. So, it really enhances one aspect of the profession that we have not been particularly strong with in the recent past.

[91] **David Rees:** Do any other Members have questions? No. [*Interruption.*] Minister, may I thank you for your evidence this morning, and may I thank the officials also? You will receive a copy of the transcript to check for any factual inaccuracies. Please let us know if there are any. Once again, thank you very much.

10:17

**Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o Weddill
y Cyfarfod**

**Motion under Standing Order 17.42 to Resolve to Exclude the Public from the
Remainder of the Meeting**

[92] **David Rees:** I move that,

*the committee resolves to exclude the public from the remainder of the meeting, in
accordance with Standing Order 17.42(vi) and (ix).*

[93] Are all Members content? Thank you very much. We will go into private session.

*Derbyniwyd y cynnig.
Motion agreed.*

*Daeth rhan gyhoeddus y cyfarfod i ben am 10:17.
The public part of the meeting ended at 10:17.*